2016

Sexual Attraction in the Therapy Room: An Exploration of Licensed Marriage and Family Therapists' Experiences and Training

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Sexual Attraction in the Therapy Room:

An Exploration of Licensed Marriage and Family Therapists' Experiences and Training

by

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A Dissertation Presented
To The College of Arts, Humanities, and Social Sciences
In Partial Fulfillment of the Requirements
For the Degree of Doctor of Philosophy

Nova Southeastern University

2015

Nova Southeastern University

The College of Arts, Humanities, and Social Sciences

This dissertation was submitted by Rafiah H. Prince under the direction of the chair of the dissertation committee listed below. It was submitted to the Graduate School of Humanities and Social Sciences and approved in partial fulfillment of the requirements for the degree of Philosophy in the Department of Marriage and Family Therapy at Nova Southeastern University.

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12/1/15

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Acknowledgments

I would like to start by thanking God for being my guiding light and giving me the strength and courage to complete my Ph.D. There were many obstacles and miracles that occurred during this process that I was able to overcome and embrace with God's help.

Next, I would like to thank my husband, Sheldon, who has been by my side encouraging me to believe in myself, never settle, and pursue my professional goals. In addition, I would like to show gratitude to my two sons, Arthur and Oscar, who were both born during the process of writing my dissertation. I would also like to acknowledge my mother for her hard work and sacrifice in providing me with the strong upbringing and education to be the first in my family to receive a Ph.D. In addition, I would like to thank Denise, my editor and friend, for all of her support.

Lastly, I would like to thank my Chair, Dr. Shelley Green, for her support, wisdom, and feedback during the process. Without her guidance this would have been an impossible task. Moreover, I would like to thank my committee members, Dr. Christine Beliard and Dr. James Hibel, for their helpful suggestions, critiques, edits, and support.

As this chapter of my life comes to an end, I am overjoyed but saddened to say goodbye. Without the professors and staff in Nova Southeastern University's Marriage and Family Therapy program I would not have been able to achieve the professional success that I have thus far or, more importantly, help many individuals and families during their most trying times.

“You never know how strong you are until being strong is your only choice”

- Bob Marley

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Abstract

The client-therapist relationship is an essential part of therapy and is central in helping clients achieve therapeutic goals as the joining process facilitates the change process. However, in an effort to create a space for change, there is a possibility that professional boundaries may become blurred wherein a client may express a sexual attraction toward their therapist. To explore this phenomenon, the researcher employed convergent parallel mixed method design to explore the experiences of Licensed Marriage and Family Therapists (LMFTs) who have experienced sexual attraction from their clients. The study was conducted online through a secure forum. Implications for clients, therapists, and the field of marriage and family therapy are discussed. The research suggests that education and training are critical in assisting therapists when dealing with sexual attraction issues.

CHAPTER I: INTRODUCTION

Background

During my clinical training as a doctoral student at Nova Southeastern University, I was challenged by a case in which a client was sexually attracted to me, testing the boundaries of our therapeutic relationship. The client voiced his attraction in-session, over a five-week period, during which the frequency of those statements steadily increased. His expressions ranged from minor comments to more blatant statements about my clothing and my physical appearance. On one occasion, the client brought in a magazine photo of a woman he found attractive and commented on how I looked like the woman in that magazine photo. He then asked me if I could wear my hair like the woman in the magazine and expressed that he had always been attracted to women who were my physical type.

When the client, a White male in his mid-forties, first came to see me at the university clinic, we had a typical first session. We covered what had brought him to therapy and what he wanted to get out of therapy. The client responded that he wanted to work on issues with his wife and his daughter, sexual issues, drug abuse issues, and his bipolar diagnosis. Toward the end of the first session, the client stopped talking about family issues and changed the subject to comment on how beautiful my skin was—in fact, how beautiful I was. I was shocked by the comment, but I continued talking about the client's presenting problem. As the comments increased, I questioned whether this was a client I would feel comfortable continuing to see, especially if we were going to be talking about sexual issues.

I felt lost. I was not sure how to address the situation. I had received some training in this area, but training did not prepare me for this reality. Anticipating upcoming sessions caused me to feel anxious. I began questioning my choice of outfits and wondering about the effectiveness of the therapy I was providing. These are common feelings experienced by therapists dealing with sexual attraction from clients (Davis, 1994; Harris, 2001; Hobday, Mellman, & Gabbard, 2008; Norris, Gutheil, & Strasburger, 2003; Pope, Holroyd, & Sonne, 1993; Rutter, 1989).

I knew that I would have to review the case in weekly supervision meetings, and I feared it would appear that I could not handle my case or that maybe I was not prepared to see clients on my own. In addition, I had concerns about bringing up the attraction (or his comments about me) to my client, because I felt that the client was testing the boundaries established in therapy and I feared his reaction. According to Norris et al. (2003), a boundary can be defined as an edge of appropriateness in a therapeutic setting. Nevertheless, because boundaries had been crossed, I addressed my perceptions of what was going on in the therapy room with my client. According to Rutter (1989), this would allow the client to see me as a therapist and not as a part of his fantasy world, while letting him know that I was aware of the comments.

I was having a difficult time getting around my client's increasingly direct statements about my appearance and was curious about the genesis of my client's behavior. When reviewing the case with my supervisor, I was encouraged to express how I was feeling in supervision and to continue to address the behavior with the client. When I addressed the client, he confirmed his feelings. I explained and established the boundaries for therapy that would have to be adhered to in order for us to continue

working with each other. The client then revealed other areas in his life where he had been testing boundaries, which included substance abuse, a relationship with a woman outside his marriage, inappropriate comments to women in general, chronic masturbation, and fantasizing about his 14-year-old daughter's friends. What was happening in therapy mirrored challenges he faced in his everyday life. My supervisor suggested a co-therapy session where my supervisor and another female MFT professor would be present with me. When asked, the client agreed to participate in a co-therapy session. Because I addressed the attraction and set up a co-therapy session, I felt confident about my decision to continue seeing the client until he was placed in a residential treatment facility for substance abuse.

Seeking supervision gave me the courage and support I needed to handle the situation with a troubled client. It would have been easy to see my client's comments as sexual harassment because at times they were about my physical appearance and could be construed as sexual in nature. Levenson (2006) points out that "sexual harassment is defined by the United States Equal Employment Opportunity Commission (EEOC) as unwelcome sexual advances, request for sexual favors, and/or other verbal or physical conduct of a sexual nature" (p. 2). When using a systemic lens while working with clients, it is important to understand how a person's behaviors, environment, and relationships are connected. Dismissing this behavior as sexual harassment would have limited the possibility of getting to the core of the client's challenges and addressing my own struggles as a developing therapist.

This case presented many challenges for me personally and in my professional development as a therapist. It can be uncomfortable for females when males make

generalized comments of a sexual nature about females' appearance, and I can only imagine how males feel when women make sexual comments toward them. Every day, women are faced with ongoing challenges that may be presented in the form of construction workers' cat calls or in the form of sexual comments made by co-workers. Men are faced with similar situations, for example when they are sexually seduced by women seeking drinks at bars or who are seeking a higher positions at work. This dynamic is a reflection of the dominant discourse between men and women in many societies.

I was taken aback by some of the comments that my client made, and I would often find myself screaming in my head. It would have been easy to walk out, but I knew that walking out would not help the client and would not help me grow as a therapist. I began to feel an isomorphic struggle that mirrored my client's challenge of being torn between giving up and trying to get help.

As therapists, it is important for us to be helpful to our clients. We do what we can to provide them with the best service, but in cases like this, it is also important to understand that we are not only therapists, but also human beings. This case left me wondering whether I was the only therapist who had encountered a client who openly expressed his or her sexual attraction to the therapist. To my surprise, when speaking and presenting to master's level students and colleagues, it became apparent to me that attraction in the therapy room happens much more often than it is addressed. According to Harris's (2001) research study on marriage and family therapists (MFTs):

> Participants indicated which emotions they believed they would experience if a client expressed an attraction toward them. Although the majority indicated that

> they would feel cautious (85%) and uncomfortable (69%), a large number of participants indicated that they would feel nervous (53%), flattered (48%), self-conscious (46%), respectful (44%), and anxious (44%). A sizeable minority indicated that they would feel embarrassed (22%), vulnerable (18%), and even scared (15%) in this situation. (p. 124)

As therapists, we have a responsibility to our clients to provide a therapeutic setting for growth and self-discovery. Harris (2001) asserts:

> It is the therapist's job to show empathy and to convey a sense of caring for the client. This display of caring builds trust and can engender warm feelings between therapist and clients. It is not hard to imagine that the line between joining in a caring and trustworthy manner borders on the realm of attraction. (p. 128)

Sexual attraction from a client affects the system of therapy and can lead to serious and detrimental boundary violations or boundary crossings if the therapist acts on it (Pope, 1986). A boundary crossing entails behavior that is out of the ordinary, which may be harmless and not necessarily inappropriate. "Examples of crossings include helping a patient who has fallen, giving a patient an emergency taxi fare in a snowstorm, or accepting an invitation to attend a wedding. Neither harm nor exploitation is involved" (Norris et al., 2003, p. 517). An example of an inappropriate crossing would be if a therapist accepted a client's invitation to meet outside the therapy room, knowing the client is attracted to him or her.

According to Norris et al. (2003), a boundary violation is defined as any harmful activity that occurs in the therapeutic setting. The authors go on to explain:

> Examples include having sex or creating a sexualized relationship with a client, exploiting patients to perform menial services for the treater, exploiting patients for money or financial demands beyond the fee, and generally using patients to feed the treater's narcissistic, dependent, pathologic, or sexual needs. (Norris et al., 2003, p. 517)

Pope (1986) points out that these types of boundary violations have a detrimental effect on the field of marriage and family therapy, explaining that "employers, roommates, friends, co-workers, and fellow students—the lives of all can be affected by a patient's or therapist involvement. The ripple effect can touch families, agency, university department, or business" (p. 68). Although Pope (1986) and Norris et al. (2003) do not specifically address clients being sexually attracted to their therapists, they do draw attention to the issue. The authors define boundary violations and crossings and point out their consequences. This is important, because it helps therapists establish guidelines and a contextual framework when dealing with client sexual attraction.

Sexual Attraction in Therapy

Until recently, there has been little attention in the marriage and family therapy field devoted to client sexual attraction (Harris, 2001). Much of the work on sexual attraction has primarily been researched in the field of psychology. According to Pope and Bouhoustsos (1996), Hippocrates set the groundwork for sexual attraction in the therapy room, and Freud developed the theoretical basis. Pope and Bouhoustsos explain Freud's ideas around sexual attraction and therapy, noting:

> In 1915, Freud differentiated the patient's transference as a clinical phenomenon from the nonclinical experience of "falling in love." He emphasized 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 has no reason whatsoever therefore to be proud of such a conquest," and it would be called outside analysis. (p. 29)

Marriage and family therapists have a foundation in the theories proposed by the founding fathers of modern day psychology, but they are also informed by the theories unique to the MFT field, which offer new ways of working with and understanding clients. The fields of psychology and marriage and family therapy do share some similarities, which include providing therapeutic services and interventions, developing therapeutic relationships with clients, and working in common therapy settings. These parallels may allow for MFTs and psychologists to encounter similar situations with clients, such as the occurrence of sexual attraction in the therapy room. The therapy room can be a place where clients are free to share and expose many vulnerable feelings to their therapists. A therapist without proper training and ethics may be vulnerable in certain situations in which boundary crossings and violations can occur. Harris (2001) states:

> Despite this rigor, many therapists have questions about how to conduct themselves clinically. When it comes to sexual attraction we have a responsibility to educate about and even normalize the process of being attracted to another person. At the same time, we need to promote sound ethical, moral, and clinical practices. Helping MFTs discuss the issue of attraction in therapy may prevent some therapist form acting unethically. (p. 127)

Boundary crossings and violations can lead to sexual intimacy, which can be defined as "touching and being touched not only flesh to flesh, but emotionally and spiritually too" (Ogden, 2007, p. 166). Sexual intimacy can also include sexual contact, which can be explained as "intentional touching, either directly or through the clothing" (Douglas, 2000, p. 76).

Researchers have attempted to address the issues of sexual attraction in therapy. For example, Brock and Coufal (1994); Harris (2001); and Nickell, Hecker, Ray, and Bercik (1995) have presented research primarily focused on master's level therapists in a university setting who were attracted to their clients. Brock and Coufal surveyed MFTs in an attempt to understand ethical practices in the field. Their research on ethics underscores the fact that sexual attraction does happen in the therapy room.

Harris (2001) stresses the need for more research in the field on the issue of sexual attraction because of the risk of sexual boundary violations. Harris's study suggests that many MFTs are not exposed to sexual issues and topics like sexual attraction in their training programs. He also states that as a result of this lack of training, MFTs are uncomfortable with sexual attraction, and many may not be handling these types of situations properly when they encounter them.

Nickell et al. (1995) attempted to collect information about ethical practices, beliefs, and training in the MFT field. In their study, they found that therapists are sometimes attracted to their clients. The researchers found that "many therapists do at times experience sexual attraction to clients. Indeed, 100% of male respondents indicated experiencing at least rare or occasional feelings of sexual attraction to clients within the last two years, as did 73% of female respondents. (Nickell et al., 1995, p. 320). The

results of the study further the idea that attraction is possible for both therapists and clients. Accordingly, the researchers stress the importance of macro-planning to handle attraction in the therapy room. They suggest that the macro-planning should include wide-scale training about attraction, supervision from supervisors who are comfortable discussing sexual issues, and adequate ethical guidelines from professional organizations that address attraction (Nickell et al., 1995).

Insufficiencies in Previous Research

Studies on the issue of sexual attraction in therapy have mostly dealt with either therapists' attraction toward their clients (Brock & Coufal, 1994; Nickel et al., 1995) or MFT students and their experiences with sexual attraction in the therapy room (Harris, 2001). The existing research lacks information about the experiences of licensed professional MFTs faced with clients who are openly attracted to them and the steps they can take to ensure the integrity of their clients and the field. According to Nickel et al. (1995), most MFTs do not think that they could find themselves involved in a sexual boundary violation, despite some mention of it during the training process, but research shows that MFTs are sometimes attracted to their clients (Brock & Coufal, 1994; Nickel et al., 1995). Norris et al. (2003) expand on the idea that boundary issues are common and further assert that all therapists are susceptible. They explain: "Next to suicide, boundary problems and sexual misconduct scores highest as the cause of malpractice actions against mental health providers" (Norris et al., 2003, p. 517).

A plethora of research shows that a sexual relationship between a therapist and client is damaging to the therapist, the client, the professional community, and all connecting systems (Gabbard, 1995; Harris, 2001; Norris et al., 2003; Overholser & Fine,

1990; Peterson, 1986; Pope, 1990). While a flirtatious remark from a client may not appear to present a future boundary crossing or violation, it is important to have the tools, ethics, and training to address sexual attraction from clients in therapy.

Purpose of the Study

Research Question

This study focused on the experiences of licensed MFTs who have encountered sexual attraction from a client in the therapy room. The research attempted to bring new understanding to the field of marriage and family therapy regarding the topic of clients' sexual attraction toward therapists. The following questions guided my research:

1. Are licensed MFTs experiencing sexual attraction from clients?
2. How do licensed MFTs handle sexual attraction from clients?
3. Are licensed MFTs being trained to handle clients who are openly attracted to them?
    a. How are licensed MFTs being trained about sexual attraction?
    b. Does continuing education and training on sexual attraction exist?
    c. Are licensed MFTs seeking continual education on this topic?
    d. Are they seeking supervision?
4. What are the commonly held beliefs that licensed MFTs have about sexual attraction in the therapy room?
5. What are the experiences of MFTs who have experienced sexual attraction from clients?
6. Do MFTs experience attraction to their clients?

Summary

In summary, Chapter I introduces the research topic of client sexual attraction in the therapy room. The chapter gives a brief overview of current research addressing the topic of sexual attraction in therapy. Moreover, the chapter also addresses therapists' attractions toward clients and the possibility of boundary crossing and violations. Chapter I proposes a need for research on the experiences of licensed MFTs who have had clients attracted to them. In addition, the chapter justifies a need for research in the area because of the possible risk of boundary violations. Chapter II will offer an in-depth review of the literature on the topic, Chapter III explains the method of research, Chapter IV explains the research findings, and Chapter V reviews the conclusions and implications.

CHAPTER II: REVIEW OF THE LITERATURE

The therapeutic relationship can be the basis for therapeutic change (Becvar & Becvar, 1999; de Shazer, 1982; Flaskas & Perlez, 1996; Hoffman, 1981; Hoyt, 1994; Sanders & Tomm, 1989; Walter & Peller, 2000). Change in therapy is a relational process, and "psychotherapy research has shown that a key factor in therapeutic change across all modalities and schools is the relationship between therapist and client" (Fishbane, 2001, para. 19). When a client interacts with the therapist in a sexual manner, such behavior can have a great impact on the therapeutic relationship. This research not only provides a foundation for examining this topic, but also attempts to discover how MFTs handle sexual attraction from clients and whether they are properly trained to handle the boundary issues that arise when clients demonstrate sexual attraction toward them.

Sexual Attraction in Therapy

When a client is openly attracted to a therapist, the therapeutic relationship can be compromised. This raises the question of whether therapists are being trained to handle clients who are openly attracted to them. If they are trained, what type of training do they receive? If they are not trained, how are they handling sexual attraction from clients out in the community? The present study was aimed at addressing these questions. According to Harris (2001), "A random sample of AAMFT clinical members (n = 189) answered questions about beliefs, attitudes, and practices regarding sexual feelings in therapy. More than one-half (55%) of the respondents reported little or no formal training on the topic" (p. 124). Harris proposes that sexual attraction in the therapy room has been seen as a taboo topic because of discomfort and the fallacy that MFTs are rarely

placed in situations in which sexual attraction from clients can occur. Harris asserts that it is a misconception to think sexual attraction does not occur just because there is more than one person, for example —a family or a couple —in the therapy room. Harris sought research that dealt specifically with MFTs in regard to the training they received for handling sexual attraction from clients and dealing with other boundary issues. This lack of research could be the reason why the topic is understudied or not discussed in the field of MFT. As Harris explains:

> Sexual attraction occurs in therapy, and many therapists feel uncomfortable dealing with it. Considering how harmful a problem sexual attraction could be if it were acted on, it is surprising that more attention has not been dedicated to studying this phenomenon. (p. 124)

Boundaries and Systemic Epistemology

Systemic therapy is concerned with relationships. A systemic therapeutic relationship derives from an epistemology that offers clients care, respect, and an open realm of possibilities. It is "a unifying theory, and as such, represents a paradigm shift in terms of how we understand human behavior. Instead of studying objects and people discretely or in isolation, we now have a means of studying in relationships" (Becvar & Becvar, 1999, p. 6). According to Flemons (2002), when a therapist and a client work together, they form a relationship in which the therapist becomes a part of the client's systems, and they connect in a way that fosters change.

Working from a systemic lens opens the door to many possibilities; anything and everything is possible. Bateson (2000) gives a great example with a piece of chalk. He claims that one piece of chalk has a multitude of potential facts by saying, "And within

the piece of chalk, there is for every molecule an infinite number of difference between its location and locations in which it might have been" (Bateson, 2000, p. 459). It is possible to punctuate the world in any way; "the point is that a world can be discerned in an infinitude of ways depending on the distinction one establishes" (Keeney, 1983, p. 19). As therapists, we enter relationships in which we are not only observing the systems or clients that we work with but also becoming participants within those systems. Once a therapist becomes a participant in the client's system, there has to be an openness that allows the therapist to understand the systemic complexities. As explained by Keeney (1983), "The intertwining systems of therapist and family are like moiré patterns, where two distinct patterns interact to create an autonomous hybrid pattern. It is in this moiré-like system that a therapist cannot consider himself separate from a family" (p. 134). Von Foerster (1984) distinguishes between describing therapy as the study of systems or as an observing system that is not isolated and is, instead, circular and connected. Flemons (2002) strongly believes that the therapist (observer) is a part of the system being observed. He proposes that "crossing the boundary from outsider to insider precludes your viewing clients as other, and accords them the respect necessary for you to work with them" (Flemons, 2002, p. 58).

Anderson (1997) explains that being part of a system as an observer promotes change within that system. When a therapist observes a system, it is important that he or she is able to take a non-judgmental stance and understand the client's experiences in a way that fosters change. Anderson claims that this awareness allows therapists to see beyond prescribed assumptions and pathologies. She asserts that the use of language, the

adoption of a postmodern lens, and the development of a therapeutic relationship built with respect enhance the therapist's participation in the system as an observer.

According to Anderson (1997), when a therapist acts as part of a system, change occurs through language between the therapist and the client. Hoffman (2002) adds that language is used to describe and punctuate experiences. When a therapist and client are working together to make new definitions, the client's beliefs and dominant narratives about reality can be recreated towards change. With this shift, clients are able to go from seeing problems as residing within themselves to instead seeing how problems are linguistically created (Anderson, 1997).

Anderson (1997) asserts that the foundation for a postmodern epistemology is based on a linguistic and relational perspective. A systemic, postmodern lens opens many possibilities for working with clients. When dealing with boundary issues related to clients' sexual attraction toward their therapists, a systemic, postmodern therapeutic approach allows therapists to access many perspectives and tools that allow them to aid clients.

Anderson (1997) defines what it means to have a postmodern epistemology, the ways this epistemology is used in the therapy room, and the possibilities behind using it. Additionally, Anderson states that a postmodern epistemology aids in change, providing a different way of viewing clients and systems. She asserts that a postmodern epistemology supports many assumptions including the assumption that therapy is a collaborative process between the therapist and the client. The client and therapist are able to co-create new truths, new realities, and new language to work towards change. According to Anderson, this collaborative relationship reflects respect for the client's

experiences and an appreciation for the client's perspectives. Flemons (2002) states that in order to understand the relationships clients have with their problems, themselves, and others, the therapist must be able to connect in a way that fosters respect and safety for both the client and the therapist. Consequently, boundary concerns can cause great stress for both the client and the therapist.

Despite the prevalence of boundary issues in therapy, there is relatively little in the literature regarding ways to protect the therapeutic relationship and ensure therapist/client safety when dealing with a client who tests boundaries. Bridges (2003) proposes that it is important to understand the underlying feelings that clients may have in therapy, as these feelings can affect the therapeutic relationship and lead to boundary violations. Bridges also asserts that it is important to develop understanding and meaning around what clients may be experiencing in therapy, noting: "The process of holding, naming, and mutually discovering the mutual relational, affective and developmental meanings of such feelings in each treatment dyad deepens the therapeutic relationship and conversation" (p. 19). This sheds light on the difficulties that therapists encounter when seeking to understand the nonverbal experiences of their clients, which affect the therapeutic process. According to Bridges, a lack of understanding about clients' nonverbal experiences may set the stage for possible boundary crossings or violations (2003).

Bridges (2003) explains that when addressing sexual attraction, therapists tend to pull away from their clients instead of being curious about those unspoken feelings. Pulling away may cut the therapeutic connection between the client and the therapist, which limits the possibilities for change and joining. However, if therapists allow for

communication and curiosity to occur about these feelings of attraction, there could be more understanding. Bridges goes on to explain that "creating a safe place for the unfolding of the therapeutic relationship and for the emergence of patient therapist enactment involves a therapist's willingness to remain fluid and open to influence" (p. 23).

Therapists have to be open to testing their own levels of comfort, which presents a challenge, because it could leave them emotionally vulnerable. Bridges (2003) elaborates on the importance of being trained about sexual boundary issues and being able to manage the discomfort associated with sexual attraction in the therapy room. According to the author, as therapists, we have the responsibility to ensure a safe environment for our clients and ourselves. "Creating a safe place for destabilizing affects and the unfolding of the therapeutic relationship opens up space for emotional engagement between patient and therapist in ways that may lead to transforming affective as well as self-relational change" (Bridges, 2003, p. 13).

Sexual Boundaries in Therapy

There is insufficient information available in the literature about sexual boundary issues in therapy; what is available focuses primarily on conceptual issues and does not offer practical guidance for clinicians (Berzoff, 1998; Celenza, Gans, & Woolley, 2004; Demayo, 1997; Fisher, 2004; Overholser & Fine, 1990; Pathe, Mullen, & Purcell, 2002). Rutter (1989) addresses boundary issues by suggesting that the therapy room can be transformed into an area where boundaries become fuzzy. He states that the balance of power between a male therapist and a female client could present potential breaches. Rutter provides helpful ways of protecting, defining, and maintaining the therapeutic

process and environment in response to ambiguous boundaries. He directly addresses the possibility of clients making sexual remarks and suggestions to their therapists, identifies the risk of sex between therapists and their clients, and discusses the implications of these particular actions to the therapeutic process. Rutter (1989) examines the difference between males and females in this regard and explores the steps taken by a therapist of each gender to maintain boundaries. He explains that it is important for therapists to monitor boundaries at all times when working with clients.

Norris et al. (2003) claim that boundary issues can cause difficulties in the therapeutic process. According to the authors:

> Television and movie dramas have portrayed boundary dilemmas in various ways, humorous and straight; consider the television program *The Sopranos* and the film *Analyze This*. Despite broad agreement in psychiatry that sexual misconduct and other boundary violations can cause notable harm to patients, some of our most senior accomplished practitioners and teachers continue to find themselves embroiled in these difficulties. (Norris et al., 2003, p. 517)

Norris et al. (2003) explain that a boundary violation is any harmful activity that occurs in the therapeutic setting. They further state that it is important for therapists to address boundary violations:

> . . . denial about early problematic situations, which can lead to them evolving into full-fledged boundary disasters, is another common factor in clinical misadventures—particularly with more seasoned and experienced therapists. Evasion, externalization, and rationalization may be used by the therapist to help

> maintain the pretense that boundary problems are not serious, not harmful, or even not occurring at all. (Norris et al., 2003, p. 517)

In many cases clients may test these boundaries. Norris et al. (2003) explain, "Thus if a patient requests, demands, provokes or initiates a boundary violation as many do, the clinician must refuse to participate in the behavior and then must explore the underlying issues, aided by consultation as indicated" (p. 518).

Maintaining appropriate boundary settings not only benefits the client, but also provides a safe environment for the therapist; "thus, mental health professionals must be prepared to manage problematic situations that arise during such collaborative work" (Overholser & Fine, 1990, p. 462). Overholser and Fine (1990) stress that therapists dealing with sexual boundary issues, regardless of their level of experience, should seek consultation from a supervisor or MFT specialist who deals with sexual issues or boundary issues.

Celenza (2006) suggests that having a couch in the therapy room sets the stage for sexual boundary violations. She offers the metaphor of the therapy room as a stage and the couch being a prop for sexualized fantasies and a potential place for boundary violations. Celenza goes on to explain:

> Some sexual boundary violations, perhaps the most notorious type, however, make use of a displacement object and thereby are more accurately referred to as a displaced perverse scenario. In these cases of sexual boundary violations, the effort to degrade is directed primarily not to the other but, rather, to the profession, the body, or figure that oversees the dyad: hence the use of the symbol

> of the couch, the icon of psychoanalysis, as a place to enact this perverse scenario. (p. 116)

According to Celenza (2006), these perverse scenarios mainly have to do with the dynamics of therapy and the power struggle between the therapist, client, or authority figures. Many times these struggles translate into boundary violations or violence toward the practice of therapy, clients, and the therapist.

Celenza (2006) offers a perspective that reflects a traditional therapeutic standpoint, which differs from the theoretical basis of this study. She asserts:

> Again, it is worth reminding ourselves that acute suicidality in the patient is a major feature in over half of cases of sexual boundary violations. When the patient's desire is focused on the analyst, the refusal to engage in a sexual/love relationship can become a life-or-death struggle between them. (Celenza, 2006, p. 22)

Celenza further points out how important it is for therapists to resist clients who test the structure of therapy with their sexual attraction. This process may have a disempowering effect on the therapist and the therapeutic process and may be a reflection of power struggles that the client is experiencing outside of the therapy room (Celenza, 2006).

Boundary Violations in Therapy

The possible consequences of boundary violations and client sexual attraction can be detrimental to both therapist and client. According to Pope (1990), the extreme case of client-therapist sex can have lasting effects on the client and the therapist. He posits that sexual intimacy between a therapist and client can be compared to incidents of abuse, rape, and incest because the victims tend to hide their experiences. Pope further claims

that when sexual intimacy occurs in therapy, the therapist and client mirror the same behaviors as victims of violent crimes in that in both situations there is underreporting of the incident, a lack of acknowledgement that the phenomenon exists, and neglect by the mental health field (Pope, 1990).

New awareness about the occurrence of sexual intimacy between therapists and clients opens the door to exploring different ways to address it. According to Pope (1990):

> The sexual abuse of patients could no longer continue as the "problem with no name," it is increasingly difficult to dismiss virtually all accusations as groundless, as the expression of individual psychopathology or some innate female tendency to false sexual charges against men. Like rape, incest, and other forms of sexual abuse, sexual abuse of patients is no longer invisible. (p. 232)

Pope emphasizes the position of power that therapists have in the therapy room and calls for standards and accountability from professional board, and claims there are obstacles in setting standards, agreeing on definitions of sexual intimacy, and maintaining accountability.

According to Pope (2011), clients who have been sexually intimate with their therapists experience a number of possible harmful reactions, which include ambivalence, cognitive dysfunction, emotional lability emptiness and isolation, guilt, impaired ability to trust, increased suicide risk, role reversal, boundary confusion, and suppressed anger. Pope explains that many clients are put in positions in which they feel vulnerable and lost. He elaborates, "Caught between two sets of conflicting impulses, those suffering this consequence may find themselves psychologically paralyzed, unable to make much

progress in either direction" (Pope, 2001, p. 958). According to Pope, clients may feel silenced by the experience of sexual intimacy with a therapist and be reluctant to file a report, which can result in further negative consequences.

Pope (2001) emphasizes the consequences of cognitive dysfunction due to sexual involvement between client and therapist. According to the author, cognitive dysfunction interferes with the client's life outside of therapy, and it can manifest itself in different impairments. Pope explains, "The flow of experiences will often be interrupted by unbidden thoughts, intrusive images, flashbacks, memory fragments, or nightmares" (p. 959).

Pope (2001) also mentions an additional potential consequence for clients who have been sexually involved with their therapists is a sense of emotional lability. According to Pope, "Intense emotions may erupt suddenly and without seeming cause, as if they were completely unrelated to the current situation" (p. 959). Moreover, clients may feel as if they have lost control of their lives, which can result in emptiness and isolation (Pope, 2001). As Pope explains, "The sense of emptiness is often accompanied by a sense of isolation, as if they were no longer members of society, cut off forever from feeling a social bond with other people" (p. 959).

Many clients who have been sexually intimate with their therapists may experience guilt and feel that the sexual intimacy is wrong because it is not a common practice in therapy (Pope, 2001). Most clients are aware that being sexually intimate with their therapists is not the typical experience when a person goes for therapy. When there is sexual intimacy between therapists and clients, role reversals and boundary confusion may occur (Pope, 2001). He elaborates:

> The therapist brings about a reversal of roles: the sessions and the relationship are no longer about the therapist being of use to the patient in service of the patient's welfare but rather the patient being of use to the therapist in service of the therapist's sexual gratification. (Pope, 2001, para. 26)

Therapists who engage in sexual intimacy with their clients change the objective of therapy. When clients come to therapy, they hope to find new ways to manage and solve their challenges. Once sexual intimacy occurs between the client and the therapist, therapy becomes a place where the focus of attending to therapeutic needs no longer exists. According to Seto (1995), this creates a shift in the meaning of therapy; moreover, it creates unclear boundaries and unbalances the structure of therapy.

Pope (2001) claims that many clients who have been sexually intimate with their therapists experience suppressed anger. He states, "Many patients who have been sexually abused by a therapist are justifiably angry, but it may be difficult for them to experience the anger directly" (Pope, 2001, p. 961). Pope claims that those therapists who are intimate with their clients use their therapeutic skills to intimidate and manipulate clients to fulfill their sexual desires. As a result, clients have a hard time expressing their emotions. According to Pope, the profound effects of sexual intimacy with clients include increased suicidal risk. He explains, "The research published in peer reviewed journals suggest that about 14% will make at least one attempt at suicide and that about one in every hundred patients who have been sexually involved with a therapist commit suicide" (Pope, 2001, p. 961).

Therapists and Sexual Boundary Violations

While the possible consequences of sexual boundary violations may be detrimental to clients, they also have a profound impact on the therapist (Peterson, 1992; Pope, 1994; Pope & Bouhoustsos, 1986; Pope, Sonne, & Holroyd, 1993). According to Pope (1986), many therapists face lawsuits that damage their careers, result in the loss of professional licenses, jobs, and practices, and cause damage to their families, reputations, and self-worth. Peterson (1992) explains, "The shame many professionals feel is disabling and even life-threatening. They have fallen from such a high view of themselves to such a low state. When they go that way, they see only blackness" (p. 152). According to Peterson, many therapists try to come to an understanding about sexual boundary violations and experience shock and shame as a result of their behaviors. Peterson (1986) claims that many therapists in these situations never thought they would find themselves involved in a sexual boundary violation with a client. He says:

While the role of the professional and the client is not the same, the violation explodes the world for both of them and sends them on a similar journey. Like the client, professionals strive to gain clarity to make sense out of what went wrong. They, too, search for safety to reduce their fear and for control to lessen their helplessness. Like the client, they need support to relieve their shame and isolation (Peterson, 1986, p. 162).

Ethics and Sexual Boundaries

Cottone's (2001) research on ethics and sexual attraction with boundary issues reflects a social constructivist approach. According to Lackmann and Berger (1967), social constructivism can be defined as a way people create meaning through their environment and experiences with each other. In addition, social constructivism

proposes that many social norms are mutually enforced and shared through common knowledge. Much of social constructivism is grounded in biology and the idea that language, social interaction, and social context play a key role in creating reality (Armon-Jones, 1986; Burr, 2003; Fine, 1996; Gergen, 1985, 1991; Harre, 1986; Kukla, 2002; Maturana, 1978, 1988; Maturana & Varela 1980; Von Glaserfeld, 1984). Cottone (2001) proposes that there should be a standard of ethics based on social constructivist theories.

Cottone's (2001) social constructivist approach proposes that ethical decisions should be discussed collectively, and considerations should be made for context, social interactions, and norms. He further suggests that when dealing with issues of sexual intimacy with clients, many factors should be taken into account. One such factor is social context. Cottone offers that sexual intimacy in therapy is forbidden; within the social context it is seen as inappropriate. When working with clients, therapists should consider the possible involvement of other systems such as family, friends, and legal professionals. Cottone (2001) recommends developing strong links to the professional culture for therapists. He explains:

> Social constructivist ethical decision-making means that the professional must avoid linkages of vulnerability and cultivate linkages of professional responsibility. Relationships should be chosen wisely and in accord with the larger socio-legal consensus that pervades professional practices. In other words, ethical decision making occurs well before a crisis of consensuality arises. It is implicit in the professional culture. It means a rich professional network is established and that actions are taken to prevent and avoid contact with social

> networks in which challenges of "right" and "wrong" must be answered. (Cottone, 2001, p. 42)

Cottone asserts that as professionals, our actions with our clients affect the system of therapy. He further emphasizes that it is important for professionals to communicate and be part of a strong professional culture that supports appropriate ethical standards.

Harris (1995) points out:

> According to the manual on accreditation provided by the American Association for Marriage and Family Therapist and Family Therapy (AAMFT, 1991a), every accredited training program must make an effort to teach ethical and professional issues to help develop a "professional attitude and identity". (p. 38)

The AAMFT (2015 has set training standards that address ways to avoid negative consequences. The code of ethics specifically states:

> Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken. (AAMFT, 2013)

The AAMFT Code of Ethics also states that MFTs are obligated to follow the code and report any unethical conduct. According to the AAMFT Code of Ethics:

1.4 Sexual intimacy with clients is prohibited.

1.5 Sexual intimacy with former clients or with known members of the client's family system is prohibited.

1.6 Marriage and family therapists comply with applicable laws regarding the reporting of alleged unethical conduct. (AAMFT, 2001)

Mental health professionals in all disciplines have an ethical responsibility to maintain the boundaries of therapy. As Pope (2001) explains:

> It is the therapist who is licensed by the state in recognition of the need to protect patients from unethical, unscrupulous, and harmful practices, and licensure boards and regulations that clearly charge therapists with refraining from this form of behavior that can place patients at risk for pervasive harm. (p. 958)

Addressing the need for more training on issues of sexual attraction in therapy, Pope, Tabachnick, and Keith-Spiege (1986) explain that many existing studies on the topic have focused on the experiences of psychologists, social workers, and psychiatrists. The authors assert that it is important to produce more systemic, empirical studies in the area of sexual attraction in therapy that can be applied to all mental health disciplines. As MFTs, we run into similar situations as our counterparts, but our epistemologies are different and hence, we approach therapeutic situations differently. Pope et al. emphasize the importance of training and continuing education. They state, "Addressing the issue must not be limited to a one-hour lecture, set apart from the normal curriculum. Education regarding this topic can be an appropriate part of almost all clinical and professional coursework and training" (Pope et al., 1986, p. 87). As discussed earlier, it

is important for therapists to be prepared for sexual attraction in the therapy room because of the detriment to clients, therapists, and the field of therapy.

Schwartz and Olds (2002) also explore the importance of proper training for new therapists on dealing with sexual boundary issues. They explain the ideas behind emotional closeness and how boundaries can be blurred because of the closeness involved in the therapeutic relationship. The sexual boundary issues covered in Schwartz and Olds's article include effective psychotherapeutic engagement and sexual boundary violations. The authors focus on preparing therapy trainees by educating them on boundaries issues, stating:

> Trainees can then be overwhelmed by a sense of danger in every direction such as the possibility of stumbling into behaviors that are apparently harder to avoid than one would think, the terrifying impact on professional reputation, the risk of responding to these threats by a defensive withdrawal from meaningful engagement. (Schwartz & Old, 2002, p. 408)

Harris (2001) conducted a study to assess how family therapists are trained to deal with issues of sexual attraction. According to the author, despite modest research done with family therapists on the issue of sexual attraction, it does occur in the therapy room. Harris's study sought to discover whether new therapists are prepared to handle situations in which they are attracted to clients or clients are attracted to them. Surveying 256 participants from accredited marriage and family therapy programs across the United States, Harris attempted to measure the beliefs, experiences, responses, and vignettes on how therapists handle sexual attraction in the therapy room.

Most of the MFTs in Harris's (2001) study reported feeling uneasy about having a client attracted to them or working with a client to whom they were attracted. Harris also uncovered a gender difference: male therapists experience more attraction toward clients than women therapists do. The participants' responses indicate that MFTs were open to discussing issues of attraction to colleagues, yet Harris acknowledges that some therapists experience confusion about how to handle sexual attraction in the therapy room and how to process it personally. This research demonstrates that it is important for therapists to receive proper training and supervision about issues related to sexual attraction.

The current study differs from Harris's (2001) study, because it is centered on the experiences of Licensed Marriage and Family Therapists (LMFTs) rather than MFT students. Often, LMFTs do not have the supportive community of the university setting that students do, and therefore, can be isolated from the community. In addition, they have more clinical experience and have thus encountered a wider range of situations in therapy with less oversight.

Harris (2001) confirms the importance of training that emphasizes the therapeutic relationship and shows how easily the process of joining with a client can transform into attraction. He elaborates:

> Addressing sexual attraction begins with educators who teach ethics courses in MFT. Dedicating at least one three hour lecture on the topic would dramatically increase the amount of attention that attraction in therapy has traditionally received in graduate education. This sends a message that we, as a profession, realize that attraction can happen and that if it does happen, it does not mean anyone is or has been acting unethically. (Harris, 2001, p. 125)

Harris's study concludes with a call for further research around sexual attraction in the therapy room within the MFT arena.

Pope, Holroyd, and Sonne (1993) have brought attention to therapists' reactions to sexual feelings in therapy. Pope et al.'s (1993) list of common reactions derived from the therapist participants in their study include:

- surprise, startled, and shock;
- guilt;
- anxiety about unresolved personal issues,
- fear of losing control,
- fear of being criticized,
- frustration at not being able to speak,
- frustration at not being able to make sexual contact,
- confusion about tasks,
- confusion about boundaries and roles,
- confusion about actions,
- anger at the patient's sexuality,
- and fear or discomfort at frustrating the patient's demands.

According to Pope et al. (1993), the list used in their study was compiled from the experiences of therapists in training, supervision, and consultation. They attempted to normalize the experiences of therapists around sexual feelings in the therapy room by addressing the feelings in the list. The authors' state:

> Learning that various reactions frequently accompany sexual feelings may also make it easier for therapists to accept both the feelings and the accompanying

> reactions. Knowing that many others have experienced these feelings and reactions may help the individual therapist to feel less alone and less likely to think that these reactions reflect some pathological or evil process and must be kept secret. (Pope, et al., 1993, p. 80)

Much of the literature on the subject of sexual attraction in therapy (Davis, 1994; Harris, 2001; Norris, et al., 2003; Rutter, 1989) addresses the feelings of the therapist, while Pope et al. (1993) provide a concrete list of feelings collected from their study that a therapist may experience because of sexual attraction. These resources can be helpful, but can also be limiting. Pope et al. (1993) mention that the list of feelings could limit therapists' experiences or force them to fit their emotions to the list. Regardless of the limitations of the list, these types of emotions affect the therapeutic process.

Modern Psychology

Modern psychology attempts to explain the occurrence of sexual attraction from clients in the therapy room by using terms such as countertransference and transference. Much of the literature in the psychology field (Davies, 1994; Gabbard, 1995; Pick, 1985; Tower, 1956) focuses on the phenomena of transference, which occurs when the therapist transfers unconscious feelings onto a client, and counter-transference. According to Ruesch (1961):

> Countertransference is transference in reverse. The therapist's unresolved conflicts force him to invest the patient with certain properties, which bear upon his own past experiences rather than to constitute reactions to the patient's actual behavior. All that was said about transference, therefore, also applies to counter-

> transference, with the addition that it is the transference of the patient which triggers into existence the countertransference of the therapist. (p. 175)

Pope and Bouhoustsos (1996) propose that the repercussions around therapists reacting to client attraction could be detrimental. They elaborate:

> To engage in therapist-patient sex, Freud observed, means the destruction of therapy. "If her advances are returned, it would be a great triumph for the patient, but a complete overthrow for the cure . . . The love-relationship actually destroys the influence of the analytic treatment on the patient: a combination of the two would be an inconceivable thing (Pope & Bouhoustsos, 1996, p. 29).

MFTs experience sexual attraction from clients, as do their psychology counterparts. The therapy room can be an intimate place. The systemic understanding of the process is behaviors like attraction cannot be understood in isolation, but within the systems in which they occur.

Joining and Attraction

The joining process is an integral part of therapy. As explained by Colapinto (1982), "Joining is the process of 'coupling' that occurs between the therapist and the family, and which leads to information of the therapeutic system" (p. 13). The process of joining allows the therapist to connect with the client in a way that fosters understanding and trust, and lays the foundation for doing collaborative work. According to Minuchin and Fishman (1981):

> Joining a family is more an attitude than a technique, and it is the umbrella under which all therapeutic transactions occur. Joining is letting the family know that the therapist understands them and is working with and for them. Only under his

> protection can the family have the security to explore alternatives, try the unusual, and change. Joining is the glue that holds the therapeutic system together. (p. 32)

In many ways, the therapist becomes an extension of the family by accommodating, which is described by Minuchin (1974) as the way a therapist adjusts in order to join with a family. Joining can occur in many ways including matching verbal cues, making eye contact, physically leaning in to share emotion with clients, attending to pace, demonstrating empathy, and altering physical positioning in the room (Hodgson, Lamson, & Fedhousen, 2007). According to Minuchin and Fishman (1981), joining has to be done in such a way that the therapist is able to strategically maneuver within the family system, fostering change and growth. The joining process in therapy is an ongoing process that can be referred to as "maintenance" (Minuchin, 1974, p. 126). Maintenance is an ongoing state in which the therapist maintains the accommodations for the family in order to continue joining.

According to Harris (2001), "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 and appropriate joining" (p. 127). Harris proposes that joining does involve connecting with a client in a way that could be misconstrued as attraction. In strength-based therapy practices, the use of joining is common in sessions (Sharry, 2004). Moreover, Harris asserts that strength-based techniques are used to empower clients to join with the therapist and complete and achieve their goals. Therapists who use strength-based techniques, like compliments to clients, may run the risk that the strength-based joining technique could be interpreted as attraction. According to McQuaide and Ehrenreich (1997), "most distressed clients do

not present with strengths perspective. By the time they reach out for help, the balance between resilience and vulnerability is weighted toward the vulnerability side" (para. 13). This vulnerable state could lead clients to translate the therapist's strength-based joining technique in many ways. For example, a therapist may attempt to join with a client by making a strength-based comment about the physical appearance of the client, such as pointing out weight loss or weight gain when it relates to the client's stated goal. The client, who may be attracted to the therapist, may take that comment and use it to feed the desire of attraction.

Harris (2001) elaborates on the fine line between joining and attraction and stresses the importance of making a clear distinction between the two. According to Harris:

> Whereas joining refers to the process of becoming involved with or connecting to a client and their lives around a set of clinical issues, attraction has more to do with sexual objectification, potential boundary violations, or desires for intimacy that intrude upon the therapeutic relationship. (p. 126)

Minuchin and Fishman (1981) suggest that there are times when joining can be difficult, based, for instance, on different views and chemistry. They suggest that the client be referred to a different therapist, but in many cases, that is not possible, and the effectiveness of therapy is questioned.

Gender Struggle

It has been argued that gender, sexual attraction from clients, and boundary crossings are connected (Gornick, 1989; Hobday, Mellman, & Gabbard, 2008; Rutter, 1989). Much of the existing research is about female clients and their attraction to male

therapists. According to Hobday, et al. (2008), this could be the result of male dominance in the mental health field (Gornick, 1986).

Gornick (1986) attempted to look at differences in power and sexuality between women and men in the therapy room. As articulated by Schamess (1999), "power is the most compelling aphrodisiac" (p. 11). Gornick claims that gender plays a role in the therapeutic process in that women's experiences are under-reported because of the male dominated discourse of modern psychology and Freudian ideology. Gornick redefines the experience of female therapists who bring awareness of power and sexuality into the therapy room. According to Gornick:

> Because the dominant narrative of a male doctor treating a female patient maintains the normative structure of men occupying positions of authority over women, the importance of gender of the participants in the therapeutic dialogue is obscured. When one turns, however, to the work of women therapists with male patients—a relationship that reverses many of the assumed ordering between men and women—the impact of the gender of the participants on the therapeutic dialogue becomes more salient. (p. 301)

Gornick emphasizes that because of power in gendered relationships, having a female therapist reverses the normative role of power between men and women. As a result, the door may become open for boundary violations, potentially balancing the dominant narrative around power.

Hobday et al. (2008) suggest that sexual attraction from male clients is under-studied in the field of psychotherapy:

> Much of the literature on this topic has been written about female patients by male therapists, though, and some authors (1, 2) have suggested that male patients either are too inhibited to express sexual feelings to a female therapist or tend to act out such transferences by involving themselves in outside sexual relationships. In the last 20 years or so, however, a growing literature written by women clinicians has suggested otherwise (3-7). (p. 1525)

The authors stress the importance of being aware of sexual attraction because of the threat to the therapeutic process and concerns about safety (Hobday et al., 2008).

Hobday et al. (2008) present a case in which a male client was attracted to his female therapist. As the therapeutic process progressed, the attraction grew. The therapist found that the client was attracted to his old therapist, and he was having a hard time transitioning to her. As a result, he began belittling her, comparing her physically to his previous therapist, and making comments about her physical appearance. An excerpt from Hobday et al.'s article illustrates a conversation between Dr. Hobday and her client, in which the client compares Dr. Hobday to his previous female therapist, Dr. S:

> Do I compare Dr. Hobday to Dr. S? Yes, I do. I need to remember that Dr. S helped me through a tough time, but Dr. Hobday needs to work with me on a deeper level. Dr. S is no more. I need to quit comparing Dr. Hobday to Dr. S. They are two different doctors with different agendas. However, all things considered, Dr. S has nicer legs. Typical—men—all they think about is sex. If it makes you feel better, you have nicer boobs. (p. 1528)

Hobday et al.'s (2008) article illustrates the personal impact on therapists dealing with clients who are attracted to them. The authors explain that the therapist had trouble

getting dressed for work because she feared that the client could view her in a sexual way. The article reflects that the therapist became worried about upcoming sessions with the client and would think about sessions outside of work hours. The authors discuss that the therapist attempted to ignore what was going on in session around the client's attraction and shows how she was uncomfortable consulting with her supervisor about what she shared in session with the client.

Hobday et al. (2008) explore the steps that were taken in supervision to secure the therapist's safety. They explain that in supervision, safety precautions were mapped, a safety plan was made, the therapist's feelings of discomfort were discussed, and the supervisor helped the therapist prepare to confront the client's attraction toward her during session. This case demonstrates the occurrence of client attraction and the importance of gender as it relates to sexual attraction in the therapy room. Professional acknowledgment of this issue is necessary because many therapists are fearful of sharing these experiences based on fears of being judged, receiving blame, or exposing their work to criticism. Hobday et al. explain:

> Moreover, women, who as a gender have struggled to be seen as competent professionals rather than erotic sex objects, may feel trivialized, demeaned, or conflicted by expressions of sexual desire. Comments about their bodies may make them feel objectified, and the therapist may wish to avoid these feelings in the therapy. (p. 1531)

Finally, the authors stress the importance of therapists sharing their experiences with sexual attraction in order for other professionals to learn from them.

Gender and Sexual intimacy

In many cases, gender plays a role in how clients deal with sexual intimacy with therapists and the guilt associated with it. Pope (2001) mentions that many clients experience sexual confusion and question their sexuality because of the shame and guilt associated with being intimate with their therapist. Pope points out that according to research, more women experience sexual intimacy with therapists than men do. Furthermore, Pope discusses the misconceptions around the validity and truth of claims from female clients about sexual intimacy with male therapists in a male dominated profession like the mental health field. He asserts that it is important to address the issue of not holding clients responsible for inappropriate sexual intimacy with therapists. He states, "It is possible that gender may be associated with the ways in which this irrational guilt develops and is sustained" (Pope, 2001, para. 20).

Pope (2001) compares the experience of female clients and their guilt in this setting to the experience of rape and abuse. As a consequence, women may feel that they are to blame or could have avoided the sexual intimacy if they had done something differently. Pope claims that regardless of the gender of clients, the result is an impaired ability to trust. He elaborates, "When a therapist intentionally and knowingly violates their patient's trust, as they do when they decide to become sexually involved with them, the effects on the patient's ability to trust can be profound and lasting" (Pope, 2001, p. 960).

Sexual Attraction Documented

In Flemons's (2002) book, *Of One Mind*, he describes the experience of one of his female supervisees, who was seeing a male client who was gripped with frequent and

public masturbation. The client decided to use the therapy session as an opportunity to masturbate. The female therapist was very uncomfortable with the male client masturbating during the session, and she was torn about how to address the issue in a therapeutic manner. The therapist had to make a decision about how to handle the masturbating. She could explore its meaning, talk about it, not allow the masturbation in the office, or refer the case to someone else. After consideration, the therapist decided to establish boundaries related to the client's masturbating, forbidding masturbation during the session in order to work with him to resolve his challenges. Flemons (2002) uses this example to explain that safety is an issue. This female therapist was meeting with her male client in an empty office suite during the weekends. This brings up many issues that therapists face: safety, comfort, boundaries, seeking help, and the integrity of the therapeutic relationship.

According to Harris (2001), most therapists do not feel comfortable continuing therapy with clients who are sexually attracted to them. Yet, what happens when a therapist reacts negatively toward a client who is sexually attracted to him or her? Pope and Bouhoustsos (1996) give the example of a female client who was attracted to her male therapist. The client had gone to see the therapist to work on her relationships with men, but because of the attraction, she was having a hard time addressing those issues. As weeks passed, the client became more and more attracted to the therapist, which in turn led her to engage in vivid sexual fantasies. The client decided that she was going to reveal her feelings to the therapist, despite believing that she might have to end therapy because of her attraction. As the client shared her feelings, the therapist found himself equally attracted to her. As a result, he attempted to kiss her and remove her clothing.

The client felt vulnerable and started to cry. According to Pope and Bouhoustsos (1996), that event was the most traumatic event in the client's life, and it required her to seek continuous psychotherapeutic treatment.

The examples presented above raise important issues about sexual attraction from clients, and how the crossing of boundaries due to such attraction can be detrimental and stressful to the therapeutic relationship. When working with clients, a therapist must be prepared to handle many situations. As articulated by Overholser and Fine (1990), "mental health professionals must be prepared to manage problematic situations that arise during such collaborative work" (p. 462).

Sexual Attraction in Therapy

Thoreson, Shaughnessy, and Frazier (1995) discuss sexual contact between therapists and clients during the course of therapy and the effect it has on the field of therapy. They argue that there is a need for more research on this issue for all types of mental health professions. According to Thoreson et al.:

> In summary, sexual contact in professional relationships is receiving increased attention in the literature. However, existing data is limited in several respects. First, because most of this data have been collected from doctoral level psychologists, we have little information on mental health professionals with master's level degrees. (p. 87)

Thoreson et al.'s (1995) study attempted to test female counselors' experiences with sexual contact with clients. The researchers suggest that gender plays a role in the occurrence of sexual contact between therapists and clients. Thoreson et al.'s findings suggest that sexual contact in the therapeutic relationship occurs more frequently between

male therapists and their clients, and there is a lack of research on female therapists' perspectives and experiences regarding sexual contact in therapy. Thoreson et al.(1995) suggest that female therapists are more likely than male therapists to find it unethical to have sexual contact with clients, supervisees, or students. The researchers also propose that it is more likely for therapists to engage in sexual contact with clients after therapeutic services have completed, and they point to a lack of research on the effects of these types of relationships.

Harris and Hays (2008) performed a study that primarily focused on MFTs. They investigated whether MFTs were having discussions about sexual topics. Harris and Hays discuss that one of the primary reasons why MFTs are not having these types of discussions is there is a lack of comfort discussing sexual issues and sexual topics with their clients. The authors propose that if MFTs become more comfortable discussing topics and issues related to sex, they could, in turn, be more comfortable engaging in the process of therapy with their clients.

After surveying 175 clinical members of the AAMFT, Harris and Hays (2008) suggest a strong connection between knowledge and comfort with sexual topics. They explain, "Therapists who perceived sexual knowledge had the third largest combined influence on sexual discussions, even though it did not have a direct influence" (Harris & Hays, 2008, p. 246). The authors claim that it is important for MFTs to become more comfortable discussing issues pertaining to sexual content in therapy. Additionally, there is a need for graduate programs to address and facilitate training programs around sexual discussions, comfort, and adequate supervision that focus on being comfortable with

sexual material when it is introduced by clients in therapy. In reference to this, Harris and Hays (2008) state:

> The results of the present study support a strong direct influence of perceived sexual knowledge on therapist comfort. Therefore, for these therapists this data suggest that as their perception of their sexual knowledge increases they feel more competent and self-confident in the area. The positive influences of increasing their sexual knowledge expands their comfort levels with sexual issues, which, in turn, creates space in sessions for addressing sexual issues with their clients. (p. 247)

When it comes to sexual attraction in therapy, Harris and Hays (2008) suggest that MFTs would benefit from having knowledge about how to feel comfortable addressing it in therapy.

Nickell, Hecker, Ray, and Bercik (1995) performed a study that examined whether MFTs are trained to handle sexual attraction toward their clients. The authors conclude their study by pointing to the need for more research in the area including training programs, research on ethical standards, and the institution of ethical standards for the field of MFT. Nickell et al.'s study mainly focuses on therapists attracted to clients and does not include instances in which the attraction was solely from the client. The authors' research serves as a foundation and a springboard for more research on the issue of sexual attraction in the therapy room.

Nickell et al. (1995) surveyed 189 randomly selected AAMFT members. The study drew attention to some key points with regard to why training and research is needed in the area of sexual attraction in the field of MFT. The key points in Nickell et

al.'s study include: a lack of research in the area of sexual attraction in the therapy room, the need for empirical data to establish theory, the importance of theory in the area of sexual attraction in the therapy room, and training on the issue in the field of MFT. Nickel et al. (1995) explain that understanding how to handle issues of attraction help to preserve the therapeutic process. In addition, understanding sexual attraction in the therapy room allows MFTs to handle encounters in ways that are constructive and safe for both the therapist and the client. Nickell et al. state that "if so, training would likely help to alleviate the ambivalence by ensuring that, via a sound ability to interpret ethical implications, therapists would be well prepared to handle such feelings in an appropriate manner" (p. 322). The researchers stress that without proper guidelines established to draw attention to sexual attraction in the therapy room, therapists will not understand their mistakes.

Nickell et al. (1995) recommend training for handling sexual attraction in the therapy room and explain, "The data reveal important implications for training of marriage and family therapists" (p. 324). The researchers point out the need for training programs that address gender issues, boundary issues pertaining to appropriate touching in therapy, awareness of the AAMFT code of ethics, supervisors' awareness of the issues of sexual attraction, acknowledgment by therapists of feelings of sexual attraction, and continual assessment of issues related to sexual attraction. Nickell et al. propose that supervisors should be open to discussing issues of sexual attraction, offering guidance, ethical guidelines, and support. They emphasize that "well-trained colleagues would likely provide more appropriate feedback to their peers then uninformed colleagues"

(Nickell et al., 1995, p. 324). These guidelines may serve as a foundation for training programs dealing with clients attracted to their therapists.

Harris and Busby (1998) conducted a study focusing on female therapists who are physically attractive. According to the researchers, the female therapists' attractiveness had an effect on the therapeutic process. Clients in the study seemed to feel more comfortable and were better able to relate to a female therapist if she were attractive. Harris and Busby state that "attractiveness is an easily assessed therapist characteristic and may contribute to the client's disclosure decision-making process" (p. 255). The research points out that the first impression of the therapist is important and that attractiveness plays a role in first impressions. The article illustrates that many clients think attractive female therapists are more competent, based solely on their physical appearances. In addition, Harris and Busby claim that the gender of the client offers both comfort and discomfort about what is disclosed. They elaborate:

> Therapist-client fit seems crucial to successful therapy. Because clients may judge the effectiveness of the therapist rather quickly, based in part on limited information, clinicians need to know that, in addition to presenting problems, therapists' personal characteristics, such as attractiveness, affect clients' comfort with disclosing. (Harris & Busby, 1998, p. 255)

The study conducted by Harris and Busby (1998) was an attempt to find out whether gender plays a role in what clients disclose when their female therapist is attractive. Based on the results of the study, the authors assert that when a female therapist is attractive, male clients are less likely to disclose information that emasculates them, while female clients are more likely to make disclosures that are consistent with

social dominant discourses about women. Overall, both sexes are more comfortable disclosing to an attractive female therapist. Harris and Busby (1998) conclude that the dominant discourse that beauty is good plays a role in therapy. Attractive female therapists have more favorable results than females who are considered less attractive. This research article opens the door to exploring other ways in which the attractiveness of a therapist affects therapy and the clients who are attracted to them.

Harris and Harriger (2009) investigated sexual attraction in conjoint therapy. The study primarily focused on cases in which one of the partners was attracted to the therapist and investigated whether therapists are trained to handle and mange sexual attraction in conjoint therapy when it is presented. A questionnaire by the Commission on Accreditation for Marriage and Family Education (COAMFTE) about sexual attraction in therapy was given to 259 master's students, of which 138 responded. Harris and Harriger concluded their study by stressing the need for further research. They emphasize:

> Within the last decade, MFT has joined the ethical discussion concerning sexual attraction in the therapeutic relationship. However, the field has limited our contribution to attraction dynamics that occur within the individual therapeutic relationship, inadequately addressing the implication of sexual attraction in our discipline. (Harris & Harriger, 2009, p. 214)

Harris and Harriger (2009) note that MFTs work from a systemic lens and operate in the context of family systems. Their article suggests that sexual attraction in conjoint therapy affects the system. According to the results of the study, some therapists were unclear about how to handle a partner in a conjoint therapy session who was attracted to

them. The researchers explain that "33% of participants reported uncertainty about discussing the attraction in the conjoint context."(Harris & Harriger, 2009, p. 212). Many times, therapists feel confused because of fears of damaging the therapeutic relationship because of the attraction. According to Harris and Harriger:

> Though, in response to the same three questions, a notable portion of the respondents reported being uncertain of whether they would meet individually with the attracted partner (15%), meet with the non-attracted partner (21%) or asked to meet with both members of the couple separately (27%). This degree of indecision may indicate a lack of exposure and discussion in MFT training programs to the topic of sexual attraction, especially within a conjoint context. (p. 213)

The research suggests that confronting a couple when one partner is attracted to the therapist could have a profound effect on the relationship of the couple and the therapeutic process. The therapists in Harris and Harriger's (2009) study were aware of the potential effects of sexual attraction on systems. As a result, the researchers suggest that a high number of therapists would not refer a couple to another therapist with the idea of pursuing a relationship with the attracted client.

Many new therapists are unclear about how to handle and disclose attraction from a client in a conjoint therapy session. Harris and Harriger (2009) suggest that this needs to be answered with: (a) training, (b) sexual contacts that emphasize appropriate sexual boundaries, (c) open communication with other professionals (supervision), (d) normalizing the occurrence of attraction with the clients. Harris and Harriger's (2009) study focused on master's students and did not address professional, licensed MFTs who

currently do not have the resources of a university setting. They suggest that there is a lack of preparedness in the field when it comes to attraction in the therapy room.

Summary

In summary, this chapter served as an overview of the literature on sexual attraction in the therapy room. The chapter focused on a historical and theoretical perspective of the importance of the therapeutic relationship between therapists and their clients, addressing the possible effect of boundary violations and the impact to the field, the client, and the therapist. The findings of research that have been conducted on this issue include a need for more research. Chapter III will define the methodology of this study.

CHAPTER III: METHODOLOGY

Methodology

This study utilized a mixed method research approach with a convergent parallel design. The mixed method approach combines quantitative and qualitative research for the collection and analysis of data (Creswell, 2009; Creswell & Clark, 2010; Sandelowski, 2000; Tashakkori & Teddlie, 2003). According to Creswell and Clark (2010):

> This design is used when the researcher wants to triangulate the methods by directly comparing and contrasting quantitative statistical results with qualitative findings for corroboration and validation purposes. Other purposes for this design include illustrating quantitative results with qualitative findings, synthesizing complementary quantitative and qualitative results to develop a more complete understanding of a phenomenon, and comparing multiple levels within a system. (p. 77)

According to Greene (2007), this type of research method allows the research to be pragmatic. Tashakkori and Teddlie (1998) state that when being pragmatic, the researcher values both objective and subjective knowledge, and highlights multiple points of view. In addition, the mixed method approach helps the researcher build a complete picture of what is being studied, justifying the combination of both research methods.

According to Creswell (2009), the mixed method approach pays attention to time, weight, and mixing. Mertens (2009) points out that timing refers to the order in which a researcher performs the study, for example, whether he or she completes the qualitative or quantitative segment first, or whether both are completed at the same time. Mertens

states that weight refers to whether one of the two approaches is more valuable to the study or whether they are equal in value. In addition, she claims that the mixing in a mixed method approach happens when the information is analyzed and the quantitative and qualitative ideas are merged (Mertens, 2009)

This study uses a mixed method convergent parallel design with a parallel database variant. As Creswell and Clark (2010) explain, a convergent parallel design means that quantitative and qualitative data collection occur at the same time, with equal weight for each type of method. Furthermore, the qualitative and quantitative data are analyzed separately and then merged together during the interpretations stage. Creswell and Clark claim that a parallel database variant insures that two strands of data are conducted separately then brought back together during analysis. They state, "The researcher uses the two types of data to examine facets of a phenomenon, and the two sets of independent results are then synthesized and compared during discussion" (Creswell & Clark, 2010, p. 81).

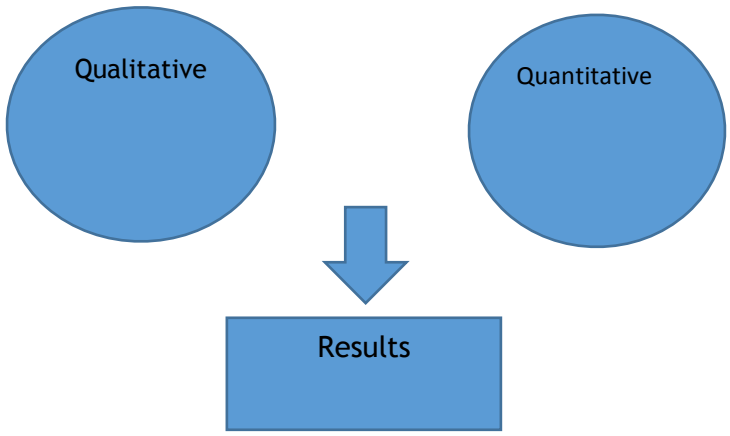


Figure 1. Convergent Parallel Design illustrates separate data synthesized into final results

The rationale for using convergent parallel mixed method design is that it complements the study by allowing for two research methods—quantitative and qualitative—to enhance each other by being collected and analyzed equally in a single phase. In addition, the convergent parallel mixed method design is pragmatic; it expands systemic understanding of the focus for this study by combining two different research methods around the topic of sexual attraction from clients. When I collected and analyzed data related to sexual attraction from clients, both means of collection and analysis supported and stabilized one another, thereby building a strong study. In addition, it allowed for more participants to be included in the study.

I performed the qualitative segment of the study utilizing an online forum board. Participants were recruited to participate in the forum through the LinkedIn website and professional networking sites provided by the AAMFT. The quantitative segment of the study, in the form of a questionnaire, was easily accessible to other members of the LMFT population who do not use the LinkedIn website. Those participants were solicited from a list of educators posted on the AAMFT website and LinkedIn. These participants were asked to pass the information in the study to colleagues who were interested in participating and who fit the criteria for inclusion in the study.

Research Questions

The research questions that guided this study are as follows:

1. Are licensed MFTs experiencing sexual attraction from clients?
2. How do licensed MFTs handle sexual attraction from clients?
3. Are licensed MFTs being trained to handle clients who are openly attracted to them?

a. How are licensed MFTs being trained about sexual attraction?
b. Does continuing education and training on sexual attraction exist?
c. Are licensed MFTs seeking continual education on this topic?
d. Are they seeking supervision?
e. What are the commonly held beliefs that licensed MFTs have about sexual attraction in the therapy room?

5. What are the experiences of MFTs who have experienced sexual attraction from clients?

6. Do MFTs experience attraction to their clients?

Quantitative Segment of the Study

Quantitative research was developed to connect environmental phenomena with empirical measurements (Kumar, 2010; Punch, 2003, 2005; Zikmund & Babin, 2006). According to Vanderstoep and Johnson (2010), quantitative research is rooted in the positivism approach, which states that data is arrived at through the use of logic and mathematical authority. For this study, I used the mixed method approach, consecutively performing quantitative and qualitative research. The quantitative and the qualitative segments of the study are weighted equally. I performed the quantitative segment by collecting data through a web-based survey. I then used the survey methodology approach, which was submitted to a univariate analysis through the Survey Monkey analyst software.

Bethlehem (2009) notes that survey methodology is used to quantify a phenomenon. According to Punch (2003), it is a non-experimental approach that is descriptive in nature. Punch explains that survey methodology specifically looks at the

relationships among variables that can be generalized back to the general population through the use of surveys. In this study, the survey method, which is commonly used in research, was appropriate because it allowed me to reach more participants. Furthermore, as Punch points out, surveys have been found to capture attitudes about phenomena. The survey method was cohesive, and allowed me to build more strength and understanding into the qualitative segment of the study (Punch (2005).

This study used a univariate analysis, which looks at variables one at a time and utilizes percentage distribution (Punch, 2005). Punch explains that researchers using percentage distribution take the portion of participants relative to the sample frame and divide them by each other. They then multiple the number of participants by 100 to find the percentage of participants who respond to the categories in the questionnaires. For example, if seven out of 20 participants respond that they felt scared when they experienced sexual attraction from a client, I divided seven by twenty (7/20 = .35), which I then multiplied by 100.(.35 x 100 = 35%), resulting in 35%. Additionally, my analysis included frequency distribution. According to Gravetter and Wallnau (2009), frequency distribution captures the exact number of participants who respond to the each of the research categories. In this study, I use bar graphs to clearly show the results of the analysis and central tendencies.

Qualitative Segment of the Study

In this study, I used grounded theory (Charmaz, 2010; Glaser & Strauss, 1965, 1967; Kvale, 1996; Rossman & Rallis, 2003) with an emphasis on the constructivist ideology. Grounded theory lends itself to this study because it allows for the theory to be

developed around the experiences of therapists who have encountered sexual attraction in the therapy setting rather than being based on a preset notion or truth.

According to Rossman and Rallis (2003), the qualitative inquiry approach was developed with the idea of exploring new ways to make sense of the world around us. The authors explain, "Qualitative inquiry as a form of research is rooted in empiricism that is, the philosophical tradition that argues that knowledge is obtained by direct experience through the physical sense" (Rossman & Rallis, 2003, p. 6). Moreover, the authors assert that the approach is naturalistic, interpretive, and uses different methods of inquiry. Much of the literature suggests that grounded theory is a common method of qualitative inquiry (Charmaz, 2010; Glaser & Strauss, 1967; Kvale, 1996; Rossman & Rallis, 2003).

The grounded theory research approach was developed by Glaser and Strauss (1965) in their study entitled "Awareness of Dying". According to Kvale (1996), Glaser and Strauss discovered a way to ground empirical data with observations and interviews. Glaser and Strauss (1967) claim that the framework of grounded theory is based on the constant comparison analysis to create the theory. Furthermore, grounded theory aims to build an understanding about the conceptual ideas around behaviors. According to Charmaz (2010), constructivist grounded theory grew from the framework of grounded theory. She asserts that constructivist grounded theory merges the basic concepts of grounded theory and social constructivism—which include an awareness of how one's interaction with the environment, social norms, and person affect the creation of one's reality—distinguishing this theory from others.

The use of constructivist grounded theory in this study allowed me to better understand the common experiences of LMFTs and whether they feel prepared to handle sexual attraction from clients in the therapy room. In addition, this methodological approach will allow the possibility of creating new meanings and descriptions of sexual attraction in therapy. The grounded theory approach gives researchers an opportunity to use emergent information to form a theory. When using grounded theory, the goal is to collect information so that a theory emerges. "A discovered, grounded theory, then, will tend to combine mostly concepts and hypotheses that have emerged from data with some existing ones that are clearly useful" (Glaser & Strauss, 1967, p. 46).

According to Charmaz (2000), constructivist grounded theory focuses on meanings that are derived from the shared experiences and relationships between participants in the study and the researcher. Charmaz (2010) claims that constructivist grounded theory allows the researcher to move away from focusing only on the observed data and look, instead, at the outside influences that affect experiences. Charmaz states:

> A constructivist approach can invoke grounded theory methods for diverse analytic and substantive problems. When Glaser argues grounded theory is a "theory of resolving a main concern" that can be theoretically coded in many ways, he offers an excellent use of grounded theory, but not the only one. For that matter, what constitutes a main concern depends on one's point of view. (p.181)

Mills, Bonner, and Francis (2006) declare that constructivist grounded theory allows for an understanding of multiple realities and truths, provides a basis for understanding meaning, and acknowledges the creation of knowledge by the viewed and the viewer.

Charmaz (2010) encourages the use of different voices and stories of experiences to reflect how they are interpreted and illustrate the understandings behind the participants' experiences. In addition, researchers using constructivist grounded theory are encouraged to be mindful of the contextual forces that influence the creation of the theory. Constructivist grounded theory highlights the different definitions of reality guiding the participants and researchers and the dominant discourses at the time of the study. Further, it allows for an understanding of how the different definitions of reality create what is *real* and how those different realities influence the foundation for the ideas and theories generated by the researcher (Charmaz, 2000).

The constructivist approach to grounded theory highlights shared experiences and relationships. It is used to explore the effects that these experiences and relationships have on the study, and it acknowledges their influence (Charmaz, 2010). Researchers are curious about the meanings behind shared experiences, and "constructivists study *how*—and sometimes *why*—participants construct meaning and action in specific situations" (Charmaz, 2010, p. 130). Constructivist grounded theory opens the door to different experiences and distinctions. It looks not only at the microcosm of experiences, but also at the macrocosm—the microcosm being the participant's experience, and the macrocosm being the larger systems involved. It allows for the researcher to develop a theory to include influences such as social norms, dominant discourse, morals, and traditions that play a hand in how one creates meaning around experiences.

"Constructivism assumes the relativism of multiple social realities, recognizes the mutual creation of knowledge by the viewer and the viewed, and aims towards interpretive meaning" (Charmaz, 2002, p. 510). In this study, the constructivist grounded

theory approach allowed me to build a theory from the experiences of different LMFTs who have encountered sexual attraction from clients in the therapy room. The research allowed me to investigate the common experience of LMFTs: how they handle sexual attraction from clients, and how they perceive other LMFTs' experiences. Additionally, it allowed me to explore the training LMFT's received and the their meaning-making around sexual attraction.

Constructivist grounded theory was appropriate for this study because it allowed for attention to a shared creation of knowledge, numerous social constructs (or the way that one formulates ideas around reality); organizations (defined as the units that we work in towards common aspirations); and relationships and researchers (to be recognized when forming theory around sexual attraction and how it affects therapy). Charmaz (2010) states:

> A constructivist approach means being alert to conditions under which such differences and distinctions arise and are maintained. Having the material to anchor the experience takes rich data and entails having sufficient knowledge so one can see differences and distinctions. (p. 131)

This study was conducted on an online forum discussion board. The therapist and the participants were able to interact and explore meanings and understandings around clients' sexual attraction toward their therapists. Constructivist grounded theory is more suitable than other methods because the issue of sexual attraction from clients affects many systems—which means that it may hold many truths—and there is an opportunity to form new constructions of theory around the experiences of therapists. According to Charmaz (2010), constructivist grounded theory reflects the researcher's experience. My

experience will be reflected in this study, as I personally encountered sexual attraction from a client in therapy. In light of this, it would be impossible for me to conduct this study as a neutral observer. In addition, I seek to form a connection between the theory I develop and the need in the MFT field for continued awareness of sexual attraction.

Procedures

This study included a purposive sampling technique, which allowed me to pick participants from a specific portion of the population based on a commonality among them (Tashakkori & Teddlie, 2003). Within that sample frame, a participant was picked to optimize the study. I selected both male and female participants with varying ranges of ages and races in order to capture a mixed sample frame. When participants expressed interest, their demographic information was considered. All participants in this study who expressed interest and returned their consent form were accepted. I was able to collect a mix range of ages and races based on my solicitations.

I used multiple methods to recruit participants for the study. For the quantitative segment of the study, I solicited participants through local and international chapters of professional marriage and family therapy (MFT) groups and LinkedIn, a website for professionals that allows them to connect with one another. The LinkedIn website has groups that are monitored and sponsored by different MFT groups, including the American Association of Marriage and Family Therapy (AAMFT). Members of this group are able to share and communicate with each other.

Qualitative Segment

For the qualitative segment of this study, I used LinkedIn to recruit participants by posting a solicitation flyer requesting that potential participants contact me by phone or email to learn how they could participate in the study.

In both segments of the study, I sent an email to potential participants explaining the study and how they could participate. I also asked them to share the study information with other licensed colleagues who may have experienced sexual attraction from a client. I selected both male and female participants from a range of ages and races in order to obtain a diverse sample of 21 participants. The survey segment of the study's demographics included 10 White females, five White males, one African- American female, one African- American male, and one Hispanic female. Six participants held licenses in Florida, two in Maryland, two in New York State, one in California, one in Massachusetts, one in Iowa, one in Pennsylvania, one in Indiana, one in Minnesota, one in Texas, and one in the United Kingdom, England. The forum segment of the study's demographics was composed of one White female who was licensed in Washington, DC, one White male who was licensed in California, and one Hispanic male who was licensed in New York State.

The survey

The survey used for this study includes 28 Likert-type questions. I created the questions based on my own experience, suggestions from my dissertation committee, and previous studies performed on sexual attraction (Harris, 2001; Pope et al., 1993). The first set of questions in the questionnaire includes demographic information including gender, race, license information, name, mailing address, and email address. The

remaining questions, which are closed-ended in nature, include unordered, multiple-choice questions. The survey can be found in Appendix A. Participants had access to the survey through Survey Monkey, which is a secure website designed to administer research studies online. The survey was accessible until all selected participants had completed it.

Participants' protection and rights

This portion of the study was performed to meet the acceptable ethical standards of practice, protecting the rights and privacy of the participants. I informed the participants of how their information would be used and protected and also informed them of the scope of the study and the role that they played in it. I asked all participants to sign a consent form to participate in the study. The consent form explained that participants could withdraw from the study at any time by informing me that they no longer wished to participate. This study maintained online communication privacy practices by using an online survey website that was secure. In addition, participants' fundamental rights were and will be protected.

Limitations of the quantitative segment

Univariate analysis does not show correlations or inversions, because the model only looks at one variable at a time; however, the qualitative research conducted in this study lent itself to addressing the relational aspect of the study, and included additional areas in the questionnaire to allow participants to elaborate on their experiences. These additional comments were submitted for analysis using the qualitative techniques discussed earlier in this chapter. An additional limitation is that the sample in this study will only represent the LMFT population.

Qualitative Segment

For the qualitative segment of this study, I used the LinkedIn website, and word of mouth to recruit participants. LinkedIn is a website for professionals that allows them to connect with one another. The LinkedIn website has a group that is monitored and sponsored by the Association of Marriage and Family Therapy. I am a member of this group. Members of this group are able to share and communicate with each other.

When carrying out this study, it was important for me to attend to ethical issues, such as privacy rights, a consideration of the consequences of my study, and maintaining a non-judgmental stance. In regard to the privacy of my participants, I gave each participant a consent form elaborating how his or her privacy may and will be protected.

I posted a description of the research project with the criteria for being able to participate and asked participants to email me. The criteria required that the participants be licensed to practice within their state, have experienced sexual attraction in the therapy room from a client or clients, and be available for the duration of the study and follow up calls. I accepted the first three volunteer participants for the study. As suggested by Ritchie and Lewis (2003), a smaller sample size is appropriate for a qualitative research study. The participants were selected based on their gender, race, and age in order to maximize diversity in the study. I then contacted the participants by email to provide them with the information about the study. This information included consent to participate in the study, details about how the participants' information would be protected, information about when the study would start and end, a description of the responsibility of the participants in the study, instructions about how to use the blog site, and contact information for the researcher.

This research study was performed online on a forum board. Online research is a way to use technology to perform research studies. Social media, online communication, and online resources are at the forefront of the development and evolution of the social sciences. As explained by Gibbs, Friese, and Mangabeira (2002):

> The development of information technology and particularly the growth of the Internet has created not only new ways in which researchers can analyze their data, but also created whole new areas from which data can be collected and ways in which it can be collected. (para. 6)

The many new ways of collecting and performing research referred to by Gibbs et al. (2002) open the arena for new ways to make research efficient. This allows the researcher and the researched to have access to research material anytime and anywhere. Kenny (2005) performed a qualitative research study that proved that engagement and group interaction over a two-month period was possible with an online forum. The study showed that rich information and data were able to be collected in an on-line format.

The present study was conducted over a five-week period and the participants were asked to post at least one response on the blogging forum for each interview question posted. Participants were able to respond to each other questions. Four interview questions were posted each week on Monday, Wednesday, Friday, and Sunday. According to Kenny (2005) and Murray (1997), asking one question at a time ensures more engagement from participants in a study. Each question was generated from one of the following sources: a prior list of questions, questions that arose during the dialogue, or from the participants on the forum. The forum remained open until the research questions were answered and no new information or discussion was generated, i.e.

saturation was reached. However, participants were free to post on the site as often as they liked until the end of the research project and were also allowed to view each other's responses to the research questions and respond to the other postings. This was done to add richness to the study by divulging participants' realities and perspectives on the topic. According to Kenny (2005):

> For the researcher, the time length provided the opportunity to refine guiding questions as increased understanding of the topic developed. Rather than questions being posed only by the researcher, participants also posted questions for others to respond to group dynamics and interaction flourished and multithreaded discussions emerged. (p. 419)

I screened the information to ensure that any inappropriate material would be deleted. If inappropriate material was posted or continuously posted by a participant, he or she would be terminated from the study. Inappropriate material would include any subject matter that belittles another's response, material that was not conducive to the study, and derogatory statements. Once the study was concluded, participants were contacted to confirm findings, review findings, and gather comments from the study.

Data Preparation

In order to achieve the goal of data generation, collection, and preparation, I viewed the discussion board questions two to three times per week in addition to saving all the information posted to the discussion board and taking detailed notes about the participants' responses to the questions posted. The online interviews functioned like a continuous conversation. The online interviews were submitted for analysis, which included these pre-selected questions:

- How many times have you experienced sexual attraction from clients in the therapy room?
- How did you feel when you experienced sexual attraction in the therapy room?
- Describe your response. Tell the story of what happened?
- How did the client express his or her attraction?
- What did the therapist say in the moment that the sexual attraction was expressed? Can you please speak about your thoughts and feelings?
- Did you continue to work with the client who was sexually attracted to you?
- Were you attracted to the client?
- Did the attraction cause you stress? If so, how did you cope with it?
- What was the end result of therapy and how did you proceed with the client who was sexually attracted to you?
- Can you please speak about your thoughts and feelings?
- What is your understanding of the roles of therapists and clients when it relates to sexual attraction?
- In your experience, how does the field of MFT respond to sexual attraction in the therapy room?
- What are our professional ideas about the culture of sexual attraction in general?
- What role might gender play in clients' sexual attraction to therapists in the therapy room? Talk about the relevance of your gender.
- How prepared do you believe you are to handle sexual attraction from clients?
- Describe the training you received regarding sexual attraction in the therapy room.
- Was the training received in the school setting or in the community?

- What was most helpful about the training you received? Least helpful?
- What would have been helpful in preparing you better?
- Did you seek supervision to assist you in handling the sexual attraction from the client?
- Did you speak to anyone about the sexual attraction that you experienced from your client in the therapy room?

Data Analysis

My analysis procedures were based on constructivist grounded theory (Charmaz, 2002, 2010). I collected data until the data was saturated, which means that I asked questions based on my overarching research question and allowed participants to comment until there was no new information forthcoming.

According to Charmaz, (2002), the observer creates the data but ensures that the analysis is correct by the interactions with the ones observed. From the information collected, I generated initial codes. Charmaz maintains that initial coding allows the researcher to come up with different codes, and it is the first step in coding. Following the initial coding process, focused coding was used to combine smaller categories into larger categories, which call for a more analytic lens from the researcher. Charmaz explains that "focused coding means using the most significant and /or frequent earlier codes to sift through large amounts of data" (p. 57). Axial coding was also conducted. As described by Charmaz, "The purposes of axial coding are to sort, synthesize, and organize large amount of data and reassemble them in new ways after open coding" (p. 60). Finally, the data collected from the message board underwent theoretical coding. According to Goulding (2002), "At the pinnacle of theoretical coding are core categories

which are higher order categories which represent the developed theory" (p. 74). This process allows the researcher to look at how the codes relate to each other, form hypotheses, and start to develop the theory (Charmaz, 2010).

I developed core categories by comparing the prevalence of the themes, or the overall commonalities across the data, and by looking at the relationships between the data. Lastly, I developed a theory around sexual attraction based on the emergent data collected from the core themes. The theory was broken down into parts (themes) and subjected to a line-by-line comparison of the data to confirm the theory. Glaser and Strauss (1967) elaborate:

> He must be looking for emergent categories, reformulating them as their properties emerge, selectively pruning his list of categories while adding to the list as the core of his theory emerges, along with developing his hypothesis and integrating his theory in order to guide his theoretical sampling at each step of the way. (p. 72)

I collected data using theoretical sampling. This procedure involved taking the data collected from the participating LMFTs and coding and analyzing it to find developing theories. According to Glaser and Strauss (1967):

> Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them in order to develop his theory as it emerges. (p. 45)

Theoretical sampling was appropriate for this study because my goal was to capture a variety of perspectives held by LMFTs related to their experiences with sexual

attraction from clients. This was done through a message board of communication between the LMFTs and me. I reviewed and categorized the communication into codes or common concepts and then further analyzed these codes to develop themes for a grounded theory. The process consisted of data triangulation, whereby I took notes to collect bits of information from each therapist and compared the data to each therapist's data until the information was saturated. As the information was collected, I continuously assessed and reassessed the data and took notes on my observations. This constant comparison method tracked the information being observed on the online messaging board.

Quality Control

In order to maintain quality control, a research study must be done with credibility, resonance, and rigor (Charmaz, 2010). In this study, I applied a triangulation method using peer debriefing, member checking, and data collecting.

In addition, the constant comparison methods allowed the researcher to look at the data collected from the online message board and compare it to find similarities. Peer debriefing took place with colleagues at Nova Southeastern University. I selected these colleagues according to their willingness to participate and their availability. I contacted the members of the study after the study was complete to confirm the information collected from the message board. Data was continuously collected throughout the study.

Theoretical sampling ensured quality control, because it allowed me to capture all variations and perspectives of the LMFTs in the study. Reflective journaling was used to ensure quality control measures and allowed me to keep an accurate account of my thought process throughout the study. Reflective journaling allowed me to be aware of

potential influences on the study and to reflect on my assumptions and how they could potentially influence the study.

Trustworthiness

To maintain quality control, I made specific efforts to ensure the trustworthiness of the study. According to Rossman and Rallis (2003), maintaining trustworthiness in a research study means insuring that the study is ethically performed and meets the acceptable standards of practice. In order to ensure the ethical validity of the study and standard methods of practice, the information was collected in the following five ways: journaling of information from the message board, handwritten observation of web board interactions and responses to questions, collection of online interviews from the message board, and maintaining an audited trail of collected handwritten observations.

When attending to ethical issues, I made sure that all participants knew that their fundamental rights were not jeopardized and were aware of how their information was being used in this study. This was documented in the consent form that was emailed to each participant in the study. Each participant signed and returned the form in order to participate in the study. In addition, a form was sent explaining the scope of the research project and the responsibilities of the participants.

When considering the possible consequences of this study, I have attended to privacy practices through online communication. I ensured that all online communication was secure and could only be accessed through passwords and an Avatar (non-identifier) created by the participants. This website and forum was closed to the public and only accessible by the participants and the researcher. Participants in the study were asked to keep all shared information confidential.

When formulating my research questions, it was important that the participants were respected and that the field benefits from the study. The last ethical issue to address for this study was a non-judgmental stance. This occurred by acknowledging my assumptions and recognizing what influences they may have had on the study. This aided me in keeping a non-judgmental stance. Since I have experienced sexual attraction from clients, I began with a set of assumptions, which included:

- Sexual attraction does occur in the therapy room.
- LMFTs do not receive enough training in regard to sexual attraction in therapy.
- Poor boundaries can affect the therapeutic relationship.
- If sexual attraction is not addressed, there can be damage to the therapeutic relationship, the client, LMFTs, and the system of therapy as a whole.
- There is a need for more training when it comes to sexual attraction.
- Uninformed LMFTs may feel lost and isolated when faced with sexual attraction in the therapy room.
- Uninformed LMFTs may be placed in compromising positions, if sexual attraction in the therapy room is not addressed.
- Clients' behaviors in the therapy room mirror what is going on in their lives outside of therapy.
- When sexual attraction in the therapy room is handled appropriately, it can lead to therapeutic change.
- There needs to be an awareness that sexual attraction from clients does exist in the therapy room.

Expected Contributions

This study attempted to establish a theory about how LMFTs who have experienced sexual attraction from clients can handle these experiences in the future. I conducted the study to attempt to provide new understanding and tools that may be useful to other therapists who are faced with sexual attraction from clients, and I attempted to address the need for more training and the acknowledgment that sexual attraction does occur in the therapy room and is experienced by LMFTs. As a result, this study confirmed the expectations and underscores the need for more research in the area of sexual attraction in therapy and more training to address this topic.

Summary

In summary, this chapter outlines the research method of constructivist grounded theory used in this study. It delineates how this method is appropriate for the study and how it was applied. This chapter also focuses on the importance of maintaining trustworthiness, ethics, standard practices, rigor, and creditability. The chapter shows how this study adheres to these standards. It also highlights the contributions to the field of marriage and family therapy around sexual attraction in the therapy room. In Chapter IV, I review the data analysis and present the results of the study.

CHAPTER IV: RESULTS

This study was conducted via a mixed method design that examines the experiences of licensed marriage and family therapists who have experienced sexual attraction from a client or clients in the therapy room. I performed the quantitative segment of the study using a web-based survey. I then analyzed the participants' responses to the survey using a survey methodology approach that I submitted to a univariate analysis in order to examine the variables one at a time and conduct percentage distribution (Punch, 2005). I conducted the qualitative segment of the study through an online blogging board and used the grounded theory approach, with an emphasis on the constructivist ideology, to analyze the participants' narratives (Charmaz, 2010; Glaser & Strauss, 1965, 1967; Kvale, 1996; Rossman & Rallis, 2003).

To merge the two segments of the study, I used the mixed methods convergent parallel design with a parallel database variant. A convergent parallel design means the researcher collects quantitative and qualitative data at the same time, placing equal importance on each type of method. I analyzed the qualitative and quantitative data separately. I performed the quantitative analysis of the data I collected through the web-based survey on Survey Monkey, which has an analyst system that uses univariate analysis to examine the variables one at a time and conduct percentage distribution. I used grounded theory for the qualitative segment of the study (Charmaz, 2010; Glaser & Strauss, 1965, 1967; Kvale, 1996; Rossman & Rallis, 2003) with an emphasis on the constructivist ideology. The analytic procedures were broken down into phases.

I first used initial coding, which allowed me to come up with different codes (Charmaz, 2010). Next I used focused coding where I combined smaller categories into

larger categories. Third, I used axial coding to sort and synthesize large amounts of data and reassemble them in different ways (Charmaz, 2010). I then used theoretical coding to examine the codes as they related to each other, formed hypotheses, and started the development of theory (Charmaz, 2010). In addition, theoretical sampling allowed me to take the categories collected from coding and analyze and refine them until saturation occurred. Lastly, I developed a theory related to sexual attraction by using the emergent data collected through the analytic procedures. After completing each segment of the analysis, I compared the information from the quantitative and qualitative versions for commonalities and then merged them together during the interpretation stage (Creswell & Clark, 2010). Using the parallel database variant, I was able to ensure that the two strands of data were conducted separately then brought back together during analysis.

Lastly, I developed a theory about sexual attraction by using the emergent data collected through the analytic procedures. The emergent theory concluded that while sexual attraction from clients in therapy presents challenges for LMFTs, we must be prepared for the possibility of such attraction. As clinicians, we make the choices on how to view clients, how to handle the attraction, and how we chose to perceive the attraction towards us. Will we chose to have this circumstance debilitate us or do we use it to empower us to provide the essential services that our clients and our communities need? We must acknowledge the dominate discourse in our society and our preconceived notions about attraction and sex. Only then, when we are comfortable talking about it and confident in our skills, boundaries, and ethics, can we be best prepared to handle sexual attractions from clients in therapy.

There is a need for training and adequate supervision for LMFTs to handle sexual attraction from clients. After completing each segment of the analysis, I compared the information from the quantitative and qualitative data to look for commonalities. The results of the study revealed five overarching themes, supportive subthemes, and statistical evidence that supports the overarching themes and subthemes. Table 1 shows the five overarching themes and subthemes. To increase the trustworthiness of the study (Sprenkle & Piercy, 2005), I used participants' narratives verbatim. I aimed to achieve credibility by engaging in member checking, cross-referencing with colleagues, and journaling.

Table 1.

Overarching Themes and Subthemes

OVERARCHING THEMES	SUBTHEMES
1. Expressed Attraction	a. Overt
	b. Covert
2. Self of the Therapist	a. Multitude of Emotions
	b. Therapist Attraction Towards Client
	c. Comfort levels
3.Using Attraction in Therapy	a. Elephant in the Room
	b. Setting Boundaries

4.Therapist Social Context	a. Cultural Experience
	b. Gender
5. Training and Supervision	a. Training in MFT Programs
	b. Not Being Prepared
	c. Seeking Help

Note: Overarching Themes and subthemes that emerged through participant responses.

Eighteen of the participants took part in the survey segment of the study—which was identified as PS—and three participants took part in the online discussion—which was identified as PD.

Expressed Sexual Attraction

The participants in this study reported experiencing sexual attraction from clients on at least one occasion, but some participants experienced it on multiple occasions. Figure 2 shows the percentages for the number of times the participants experienced sexual attraction from their clients.

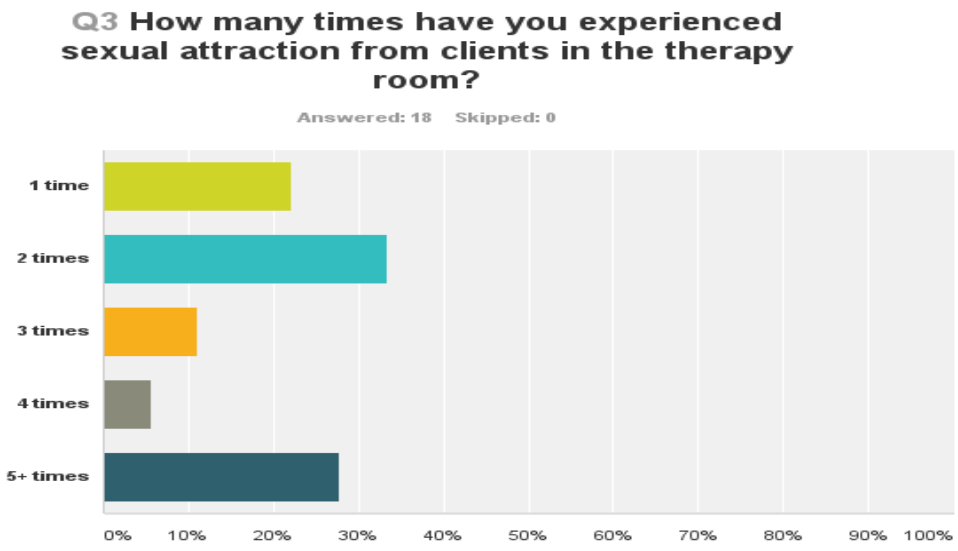


Figure 2. Number of Times Participants Experienced Sexual Attraction From Clients.

Participants described expressed attraction as being either overt or covert. All participants who experienced overt attraction from clients reported that the attraction was expressed verbally; 22% of the participants reported that the attraction was expressed physically. Twenty eight percent of the participants who experienced covert forms of attraction reported that it was emotional; 17% reported that it was spiritual, and 11% reported the attraction as *other*. Additional ways that attraction was expressed by clients included engaging in fantasies, extending invitations to meet outside of therapy, and texting.

One participant in the online discussion explained how a client overtly expressed attraction to her while she was working in a school for the blind:

> PD3: For most of the incidents, there isn't much to describe; I could just feel the tension of attraction coming from each one. One was a woman, the rest were adolescent boys or men. For one of the circumstances I can be more specific. I was working at a school for the blind. I did a group with adolescents and saw one

of them individually. It was my first internship and I wanted the therapy to be a "positive experience" so the kid wouldn't shy away from therapy in the future. I really didn't know what I was doing as I had so little experience at that point. This was a kid who was born blind. He pulled at people to feel sorry for him and to do things for him. He told me that it was hard not knowing what I looked like. Could he please touch me to get a better sense of me? My countertransference was all about survivor guilt; i.e., I felt guilty for being able to see (!!). I said "okay." He crossed the room, and sitting uncomfortably close to me, he took my hand and began to rub my wrist with one finger, back and forth, back and forth. I felt incredibly awkward and like an idiot. I quickly realized how manipulating he was being and said, "Okay, that's enough." I think I saw him only 2 or 3 times."

Some participants described a client overtly offering sex, while others talked about clients describing sexual fantasies and then overtly proposing sex with them.

PD2: I will refer to one incident that occurred while I was working at a high school. I had been working with a 15-year-old bisexual male who had initiated therapy to deal with mixed feelings about his sexual orientation. After several months of therapy and assessment client expressed a sexual interest in me. The client offered to have sex with me and stated he would not tell anyone.

PS18: Seventeen year old female client in inpatient therapy after sexual involvement with a male teacher and subsequently making false allegations of sexual involvement with a staff at a prior inpatient treatment facility. In session with me, she shared fantasies of having sex with me and made an overt solicitation."

PS10: As I had my back turned to a client while running his credit card, he asked me if I was wearing a thong. Another client going through the transition to divorce expressed an interest in dating me.

PS5: I have had one male client drunk text me several sexual texts which I addressed in the next therapy session. I had one other male client tell me in session that he fantasizes sexually about me.

PS2: Client said he had fantasized about me mud wrestling with his wife and it aroused him.

Many participants in the study explained that clients would covertly express attraction toward them. This covert attraction was expressed through nonverbal cues, body language, seductive dress, and suggestive language. At times the attraction could not be confirmed unless it was confronted in the room, but the tension was present. Participants explained their experiences:

PD1: Not sure how much detail to go into, but as an intern an adult woman who was having difficulties with her husband at the time would be in session in a skirt and while facing me, have her legs open or different visual looks she would give me, gestures etc. Was more through her non-verbal like opening her legs towards me when wearing a skirt, gazing intensely, etc.

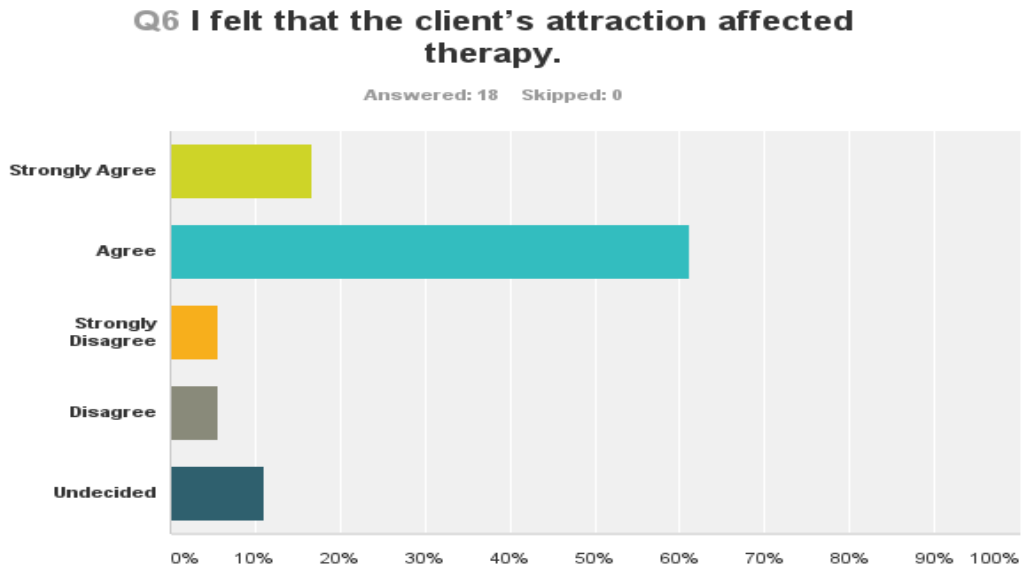
PS18: I had a second mid-30s female client with a history of affairs including sleeping with her divorce lawyer. She dressed in revealing clothing and acted in a seductive fashion when seeing me for therapy.

PS8: The other client would describe me when describing his perfect girlfriend.

PS1: I had a young female client who attempted to give me a gift for Valentine's Day and then asked if I wanted to grab coffee with her. She also asked me to meet her family.

Self of the Therapist

The participants explained their internal experiences when clients demonstrated sexual attraction toward them. They described a multitude of emotions, attraction toward their clients, and a level of discomfort. Most of the participants reported that they felt the sexual attraction affected therapy. As illustrated in Figure 3, most of the participants



reported that they felt the sexual attraction affected therapy.

Figure 3. Participants' Beliefs About How Attraction Affects Therapy

Multitude of Emotions

Many participants had a multitude of emotions when they experienced sexual attraction from a client or clients. They expressed a range of emotions that included

stress (33%), shock (22%), and flattery (11%). One participant explained that he felt anxious, uncomfortable, and confused while experiencing attraction from a blind client:

> PD3: At the time? I felt anxious, uncertain as to what would be appropriate. I felt uncomfortable and didn't want to say he could touch me. I felt confused as to how to show positive regard, acceptance, etc. to a person who couldn't see my expression, and had no way to imagine to whom or to what he ever spoke to. I felt mean to consider denying him this basic knowledge that we (I) take for granted. I also thought it was entirely possible that he knew damn well that he was being inappropriate and was taking advantage of my obvious lack of experience with doing therapy with someone who had never experienced vision at all. Because of my self-doubt and wish not to withhold, I allowed, I complied. Looking back, I am certain he was manipulating me. He had been blind his entire life; the situation may have been novel to me but it's all he ever knew. He had dealt with the challenge every moment of every day. He knew how to make connections while remaining appropriate for the circumstances.

Another participant explained feeling stressed and questioning the quality of his therapeutic services.

> PD1: Somewhat stressful yes. Stressful for me as to if I was actually understanding her gestures correctly as attraction towards me and if it was ok or not to be attracted to her. Also stressful was how to tell if the attraction both ways was therapeutically beneficial or getting in the way.

One participant explained feeling relief and gaining insight into what was going on in the room.

> PS3: I felt a little relief because I know that it is not an uncommon factor in the therapeutic process and it explained some of the anomalies that were occurring in the therapeutic process. I was a little surprised at first, but it just become grist for the mill.

One of the participants described how he felt confused and flattered that a client was attracted to him, causing him to wonder about what made him attractive to the client.

> PS14: Confused. I didn't know how to respond. I sort of felt flattered and she was very pretty. I was dating women at the time and wondered what I had done for her to feel that way towards me.

In contrast, another participant emphasized that it was not flattering but rather stressful because of the potential for false allegations.

> PS18: Not at all flattered since it was a part of known history and reason for treatment. Highly stressed due to history of her teacher being fired and trying to get a prior provider fired by what seemed to be false allegations.

It is important that LMFTs manage and acknowledge the emotions they experiences during therapy when working with clients. As Negash and Sahin (2011) point out, therapists are susceptible to experiencing compassion fatigue or secondary trauma related to high levels of stress in the therapeutic environment. This can lead to hopelessness, nightmares, negative coping skills, and burnout.

Therapist Attraction Toward Clients

Seventy-two percent of the survey participants and two of the participants on the discussion forum expressed that they had been attracted to a client during the therapy process. According to Martin, Godfrey, Meekums, and Madill (2011), “When therapists

admitted attraction to clients, they often described mutual attraction, but there were examples where the therapist seemed attracted to the client without explicit gestures from the clients" (p. 251).

This finding from the study corresponds with much of the research on this topic that highlights therapists' attraction to clients (Brock & Coufal, 1994; Harris, 2001; Nickel et al., 1995). One participant explained his experience of feeling uncomfortable and having to monitor his attraction while working with his female client.

> PD1: Made me uncomfortable...or rather "distracted." At the time I couldn't tell if it was me as a man being attracted or I suppose I could say some type of fantasy type situation or if she was doing it on purpose. Similar to not staring at her breasts when she was wearing tight clothing and leaning in, it was difficult to know if it was something I should be tracking as a therapist or my own discomfort of natural attraction. It was a gut feeling of discomfort to think it may be something more than just "my side of the room".

Many participants expressed not receiving adequate training on the topic of sexual attraction from clients. When participants did encounter sexual attraction from clients, they did seek consultation and personal therapy, which they did find helpful in managing their attraction towards clients. "Therapists must continue to use supervision, consultation, personal therapy, and didactics throughout their careers (which, incidentally, can all be part of thoughtful risk management)" (Fisher, 2004, p. 118). According to Fisher, seeking adequate supervision, personal therapy, or consultation can help professionals maintain and set clear boundaries when faced with attraction from clients. Two of the participants spoke about seeking consultation when experiencing

attraction to clients to remain clearly within the boundaries of therapy in order to manage attraction towards clients.

> PD2: Typically no. However luckily or unluckily I have been attracted to clients that did not show any sexual interest in me and this issue obviously was processed in consultation and in my own therapies.
>
> PS11: If I'm attracted to a client, it is easy to remain clear on the boundaries of the relationship and maintain my professional role and presence.

Comfort Level

While many participants felt discomfort when experiencing sexual attraction from a client, 55% of the survey participants reported that they were comfortable working with a client who had expressed attraction toward them. As shown in Figure 4, the majority of participants believed that attraction affects the roles of therapist and client.

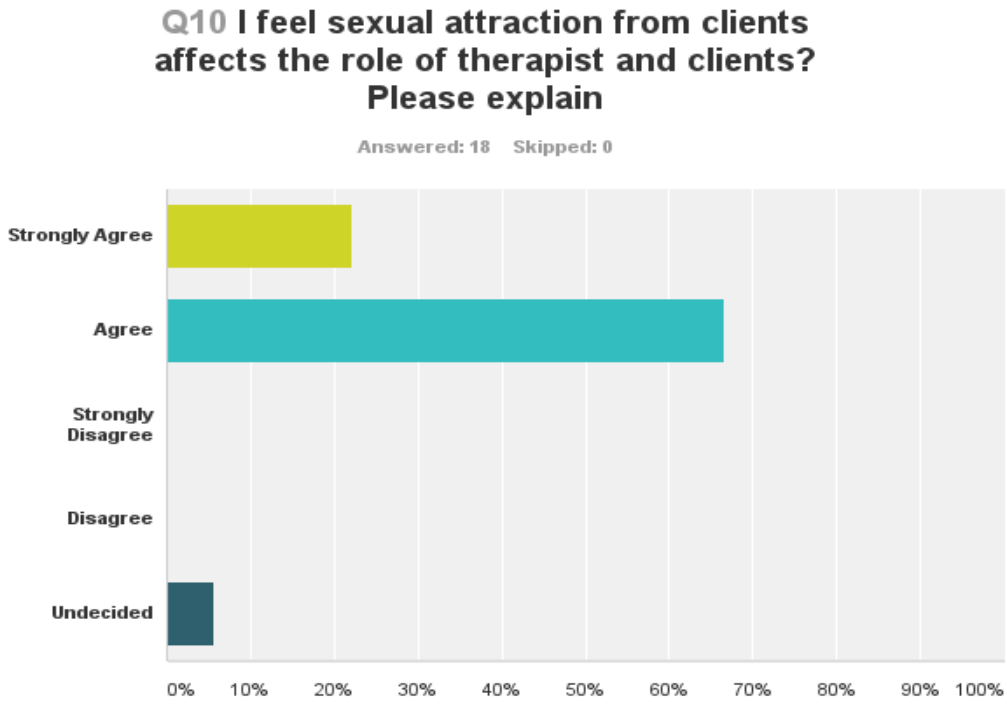


Figure 4. Participants' Beliefs About How Attraction Affects Client and Therapist Role

Many participants expressed discomfort working with clients who expressed attraction toward them. Sixty-one percent of survey participants felt that the attraction did affect the therapy, and 27% reported that they did not feel comfortable speaking to clients about the attraction. One participant expressed discomfort and fear of being sexually attacked in her office because she was often alone.

> PS7: I addressed the comments made by them and stressed the fact that a relationship that included sex would never occur. I tried to be sensitive to their feelings but I also was very stressed as I often work alone in my office and feared them sexually attacking me.

Another participant spoke about having greater discomfort while in private practice because of the lack of clinical supervision. Much of the literature revolves

around the importance of seeking supervision to help in managing comfort levels when encountering sexual attraction from clients (Bridges, 1994; Nickell et al., 1995 Pope, 1987; Rodolfa et al., 1994). According to Fisher (2004), it is important that the supervision be performed by a well-informed supervisor who is not afraid to discuss sex-related issues. The following two participants discussed their comfort level working with clients that were sexually attracted to them and their decision to seek supervision.

> PS18: The second situation with the adult woman occurred in private practice, with less clinical supervision support, so my discomfort was greater even though the risks seemed less than with the first client who had a history of false allegations.

PD2 stated that he would feel uncomfortable sharing an experience of this nature in group supervision because of fears of being judged: "I don't know if I would want a group training on this issue but rather discuss case by case basis in consultation. In a group it would be embarrassing like I was announcing I was attractive to my colleagues".

Using the Attraction in Therapy

For many of the participants, when attraction was present in therapy, their initial response was to either document it in their notes or ignore it. The most prominent approach among the participants was to find a therapeutic way to respond to the attraction. Additionally, 90% of survey participants reported that they would continue working with a client who expressed attraction toward them, and 72% of them reported that they actually did continue working with clients. This differs from the findings from earlier research, which professed that therapists were uncomfortable continuing therapy with clients who expressed attraction toward them (Bridges, 2003).

Bridges (2003) explains the importance of creating a safe place for the therapist and client. Systemic therapies assert the importance of therapists understanding the systems in which they work. The therapists' curiosity opens the door for a better understanding and respect for the systems in which they work Flemons (2002). emphasizes that in systemic therapies when a client and therapist work together, it can create change. Acknowledgment, respect for the system, curiosity, and understanding of the attraction could lead to change. This theme emerged because participants felt that bringing the attraction out into the open in the therapy room and broaching the topic with clients could lead to positive change.

Participant PS7 described this by stating, "It can deepen the therapeutic connection when addressed appropriately; it can create distance in the therapeutic relationship if the therapist is not willing to explore his/her reaction to it and how to work with it in the client's therapy." Another participant stressed the importance of maintaining an empathic relationship with clients and avoiding a shaming response.

> PS13: If it is temporary and interpreted with empathy, it can probably be managed to increase the trust of the client for the therapist. If the therapist fails to empathize with the client, there can be a shame response in client…derailing progress.

Some participants were able to normalize the experience of sexual attraction from clients and provide appropriate interventions. One participant took the approach of reframing the attraction to move the client toward change.

> PD2: Therapy was able to continue and I was able to reframe therapy as a way for the youth, for example, that I worked with to create a healthier bond with the

same sex as he historically had poor relationship and boundaries with male caretakers and male peers.

Another participant described how she uses attraction from clients as a way to create a deeper connection.

PS4: I have experienced a range of experiences, best described as a mutual, mild attraction. My experience in our culture is that we only connect deeply on an emotional level with the gender we are attracted to when we are having an intimate relationship with them. I see the exchange of sexual energy as a natural result of a therapeutic relationship that is working, and if it can be transmuted in the process of therapy, it can transform into an almost spiritual connection in its place.

Elephant in the Room

While 90% of participants in this study reported that they would continue to provide therapy to a client that was attracted toward them, many participants explained that when attraction was present in the room, they felt the need to address it. For the participants in this study, the attraction was the elephant in the room. Some participants allowed a conversation about the attraction to unfold.

PS17: I knew that the conversation needed to happen. I believe it was helpful therapeutically because the client also had to take a look at behaviors associated with her alcohol use. Among her treatment goals were developing boundaries with men and unhealthy behaviors when under the influence of alcohol. It provided a good learning example.

Other participants took a different approach.

> PS1: Yes I believe it was helpful to address it directly, as otherwise it would just be a huge looming elephant in the room.

One participant spoke about how addressing the attraction allowed her to provide clarification about the role of the therapist.

> PS15: We discussed what it was about how I positioned myself as a therapist that the client fell in love with. We discussed that what the client may have fallen in love with was not me but my therapist self, that there's a big difference between the two identities.

Setting Professional Boundaries

Sixty-seven percent of survey participants felt that attraction in the therapeutic relationship affected their role as therapist. They felt that in order to maintain that professional therapist role they would have to set professional boundaries. For example, participant PS2 said, "I set a boundary and made a plan for the client not to return until it was with his wife. I wanted to make sure he was serious about dealing with relationship issues."

Another participant talked about keeping clear and apparent boundaries.

> PS 13: I always have thought it was disrespectful to not express being flattered before going on to explain transference and what was really behind the apparent attraction. I've always been entirely comfortable discussing the meaning of the apparent boundaries being kept very clear.

One participant explained that when the attraction is mutual, it is essential to maintain boundaries.

> PS18: Overt overtures from a client must be effectively understood, managed, and interpreted for therapy to proceed. Also, realistically, sometimes a therapist is going to be sexually attracted to a client and will need to maintain her/his boundaries and ethics, as well as manage associated countertransference.

In line with this idea, another participant gave an example of an experience where he needed to set clear boundaries with a client.

> PS1: I had a young female client who attempted to give me a gift for Valentine's Day and then asked if I wanted to grab coffee with her. She also asked me to meet her family. I was married at the time and set clear boundaries that it wouldn't be appropriate.

Therapist's Social Context

Culture, including ideas related to gender, can play a key role in how we perceive reality. According to the existing research, there is a connection between gender and attraction in therapy (Gornick, 1989; Hobday, Mellman, & Gabbard, 2008; Rutter, 1989). The participants of this study explained their views on the role that gender and culture play in the experience of sexual attraction in the therapy room. The theme of the "therapist's social context" revealed itself through the participants' reports regarding their perception of social norms and how they fit these social constructs within their practice, including potential sexual attraction from clients, the way they create meaning through their environment, and their experiences with each other. "A major idea of social construction theory is that knowledge emerges from social interchange processes. It emphasizes the communal basis of knowledge through communication, negotiation, and

processes of interpretation of the individuals" (Cheung, 1997, p. 336.). Charmez (2000), highlights how different definitions of reality help in defining what is "real".

Cultural Experience

When participants spoke about their cultural experience with sexual attraction, many referred to how their race plays a role in their therapy and the populations they serve. One of the participants spoke about his experience as a white male who works with Latin American immigrants.

> PS14: Way complicated. What do you mean culture? Differences? Similarities? Of course culture does [impact therapy]. It's the water we all swim in. I am white and work a lot with Latin American immigrants who are poor. Culture played a big role in making me the professional and clearly not available to them sexually.

Another participant explained how being a Black male therapist allows him to have an intimate relationship with clients of other races that he may not have otherwise.

> PS15: It's cultural if one defines culture as 'everything learnt'. It's also cultural in the sense that the therapeutic intimacy does not happen anywhere else therefore when this happens it can easily be misunderstood as sexual love. All the clients who've fallen in love with me have been white and I am black. Culturally there aren't many opportunities for white women to engage in such an intimate dialogue with a black man.

While most participants felt that culture does play a role in their work, they shared that other factors are also present. As participant PS18 put it, "I believe other factors play a role such as client's history of abuse, prior sexual experience, having their self-image and self-affirmation intertwined with sexuality, etc. "

Gender

Gornick (1989) and Hobday et al., (2008) assert that most of the literature on sexual attraction in therapy focuses on female clients being attracted to their male therapists. Participant PS4 spoke about how, as a female therapist, her male clients are attracted to her to some degree; which works for the therapeutic process. "I feel that male hetero clients that work well with me and stick with me long term, all deem me attractive on some level. I feel that they choose me because they want to work with this energy on some level." She went on to explain that cultural assumptions and stereotypes about women affect the attraction in the therapeutic relationship: "Yes, but I feel that sexual orientation plays a larger role. I think that many men feel safer to be emotionally vulnerable with women given the cultural roles of woman as caretakers and nurturers."

One of the male participants spoke about his experience with gender.

PD1: It's interesting that as a male, I automatically feel like I should discredit my opinion as it's inherently sexist. Clearly that's not true, but figured it would be interesting to share my gut reactions. I feel that women [likely in a vulnerable state] seeking therapy from a man who they project onto as a secure base is going to increase some sexual tension. Especially if their difficulties are about their husband or the father of their children.

Many participants spoke about the experience of attraction from clients of the same sex and acknowledged its occurrence. Participant PS 18 shared, "I only have experience as a male therapist so I don't know a female therapist's perspective. I have not experienced same-sex attraction from a client but I see gay clients and fully expect it

could occur." Similarly, participant PS6 stated, "I think same sex clients can be attracted to their therapist. I believe in sexuality on a continuum."

Training and Supervision

This study elaborates on the call from previous researchers for more training in the classroom and supervision settings. As shown in Figure 5, participants were divided when asked if they felt their training was helpful. They reported receiving their training in different environments, which included school, the community, and on-the-job training.

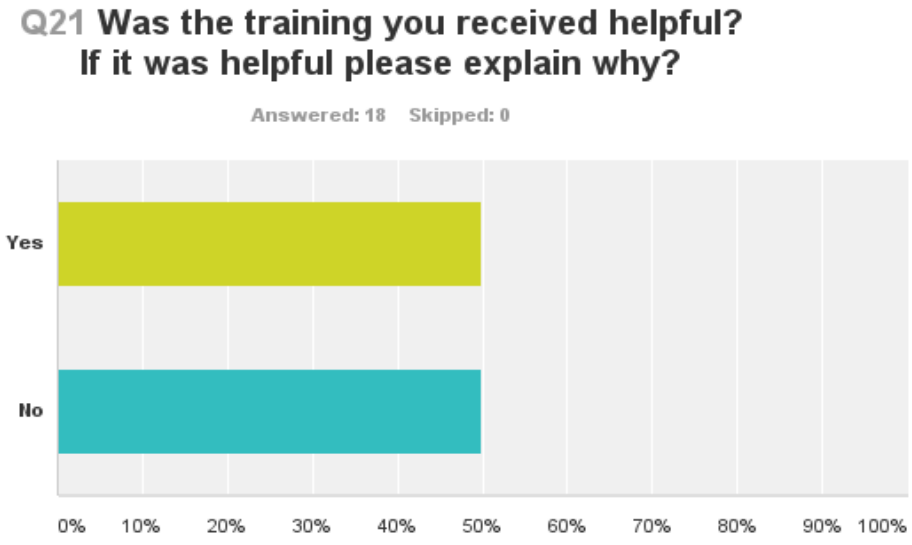


Figure 5. Participants' Rating of Training Helpfulness

In addition, the study sheds light on the ways in which licensed marriage and family therapists outside of the university setting may be isolated. Many participants used terms like *transference* and *countertransference* to explain their experiences with attraction from clients. These terms were first coined by modernist psychologists, but postmodern therapists have adapted them into our language and training. One participant elaborated on this idea. PD2 stated: "I believe the field of MFT sees sexual attraction as a

part of countertransference and should be dealt with as a clinical issue as any other type of countertransference. Obviously, legal and ethical boundaries maintain the therapeutic alliance clear."

The subthemes that emerged from this theme have to do with the participants' training experiences in school, their beliefs that they were not properly prepared to deal with attraction from clients, and the need for therapists to seek help from supervisors when it occurs. Additionally, questions arose regarding the terms *transference* and *countertransference*, and whether they fit the postmodern therapeutic philosophies.

Training in MFT Programs

While 63% of survey participants reported having received some training while in the school setting, 50% of participants felt that the training that they received was not effective. Many participants stated that they did not feel prepared to handle sexual attraction from clients and felt they needed to have more focused training about how to regulate and understand their own feelings when faced with attraction from clients. Eighty-nine percent of the participants sought help from a supervisor, 95% spoke with someone about their experience, and 67% reported that they did feel comfortable speaking about their experience.

Not Properly Prepared

Several participants described not feeling prepared to handle sexual attraction from clients in the therapy room.

> PS5: In classes it was mentioned and I was told to normalize the situation and explain that they believed they were attracted to me because I was listening to them and they felt understood. I gave this reply to the first male client and he

> laughed and said "are you crazy? That's not it, you're really hot and I want to fuck you." So in a way, I don't feel I was accurately prepared to face this situation. The second instance, my client drunk texted me about how much he liked looking at my ass and then after that I was uncomfortable turning my back to him. This interfered with therapy, because usually I do a genogram with them while I am standing and I was too uncomfortable, so I did it on notepaper sitting which I think affected his experience of seeing the genogram take place before his eyes. It was very uncomfortable for me both times it occurred and I don't feel it was addressed in school with enough emphasis on what to do or how it would make you feel as a woman.

Some participants discussed seeking supervision outside of school and in other environments. As participant PS18 explained, "On-the-job training from a skilled clinical supervisor provided excellent training and guidance. Graduate school marked that it would occur but didn't really prepare one for handling it." One participant explained that her experience with attraction in the therapeutic relationship, along with the training she received, helped to prepare her.

> PD3: I believe I am so much more prepared to deal with it now than I was the first time it occurred. I did receive training which could have been better, but experience is necessary more so than the best training. Training helps of course. But experience and talking about it with a supervisor who is not frightened by it is the best. I don't fear it and I expect it - from me or the patient or both of us. It is okay. It can be managed, and the therapy can continue. Or not. Facing it and discussing it will help you what you need to do.

Seeking Help

As illustrated in Figure 6, most of the participants sought supervision when they experienced attraction in the therapy room. While 67% of the participants felt comfortable speaking to a supervisor or colleagues about their experience, the remainder did not. This raises the question of how those other participants were able to process or were advised on how to handle the attraction. In general, the participants reported that it is important to receive support from a supervisor or colleague, to, have knowledge on the topic, and not to be afraid to broach the topic. One participant put it this way:

> PD3: Most helpful, by far, is supervision with someone who is not afraid nor ashamed by the topic. Least helpful, talking with someone who experiences it as wrong, bad, taboo, unethical, unusual, etc. You will be more likely to understand it the way they do, and all those things inhibit one's ability to deal with it effectively. That's when therapists are most vulnerable to mishandling the situation, when they fear it.

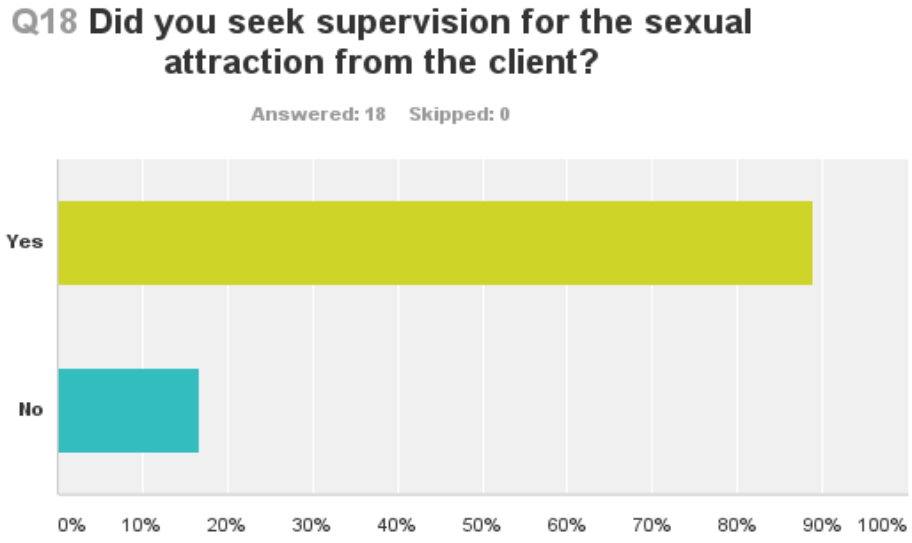


Figure 6. Participants' Responses to Whether They Sought Supervision

Researcher's Experience

All of the participants in this study were open with their responses. I believe this was possible because of the anonymity of being online. I have experienced sexual attraction in the therapy room from clients, and it caused me to feel discomfort and shock. According to Charmaz (2010), constructivist grounded theory stresses the importance of the researcher and how his or her views affect the creation of theory and the meanings behind theories that are created through the research. Charmaz explains that theory is seen as an interpretation of the research information. Taking this into account allows for insight into the influence the researcher has on the study and acknowledges the relationship between the researcher and the researched. As a result, neither can stand alone. As a theory is developed, it is constructed through not only the experiences of the participants, but also the experience of the researcher and what he or she brings into the study. During this research study journaling and memoing brought me closer to the data. I can relate to the idea that there was an elephant in the room that needed to be addressed along with the idea of setting boundaries in therapy. While my experience was different in some ways from the experiences of many of the participants, I could relate to their experiences. The participants' responses stress the need for more training in the field of marriage and family therapy to direct more attention to this topic. One participant's comment that resonated with me was PS7's experience of being fearful of being alone in an office suite with the client who was attracted to her because she was afraid of being sexually attacked by the client:

> PS7: I addressed the comments made by them and stressed the fact that a relationship that included sex would never occur. I tried to be sensitive to their

> feelings but I also was very stressed as I often work alone in my office and feared them sexually attacking me.

As a female working in private practice, I would often be alone with males in my office suite. When meeting with new clients, I found it important that I have a safety plan in order to ensure my safety. I currently work as a supervisor at a victim assistance and sexual assault program for county government. I ensure that victims of crimes such as murder, rape, violent and non-violent crimes have access to therapy and victim assistance. At the time of this writing, a client of the agency is a family whose daughter, a social worker, had been missing. Eventually, her remains were found in a dumpster and the investigation found that she was murdered by a client during a home visit. This therapist was new to working in the home visit environment. This young lady's death set a precedent. As a result of this incident, the county government no longer allows therapists to go out on home visits alone. They must go out as teams and call once they arrive and leave homes of clients. Hence, therapists who work in environments where they may be vulnerable should devise a safety plan. Likewise, safety should be an important part of training and supervision.

Summary

This chapter illustrated the findings of the mixed method research study on sexual attraction from clients in the therapy room. I was able to arrive at conclusions using statistical analysis and constructivist grounded theory, which highlighted the shared experiences of the participants and the outside influences that shaped those experiences. Collectively, the participants' experiences make up the theory. Charmez (2006) claimed that constructivist grounded theory is enhanced by adding empirical evidence in

conjunction with theoretical understanding. This study revealed five overarching themes and subthemes were supported by statistical data (Table 1). Participants in this study experienced attraction from clients in therapy overtly and covertly. They felt that this attraction did affect therapy. While many felt a multitude of emotions and comfort levels working with these clients the therapeutic process was tested. There was an overall consistency that the "elephant in the room", (i.e., the attraction), needed to be addressed. Many participants expressed the importance of setting professional boundaries with clients who had expressed attraction toward them. Additionally, participants used the attraction to move the client and the therapeutic process toward positive change.

Participants in this study were able to address some of their experiences around attraction relating to gender, culture, and their own attraction toward clients. Many participants stated they felt unprepared and needed more training in school, professional environments, and adequate supervision around attraction in therapy. My research concludes that LMFT are experiencing sexual attraction from clients in the therapy room. They feel that they are not prepared to handle the attraction due to a lack of training and accessibility to well-informed supervisors who are comfortable dealing with sexual attraction from clients. In Chapter V, I further discus the topic, the findings, the implications for the training of MFTs and the field of Marriage and Family Therapy in general, the limitations associated with this study, and my suggestions for additional research and training.

CHAPTER V: DISCUSSION AND IMPLICATIONS

This research study was sparked by my experience with sexual attraction from a client during a therapeutic session, which led me to become curious about whether other LMFTs have had similar experiences. A review of the literature revealed few studies in the field of marriage and family therapy that addressed LMFTs' experiences with sexual attraction in the therapeutic relationship. Most of the previous studies on the topic focused on either the experiences of MFT students or therapists' attraction toward clients (Brock & Coufal, 1994; Harris, 2001; Nickell et al.,1995).

Marriage and family therapists work in many settings, including private practice, government agencies, non-profit organizations, and corporations. Many LMFTS lack important resources, such as supervision, which are readily available to students in the university environment. According to Pope and Bouhoustsos (1996), the topic of attraction in the therapeutic relationship has mainly been discussed and researched within the field of psychology, which uses terms like *transference* and *countertransference* to describe the phenomenon. There is a lack of research in the field of marriage and family therapy that explores the phenomenon using our philosophies, language, and methods of working with clients. Harris (2001) explains that the lack of research in this area could be due to the taboo of speaking about attraction in therapy.

Failing to address sexual attraction in the therapy room can be detrimental (Pope, 1986). It can lead to possible boundary violations between the therapist and client. Not only can it cause stress for the client and therapist, but it can also jeopardize the therapeutic relationship and the practice of therapy. As Gerber (1995) states, "We must not censor or compartmentalize our thoughts or sexualized physical reactions and report

only those that are perceived to be socially and professionally acceptable as we will continue to greatly compromise both the therapeutic process and our growth" (p. 120).

Procedures/Method

This was a mixed method research study. I recruited LMFTs through the professional networking site Linkedin, online professional group forums, various AAMFT chapters, and word of mouth. The quantitative segment of the study was conducted using a web-based survey composed of 20 Likert-scale questions that gave participants the opportunity to elaborate on their responses by submitting a narrative with each question. Eighteen participants of mixed races and genders completed the survey. I submitted the survey questions to univariate analysis, which involves analyzing one variable at a time to reach a percentage distribution (Punch, 2005).

The qualitative segment of the study was conducted through a web-based forum. Three participants—one Hispanic male, one White male, and one White female—were asked to post once a week for five weeks to answer four questions. They were encouraged to engage in dialogue with one another around the topic and questions. The narratives from qualitative segment of the study were submitted to constructivist informed grounded theory analysis. According to Charmaz (2000), constructivist grounded theory focuses on shared experiences and relationships among participants. It is mindful of the researcher's experience with data as it relates to the study and pays attention to the contextual forces that contribute to one's experience.

The two segments of the study were merged together using a mixed method convergent parallel design with a parallel database variant. According to Mertens (2009), a convergent parallel design allows the quantitative and qualitative segments of the study

to hold equal weight, and the data collection process occurs simultaneously for both study methods. Creswell and Clark (2010) explain that using the parallel database variant enables the researcher to collect data in two different ways and then merge them together during the analysis to generate a theory.

Findings

Participants in this study reported experiencing sexual attraction from clients that resulted in a multitude of emotions and experiences. The participants claimed that attraction in therapy might be considered a normal occurrence considering the intimate nature of the therapeutic relationship. While many clients may claim to be attracted to their therapists, many participants stated that the attraction might be rooted in the presenting problems that bring clients to therapy. The findings of this study suggest that some of the risk factors that contribute to attraction from clients include poor boundaries, lack of training, and lack of formal support like well-trained supervisors. The ramifications of boundary violations and sexual attraction can be devastating not only to the client, but also to the professional and the field as a whole. Methods to mitigate boundary violations when it comes to sexual attraction from clients would include open dialogue in training programs, structured training practices in the field, and the availability of well-trained supervisors who are open to discussing taboo topics like sexual attraction.

Discussion

It is not surprising that when a therapist joins with a client and establishes closeness in the therapeutic relationship, the possibility of attraction is introduced (Bridges, 2003; Harris, 2001). The therapeutic relationship can be experienced as

intimate in many ways. When clients come to therapy they share parts of their lives they may have never shared with others. They often explore vulnerable aspects of themselves. The therapist takes a non-judgmental stance and remains open to listening, understanding, and showing compassion for the client's experience. A unique form of trust and connection is established.

Attraction occurs not only among therapists toward their clients—as previous studies in the MFT field have explored (Brock & Coufal, 1994; Harris, 2001; Nickel et al., 1995)—but also among clients toward their therapists. Therapists bear the responsibility of upholding the ethical boundaries and standards related to the avoidance of sexually intimate relationships with clients, even though engaging in appropriate relationships with clients can also test these boundaries. As Fisher (2004) emphasizes, "When therapists begin to develop sexual feelings for clients, whether or not they have had significant training on sexual ethics, the burden is on them to make sure they take appropriate steps to manage their feelings professionally and ethically" (p. 119).

As the participants in this study pointed out, there is a surprising lack of conversation, education, and training in graduate programs to prepare therapists for the inevitable attractions that will arise in many therapeutic relationships (Harris, 2001). As Gerber (1994) points out, "Whether sexualized reactions are examined in therapy depends to some extent on the therapist's perspective and training" (p. 119.)

The participants reported feeling a multitude of emotions including discomfort, shock, fear, and stress. PS3 stated, " I have never had to deal with overt, inappropriate sexual overtures or gestures. I don't know how I will react when/if that happens. It will undoubtedly be a function of the level of fear or threat it invokes in me". As was found

in previous studies, most of the participants reported that they had felt attracted to clients (Harris, 2001; Nickel et al., 1995; Pope, 1986, 1990, 2001). Not handling or managing these emotions and feelings can be detrimental, not only to clients and therapists, but also to the field of marriage and family therapy (Peterson, 1992; Pope, 1994; Pope & Bouhoustsos, 1986; Pope, Sonne, & Holroyd, 1993).

As therapists, we often work from a client-centered approach and lose sight of ourselves as we help others navigate through what can be the most trying times of their lives. Not acknowledging the self of the therapist opens the door to burnout, boundary violations, and secondary trauma, also known as compassion fatigue (Linley & Joseph, 2007; Sesan & Seda, 2011). The participants in this study spoke about cultural issues such as race, gender, and sexuality that play a role in how clients perceive them and their attraction toward them. For example, one participant was an African-American male who experienced attraction from a Caucasian female client. He rationalized that because it is not the norm for their two worlds to cross in such an intimate way, the door opened for her to become attracted to him. Additionally, participants described feeling vulnerable because they were unprepared. One client talked about having concerns for her safety when she was alone in her office with a male client who expressed attraction toward her.

Participants reported that the training they received in school was limited, brief, and ineffective. Many discussed having to learn how to handle attraction when they experienced it, which could mean avoiding discussing it with colleagues or supervisors. It is important for LMFTs to seek supervision throughout their careers. As Fisher (2004) states:

> Therapists must continue to use supervision, consultation, personal therapy, and didactics throughout their careers (which, incidentally, can all be part of thoughtful risk management). There is also some responsibility on the part of graduate programs, professors, and supervisors to discuss issues of sexual feelings, sexual attraction, self-disclosure, and professional boundaries early and often in therapists' training. (p. 118)

What participants found helpful was having a supervisor who was open and non-judgmental about their experience with attraction. It is important for MFTs to become comfortable talking about sex and sexuality issues as they pertain to therapy (Harris, 2001). Many participants felt they would have to address the attraction and set clear boundaries around the role of therapist and client. Boundary issues around sexual attraction in therapy can be detrimental to therapists, clients, and the field of marriage and family therapy. According to Folman (1991), the erosion of boundaries in therapy is the precursor for a sexual relationship with a client. When sexual attraction from clients is handled correctly, these experiences can move a client toward change and be an opportunity for learning and growth—not only for the client, but also for the therapist. Moreover, therapists can learn how to regulate and manage uncomfortable issues in therapy as they arise.

Implications for LMFTs and the Field of Marriage and Family Therapy

The results of this study suggest that as marriage and family therapists leave the university environment, they are exposed to the real possibility of sexual attraction in the therapy room. This study points out the impact that experiencing sexual attraction from clients has on the therapist who feels unprepared to handle the attraction. It is important

that LMFTs acknowledge these feelings and address them in a way that is beneficial not only for the therapist and client, but also for the field of Marriage and Family Therapy as a whole. It is important to set and maintain boundaries and avoid acting on sexual attraction toward clients. Seventy-two percent of the participants in this study reported that they had been attracted to clients at some point in their careers. This drives home the importance of LMFTs having the appropriate tools to combat boundary violations when it comes to sexual attraction in the therapy room.

As LMFTs we have the responsibility to uphold the AAMFT code of ethics and, additionally, to seek appropriate supervision, consultation, and personal therapy to manage some of the feelings that may arise when clients show attraction toward us. When working outside of the university environment it is easy to become isolated and complacent, which can set the stage for boundary violations. As participant PS7 claimed:

> It's a normal experience to be attracted to beauty, depth, honesty, to name a few qualities. There is no need to act on attraction. Yes, if there is a desire to act on an attraction in therapy, work out the underlying personal issues in therapy, explore the possible objective countertransference issues and appropriate interventions through consultation.

Some participants stated that they were able to stay curious, keep a non-judgmental stance, and address the attraction with their clients. PD3 mentioned the inherited philosophies of the Marriage and Family Therapy field that include being kind, connecting with clients, and not shaming them. In addition, she talked about how her professional experience helped her handle the attraction from clients. PD3 suggested that good therapy allows for the attraction to unfold:

> Usually I simply note it in the back of my mind. It's a common human reaction, especially when the person so rarely gets kind, close, non-shaming, genuine interest from another person. I don't want to shame the person, so I let it be. If I don't feel discomfort or react to the discomfort, the patient is more likely to tolerate the feelings without acting on them inappropriately. As I have become more experienced, some of these patients develop deeper, more complex and genuine feelings about the level of non-sexual intimacy we experience as the therapy unfolds over time. The sexual attraction wanes as the patient discovers/recognizes/identifies and tolerates and accepts the multiple layers of feelings inherent in the patient/therapist relationship.

Utilizing attraction in therapy can be beneficial and can move a session forward. Some of the techniques mentioned by participants in this study included reframing the attraction. Reframing is a technique used to help client see the challenges they present with in a new perspective (Robbins, Alexander, Newell & Turner, 1996). As PD2 explained:

> Therapy was able to continue and I was able to reframe therapy as a way for the youth for example that I worked with to create a healthier bond with the same sex as he historically had poor relationship and boundaries with many caretakers and male peers.

Other participants suggest therapists explore the underlining issues that maybe connected to the attraction. As PS16 stated, “I believe that everything that occurs in the therapeutic alliance is grist for the mill. It is all helpful, as the therapeutic relationship often mirrors other issues and relationships in the client's life”.

Based on my experience, the first step in moving a session forward is to acknowledge the attraction early on and to explore with curiousity the attraction that may be present in the room. PD10 asserts:

> We actually utilized it to help them identify what it was about and what may have been missing in their lives. It can deepen the therapeutic connection when addressed appropriately; it can create distance in the therapeutic relationship if the therapist is not willing to explore his/her reaction to it & how to work with it in the client's therapy.

PS15 uses attraction as an opportunity to moves session forward by engaging in deeper conversations in sessions, "It enables a dialogue to take place that wouldn't otherwise take place. It also highlights moral and ethical issues in terms of how I position myself."

The field of Marriage and Family Therapy needs to give more attention to the topic of sex and sexuality so that therapists become more comfortable speaking about it. As the results of this study indicate, clinicians need clear policies around safety planning and require trainings for therapists to be prepared to deal with attraction in the therapeutic relationship. When I experienced sexual attraction from a client, the most challenging aspect for me was seeking help. I feared that I would appear to be a bad or incompetent therapist. Furthermore, I thought that I may have done something to provoke the client's comments. Thankfully, my supervisor at the time was well versed in dealing with attraction in the therapeutic relationship, but as this study shows, this is not the norm.

Implications for Training and Supervision

The participants in the study stressed the need for more training in the school environment and continuing education around sexual attraction from clients in therapy.

Many participants in the study felt that the training that they received in their school or training environment only scratched the surface and did not adequately prepare them to handle sexual attraction from clients. I'm concerned that this lack of preparation could affect therapists' comfort when working with these clients, lead to ethical violations, and contribute to poor outcomes. I believe that training should include: a) ways to set professional boundaries; b) understand and manage the multitude of emotions that therapists may experience once clients express attraction toward them; c) maintain and manage comfort levels when a client expresses attraction; d) strategically bring the attraction into the therapeutic conversation; and e) address it in a way that allows for the client and therapist to grow. Lastly, training should instruct therapists on how to remain ethical and respond appropriately when they are mutually attracted to a client.

Training on the topic of handling attraction in therapy should be based on a structured lesson plan and include organized role-playing, safety planning for therapists and clients, the sharing of stories and experiences, and the development of theory and language around sexual attraction that incorporates the therapeutic principles of marriage and family therapy. Cottone (2001) offers the useful suggestion that training should include discussion about the social constructs that pertain to attraction, sex, and the professional culture as it pertains to ethics, boundaries, and sexuality issues in therapy.

I agree with the participants in this study who suggested that supervisors need to know how to supervise LMFTs who have experienced sexual attraction from clients. The participants also stressed the importance of supervisors being comfortable speaking about and exploring issues like sexual attraction from clients in order for the supervision experience to be more comprehensive. Lastly, the participants emphasized that

supervisors need to create a comfortable environment in which LMFTs in training can share their experiences with sexual attraction from clients in a manner that avoids judgment.

Limitations

There were expected limitations involved in this study. Because the study was conducted over the Internet, it may have attracted a particular type of LMFTs who were comfortable with the use of online communication. This factor could limit the ability to make generalizations about how other LMFTs are affected. I accepted this limitation in order to have a viable research study.

Another expected limitation may have been the manner in which online communication is conducted. Because online communication is not face-to-face, this limits the researcher's ability to read body language and verbal cues. In order to address these limitations, different symbols were set up to express emotions, which include:

1. ☺ - Happy
2. ☹ - Sad
3. Lol - Laughing out loud
4. :D - Big smile
5. :.(- Crying face

In addition, I asked the participants to clarify any emotions associated with their words. Attempting to address this limitation, I performed follow-up interviews with all participants in the qualitative segment of the study to ensure that my interpretations of the data were accurate. The recruitment of participants for the qualitative segment of the study also presented challenges with attrition. When I told prospective participants about

the five-week commitment and online posting requirements, many declined to participate because of their busy schedules.

Procedures and Methodological Recommendations

In both phases of the study, I experienced attrition even before the formal consent was signed and returned. I found that while many people expressed interest in taking the survey, most potential participants did not follow through with returning the consent form and demographic questionnaire. More specifically, the delicate nature of the topic of sexual attraction may cause discomfort when asking LMFTs to share their experiences. For example, a potential participant stated she and the other therapist in her office would like to take the survey, but expressed discomfort in sharing their names and other demographic information.

This is understandable given the taboo nature of the topic Harris (2001). This presents a significant challenge when recruiting participants, yet the demographic information is an important part of the study. First, the information confirms some of the inclusion criteria; second, it provides context; and third, it distinguishes the study from other studies. I was able to complete the demographic questionnaire for all participants in two ways: by it being returned by the participants or by communication during the registration portion of the study through online communication. In consideration of this, a researcher should allow time for the recruitment process and be available to possible participant to answer question and have open dialog.

Recruitment of participants for the qualitative portion of the study also presented challenges with attrition. I believe a primary factor for the attrition was the 5-week commitment and online posting requirements. When told about the five-week

commitment and online posting requirements, many prospective participants declined to participate, because of their busy schedules. I would recommend when setting up the requirements for an online forum research study that the commitment time and duration for participants be short-term.

Utilizing a mix method methodology helped to overcome these challenges in participation. It made it easier to capture LMFTs experience by allowing participants to have a choice in ways they could participate in the study. If a participant could not dedicate the time for the online forum, they were able to participant the short survey. Moreover, using a mix method approach allowed participants who were not computer savvy to participate in the study. One participant did not have access to a computer and I was able to mail the survey to that participant. In addition, the mix method approach allow for me to collect and capture more data.

Recommandations

Based on the results of the study, I recommend the implementation of training programs within the university environment and mandatory continuing education opportunities for LMFTs. I recommend that MFT training programs include a course addressing sexual attraction and sexualized topics that therapists may encounter during their practice. This course would include conducting role-plays of sessions where client attraction is present. Participant PD2 stated that the role-plays should center on the therapist's experience: "Maybe a role play. Least helpful has been over focus on the client and less focus on what the therapist (me) went through". Additionally, presentations from therapists who have experienced sexual attraction from clients and who could share their experiences and mentor new therapists would be beneficial. Sixty-six percent of

participants in this study did speak to a colleague or supervisor about the attraction. This would give participants a chance to share with individuals who are knowledgeable on the topic. Weekly articles could be assigned to learn about the current cultural perspective on sexuality. Dominant norms around sexuality could be explored and how this plays a role within the therapists' lives and in the therapy room. PS7 explained: "We have internalized our culture's judgment, strictures & roles; many of us do not know how to experience intimacy without relating it to sexuality, for example". PD3 furthers:

> We need to understand, or believe we understand, our experiences, so when explanation is unclear, we fill in the gaps with supposition, superstition, magic, etc. We attribute shame, fear ecstasy, delight and such to things according to cultural norms. Falling in love is natural and beautiful in one culture, and whimsical in another, and dangerous in yet another.

Safety guidelines for clients and therapists should also be a part of the training. These safety guidelines should include: ways to stay safe when working in private office suites, conducting proper phone intake assessments before first appointments, conducting continual safe checks, and managing safety with the therapy room/space.

Additionally, the course should require journaling of therapist experiences, reactions to weekly assignments, presentations, and topics. PD1 explained, "It would be helpful if I had a training on how to track my own emotions as well as how to utilize and know when it's helpful for the client".

This training would assist therapists in learning how to handle sexual attraction in therapy in ways that foster therapeutic growth in accordance with Marriage and Family Therapy philosophies, and provide a safe place to share their experiences. These

recommendations could be included as supplementary training to meet the sexuality or ethics class requirements at universities and colleges.

These recommendations are an attempt to address the lack of education indicated by participants of this study and to create opportunities for therapists to feel comfortable expressing their experiences with attraction from clients. Additionally, supervisors and trainers should develop strategies to manage and define boundaries around attraction from clients, set ethical guidelines, and have open forums for therapists to share their experiences and feelings that may arise from sexual attraction from clients. Moreover, there is a need for trainers and supervisors who are comfortable speaking about attraction in therapy, as this process can normalize the occurrence of attraction from clients and the feelings therapists may experience around sexually charged situations.

As a result of the study, it became evident that it is important that therapists be mindful of self-care. The therapists interviewed for this study experienced a multitude of emotions when they experienced the attraction, which included stress and anxiety. As therapists, we are exposed to a lot of different information and stories from clients. The stress from some the information or stories that clients share can lead to secondary trauma or compassion fatigue. It is important that therapists understand that in order to best serve our clients, and be effective therapists, we have to take care of ourselves and not be afraid to ask for help

The prevention of boundary violations not only benefits clients but also therapists and the field of Marriage and Family Therapy. When sexual attraction is present in therapy room, boundary lines can become blurred, especially when the attraction between therapist and client is mutual. If a therapist finds himself or herself in this position, it is

recommended that the therapist seek supervision, consultation, or therapy to address underling issues and future treatment planning for the client and the attraction. If it is deemed that the therapeutic relationship is not of benefit to the client or that clinical work is becoming inappropriate, a referral should be made to a different therapist or provider.

This study also reveals the need for more research on LMFTs' cultural experiences of same-sex attraction from clients as well as more research on the subject of technology and sexual attraction. For example, one participant in this study described receiving texts of a sexual nature from a client. Future studies should explore the issue of setting boundaries with technology used in the therapeutic relationship. According to Devi (2011), clients have become more technologically savvy. As technology becomes more advanced, training for LMFTs about how to handle sexualized texts, emails, and social media outlets from clients who are attracted toward them will be essential. The results of this study suggest the need for further research and attention to the topic of sexual attraction from clients, as well as more discussion around the topic as it pertains to the experience of LMFTs.

Summary

In conclusion, this mixed method research examined the experiences of LMFTs who experienced sexual attraction from clients during therapy. This study highlights the occurrence of attraction from clients in therapy and the experiences of LMFTs who felt they had not been trained or prepared adequately to handle such attractions. This study points to the need for better training programs, well trained supervisors, and discussions within the field of Marriage and Family Therapy as a whole about sexual attraction in therapy. We must not continue to ignore attraction in therapy simply because it is too

uncomfortable or difficult to discuss. We owe it to our clients to provide an environment where therapists are well informed to handle sexual attraction in the therapy room. It is incumbent upon us to create a therapeutic environment that offers clients understanding and respect despite the challenging topics they present.

LMFTs that are properly prepared to handle sexual attraction can offer a safe therapeutic environment where a therapist is mindful of boundaries in therapy and follows the ethical guidelines established by The American Association of Marriage and Family Therapy. Providing a safe therapeutic environment affords our clients respect and an understanding through which to explore their attraction or make appropriate referrals as necessary.

This study is beneficial to the field of Marriage and Family Therapy because it can serve as a springboard for discussion, trainings, supervision, and consultation about attraction from clients. Some of the emergent themes included themes include: Expressed Attraction, Self of the Therapist, Using Attraction in Therapy, Therapist's Social Construct, and Training and Supervision. This study highlights discussion, implications to the field, and recommendations for considerations. Moreover, the concluded research encourages further research on the topic.

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Appendix A

Survey from Survey Monkey

*** 1. Please enter your assigned id number**

2. Have you experienced sexual attraction from a client in therapy? Please explain your experience.

- ☐ Yes
- ☐ No

(Please specify) Required 

3. How many times have you experienced sexual attraction from clients in the therapy room?

- ☐ 1 time
- ☐ 2 times
- ☐ 3 times
- ☐ 4 times
- ☐ 5+ times

*** 4. How did you feel when you experienced sexual attraction in the therapy room? Please explain.**

- ☐ Stressed
- ☐ Shocked
- ☐ Flattered
- ☐ No Feelings
- ☐ Other

Other (please specify)

5. I felt comfortable working with the client who expressed sexual attraction towards me?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Undecided

6. I felt that the client's attraction affected therapy.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Undecided

*** 7. I felt comfortable speaking to the client about his or her attraction towards me? If so was it helpful to speak about the attraction? Please explain?**

- ☐ Strongly Agree
- ☐ Agree
- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Undecided

(Please specify) Required

8. I felt comfortable speaking to a supervisor or colleague about my experience?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Undecided

9. How did the client express attraction?

- ☐ Verbally
- ☐ Physically
- ☐ Emotionally
- ☐ Spiritually
- ☐ Other

*** 10. I feel sexual attraction from clients affects the role of therapist and clients? Please explain**

- ☐ Strongly Agree
- ☐ Agree
- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Undecided

(Please specify) Required

*** 11. I feel culture plays a role in sexual attraction from clients? Please explain.**

- ☐ Strongly Agree
- ☐ Agree
- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Undecided

(Please specify) Required

12. Do you feel the field of MFT addresses sexual attraction in the therapy room?

- ☐ Yes
- ☐ No

*** 13. Do you feel that gender plays a role in sexual attraction from clients in therapy room, If so how do you know?**

- ☐ Yes
- ☐ No

(Please specify) Required

14. Have you been attracted to a client?

- ☐ Yes
- ☐ No

15. Has attraction in the therapy room caused you stress ? If so, how did you cope with it? Please explain if yes.

- ☐ Yes
- ☐ No

(Please specify) Required _____

16. Would you continue services with the client who was sexually attracted to you?

- ☐ Yes
- ☐ No

17. Did you speak to anyone about the sexual attraction that you faced from client in the therapy room?

- ☐ Yes
- ☐ No

18. Did you seek supervision for the sexual attraction from the client?

- ☐ Yes
- ☐ No

*** 19. Do you feel that you were trained in regard to handling sexual attraction from clients? Please explain the training.**

- ☐ Yes
- ☐ No

(Please specify) Required _____

20. Was the training received in a school setting or in the community?

- ☐ School
- ☐ Community

☐ Other

*** 21. Was the training you received helpful? If it was helpful please explain why?**

☐ Yes
☐ No
(Please specify) Required _____

22. Have you continued therapy with the client that was sexually attracted to you?

☐ Yes
☐ No

Appendix B

Dyadic Interview Questions Guide

1. How many times have you experienced sexual attraction from clients in the therapy room?

2. How did you feel when you experienced sexual attraction in the therapy room? Describe your response.

3. Tell the story of what happened?

4. How did the client express attraction?

5. What did the therapist say in the moment that the sexual attraction was expressed?

6. Can you please speak about your thoughts and feelings?

7. Did you continue to work with the client who was sexually attracted to you?

8. Were you attracted to the client?

9. Did the attraction cause you stress? If so, how did you cope with it?

10. What was the end result of therapy and how it proceeded with the client who was sexually attracted to you? Can you please speak about your thoughts and feelings?

11. What is your understanding about the roles of therapists and clients as it relates to sexual attraction?

12. In your experience, how does the field of MFT respond to sexual attraction in the therapy room?

13. What are our ideas about the culture of sexual attraction in general?

14. How might gender play a role in sexual attraction from clients in the therapy room? Talk about the relevance of your gender.

15. Did you speak to anyone about the sexual attraction that you experienced from your client in the therapy room?

16. Did you seek supervision for the sexual attraction from the client?

17. How prepared do you believe you are to handle sexual attraction from clients? Describe the training you received regarding sexual attraction in the therapy room.

18. Was the training received in the school setting or in the community?

19. What was most helpful about the training you received? Least helpful?

20. What would have been helpful in preparing you better?

Appendix C

Contact Information for the Researcher

Rafiah H. Prince LMFT
RP@rafiahprincetherapy.com
786-261-9008
1309 Templeton Place
Rockville, MD 20852

Appendix D

Solicitation Flyer

Call for Participants

A Research Study performed by a PhD candidate at Nova Southeastern University is looking for Licensed Marriage and Family Therapists who have experienced sexual attraction from a client or clients in the therapy room.

This is a study that will take place on an online forum. The participants will be asked to post responses around their experiences on a weekly basis. Participants will be able to post under an alias to protect their identities. The information will be protected by secure log- in to maintain privacy. The forum responses will be destroyed after the study. The researcher will be conducting follow up phone calls to ensure the meanings behind information collected.

If you are interested, please contact the email below or phone number.

Rafiah H. Prince LMFT
RP@rafiahprincetherapy.com
786-261-9008

Appendix E

Adult Consent Form

Consent Form for Participation in the Research Study Entitled
Sexual Attraction from Clients in the Marriage and Family Therapy Field: An Exploration of Licensed Marriage and Family Therapists' Experiences and Training
Funding Source: None

IRB protocol #:

Principal investigator(s)
Rafiah H. Prince, M.S.
511 NE 38th st
Miami ,Fl 33137
786-261-9008

Co-investigator(s)
Shelley Green, PhD
3301 College Avenue
Fort Lauderdale, fl 33314
954-262-2300

For questions/concerns about your research rights, contact:
Human Research Oversight Board (Institutional Review Board or IRB)
Nova Southeastern University
(954) 262-5369/Toll Free: 866-499-0790
IRB@nsu.nova.edu

Site Information: https://saittr.proboards.com

What is the study about?
This is an invitation to participate in a study that will examine shared experiences of licensed marriage and family therapist who have experienced sexual attraction from a client or clients in the therapy room.

Why are you asking me?
You are being asked to participate in this study with 18 other licensed marriage and family therapists because you have experienced sexual attraction in the therapy room from a client or clients.

What will I be doing if I agree to be in the study?
This study will be preformed over a minimum of five weeks . Unless you are participating in the survey portion of the study which should take 30-45 minutes. Within the five weeks there will be two questions asked per week under each week's category. The participants are to post within two days of the posted question each week. The questions will be posted on Mondays, Wednesdays, Friday, and Sunday. Any added questions that are generated through posts on the board are at the discretion of the participants. The participants can comment

and respond to each other's posts as it relates to your experiences with sexual attraction. Participants are asked to be respectful of each other's experiences. If this is not abided by, the researcher has the right to terminate the subject's participation in the study. There is no maximum to post, but a minimum of twice per week. A week after the study ends the researcher will contact all participants to confirm findings.

Is there any audio or video recording?
This study will be performed on an internet forum board and a secure survey site. All typed responses will be stored within the Proboards website and Survey Monkey and printed by the researcher. The Proboards website and Survey Monkey is locked by password, which the researcher only has access. The forum will be destroyed 36 months after the study is completed. The printed portions of the forum board will be locked in a filing cabinet until it is destroyed by a shredder 36 months after the end of the study.

What are the dangers to me?
This research study involves minimal risk. Although some experience some risk associated with sharing complex situations, which may cause feelings of stress and anxiety. If this is the case a referral will be made to address these feelings. If you have any questions please feel free to contact the researcher Rafiah H. Prince (786) 261-9008 or the IRB board at the number above with questions about your research rights.

Are there any benefits for taking part in this research study?
There are no benefits to you for participating in this research study.

Will I get paid for being in the study? Will it cost me anything?
You will not be paid for participating in this study and it is at no cost to you.

How will you keep my information private?
Each participant will be given a non-identifier when using Proboard by the research used when posting on the forum board. Participants using Survey Monkey information will only be accessible by the research and administrative features of the site. Survey Monkey is a secure site and used to perform academic research. The forum and surveys will be destroyed 36 months after the completion of the study. The printed forum and survey pages will be stored in a locked file cabinet and will be shredded 36 months after the study is completed. All information collected will be kept confidential unless required by law to disclose information from the study. In addition, the IRB, regulatory agencies, and the researcher research committee may have access to the information collected from the study.

What if I do not want to participate or I want to leave the study?
This study is voluntary. At any time in the study you are free to withdraw without any prejudice. If you decide to leave the study, any information collected before

the date of leave will be used and stored for 36 month after the conclusion of the study.

Other Considerations:
If any new information arises from the study that may cause you to reconsider participating in the study the researcher will notify you.

Voluntary Consent by Participant:
By signing below, you indicate that

- this study has been explained to you
- you have read this document or it has been read to you
- your questions about this research study have been answered
- you have been told that you may ask the researchers any study related questions in the future or contact them in the event of a research-related injury
- you have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights
- you are entitled to a copy of this form after you have read and signed it you voluntarily agree to participate in the study entitled *Who's Prepared for the Big Bad Wolf: Sexual attraction in the Therapy Room*

Participant's Signature: _____ Date: _____

Participant's Name:_____ Date: _____

Signature of Person Obtaining Consent: _____

Date: _____

Appendix F

Steps to Entering the Study

Qualitative Segment of the Study:

1. Contact researcher for user name
2. Visit the forum website: https://SAITTR.proboards.com
3. Register on Proboards by clicking on the registration icon at the top of the page
4. Await for the approval by email from the researcher
5. Once approval is accepted you are free to participate in the study

Quantitative Segment of the Study:

1. Contact the researcher at Rafiah44@hotmail.com
2. The research will then email the link to Survey Monkey to access the survey
3. Participants will take the survey
4. Participants will submit the survey

Appendix G

How to Post on Proboards

1. Once logged in, click on the week that corresponds with the time frame of the study
2. There will be a question posted that corresponds with the study
3. Type answer as it relates to the question
4. Click “post”

Appendix H

Participants' Responsibilities

1. Post to weekly questions
2. Post in reference to experiences
3. Be respectful to the experiences of fellow participants in the study
4. Participate for the full length of the study
5. Notify the researcher of any obstacles
6. Notify the researcher if you are unable to participate for the full duration of the study
7. Participate in a follow up phone call with the researcher to confirm findings
8. Answer survey questions honestly

Appendix I

How the Study Works

This is a study that will last a minimum of five weeks, unless the participant is participating in the survey portion of the study, which only requires 30-45 minutes. Within the five weeks, there will be four questions asked per week under each week's category. The questions will be posted on Mondays, Wednesdays, Fridays, and Sundays. Any added questions that are generated through posts on the board are at the discretion of the participants. The participants can comment and respond to each other's post as it relates to your experiences with sexual attraction. Participants are asked to be respectful of each other's experiences. If this is not abided by, the researcher has the right to terminate the subject's participation in the study. There is no maximum to post, but a minimum of four times per week. The participants taking the survey portion of the study are required to complete the survey in its entirety. Two weeks after the study ends, the researcher will contact forum board participants to confirm findings.

Appendix J

Information About the Study

The therapeutic relationship is an essential part of therapy. This research project underscores how the therapeutic relationship is tested when clients are sexually attracted to their therapists. This study will attempt to develop a theory around how licensed marriage and family therapists handle sexual attraction from clients. This is performed by a PhD Candidate in Marriage and Family therapy department at Nova Southeastern University Rafiah H. Prince, LMFT.

Appendix K

FAQ Proboards

1. Q: Is my identity hidden on the form?

   A: Yes, you will be given a non-identifier by the research before the study begins. When you post responses to research question that non identifier will appear.

2. Q: How will this information be used?

   A: This information will be used to form theory for a dissertation at Nova Southeastern University around what therapists experience when there is sexual attraction from a client or clients in the therapy room.

3. Q: How can I contact the researcher?

   A: You can email the researcher at RP@rafiahprincetherapy.com or call at 786-261-9008

4. Q: How long is the study?

   A: The study will last for at least 5 weeks or until there is no additional information posted by participants.

5. Q: When does the study start?

6. Q: Is there a timeline to post on weekly questions?

   A: Yes, there will be four questions asked a week. The questions will remain open until there is no additional information submitted by participants.

7. Q: How do I post?

   A: Click on the week that corresponds with the study, Type answer in the dialog box, and click post.

8. How often can I post?

9. Q: Do I have to post for each question each week?

   A: Yes, please post as it relates to your experiences

10. Q: What is the minimum requirement for posting?

A: Four times a week, but it is at your discretion if you choose to post to generated questions from others' responses throughout the study.

11. Q: What is the maximum requirement for posting?

A: There is no maximum, but please post as it responds to your experience.

12. Q: Can I respond to other participant's post?

A: Yes, you can respond to other participants' posts. Please, be respectful to each other's experiences. The researcher will be monitoring the site to ensure appropriateness and deleting any inappropriate information.

13. Q: What if I can no longer participate in the study?

A: Please notify the researcher

FAQ Survey Monkey

1. 1. Q: How will this information be used?

A: This information will be used to form theory for a dissertation at Nova Southeastern University around what therapists experience when there is sexual attraction from a client or clients in the therapy room.

2. Q: How can I contact the researcher?

A: You can email the researcher at RP@rafiahprincetherapy.com or call at 786-261-9008

3. Q: How long is the study?

A: The survey takes between 30- 45 minutes

4. Q: What if I can no longer participate in the study?

A: Please notify the researcher

5. Q: How do I access the survey:

A. The research will email you a link to the survey via email.

Appendix L

Solicitation Flyer Survey

Call for Participants

A Research Study performed by a PhD candidate at Nova Southeastern University is looking for Licensed Marriage and Family Therapists who have experienced sexual attraction from a client or clients in the therapy room.

This is a study that will take place on a survey website call Survey Monkey. The participants will be asked to respond to a survey which takes between 30-45 minutes to complete.

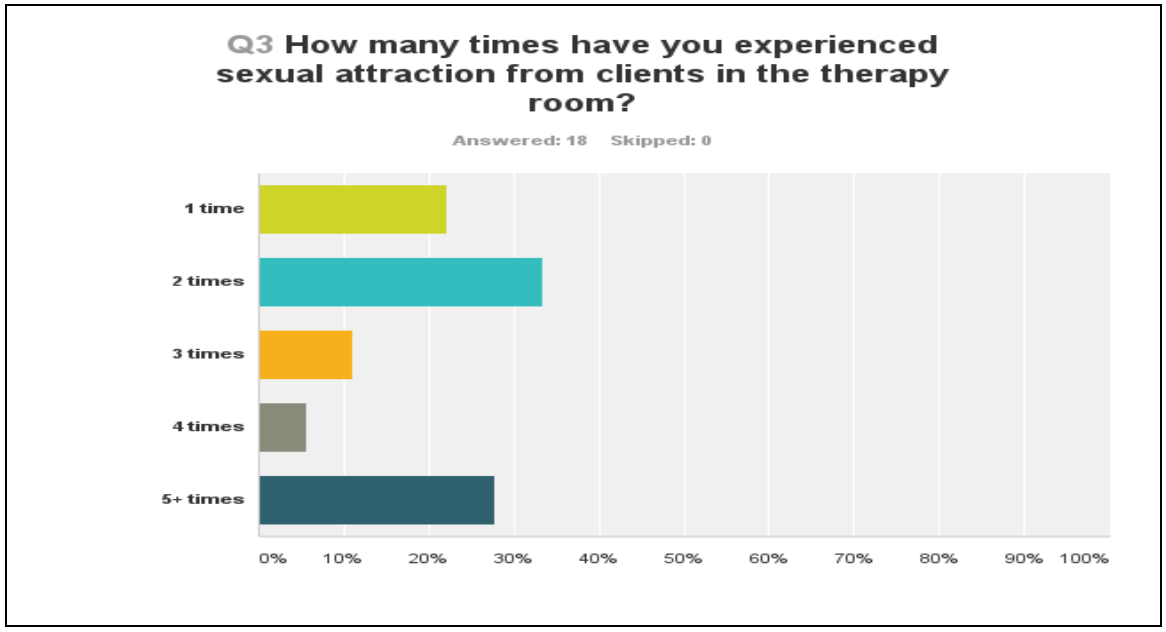
If you are interested please contact the email below or phone number, or pass this information on to other LMFTs who may be interested in participating.

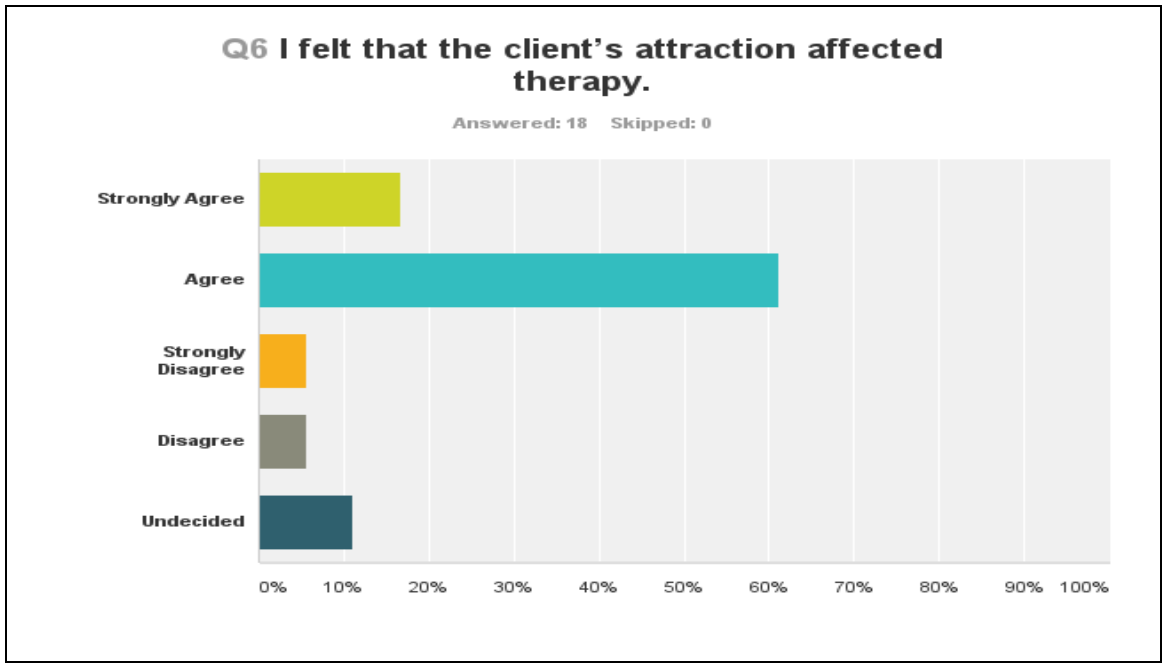
Thank you,

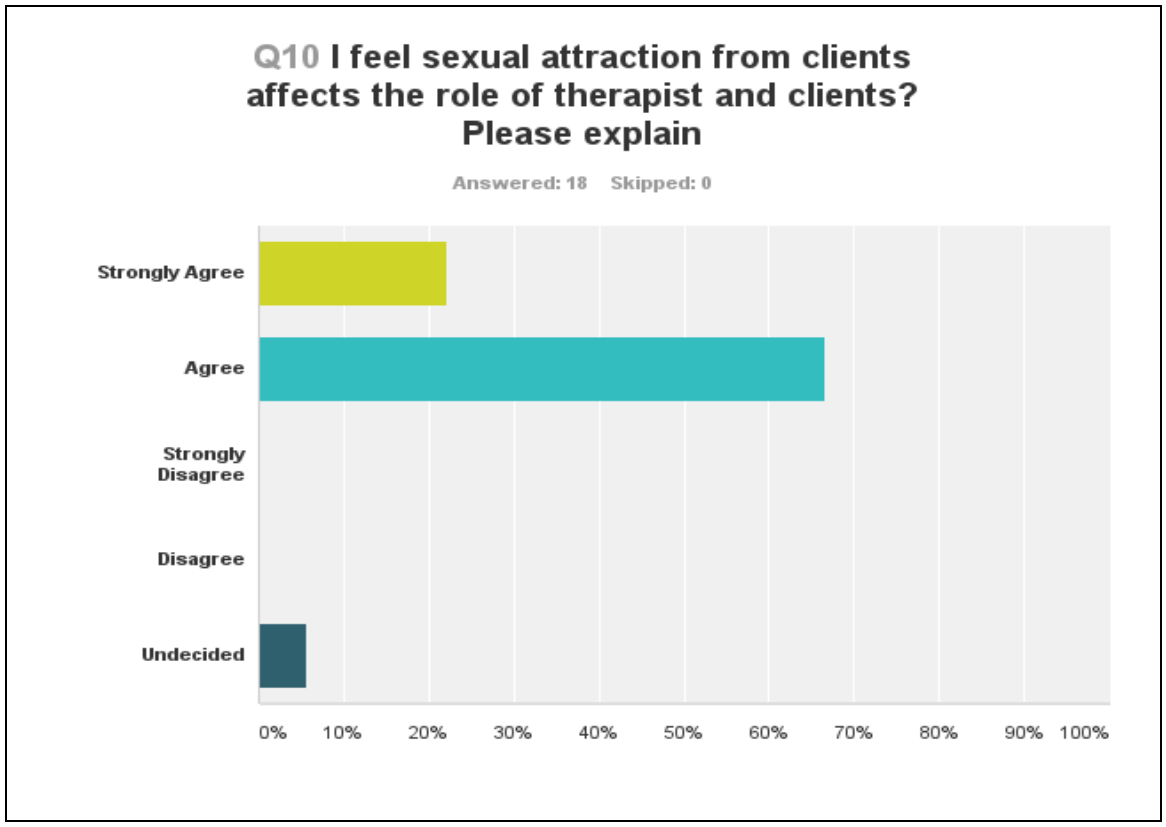
Rafiah H. Prince LMFT
RP@rafiahprincetherapy.com
786-261-9008

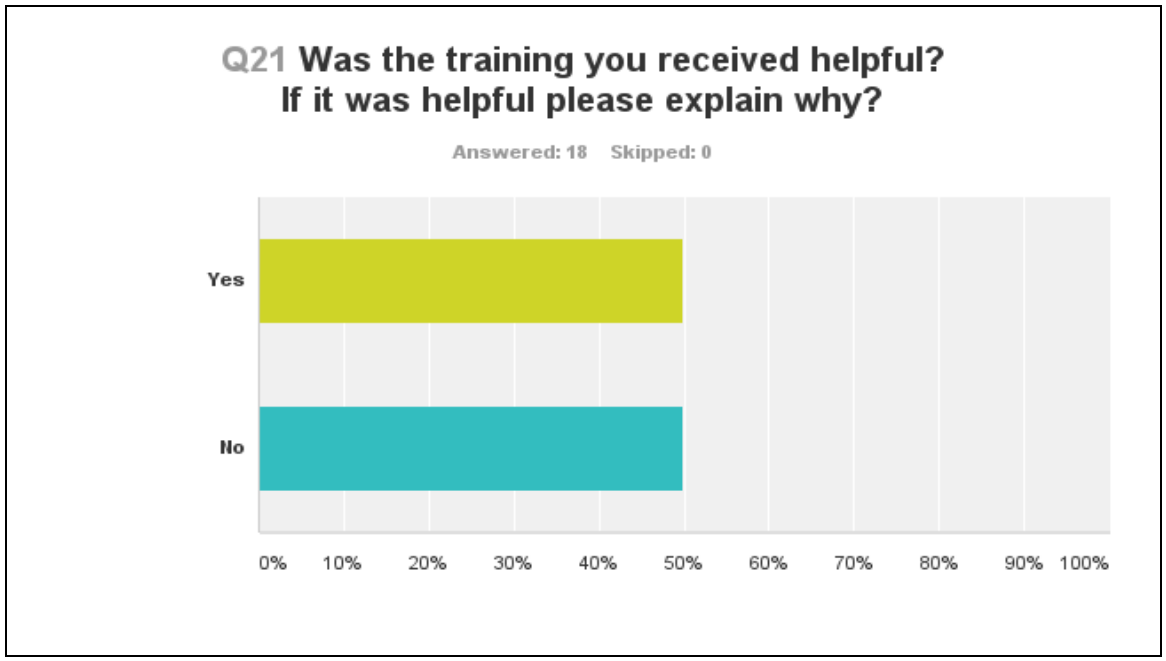
Appendix M

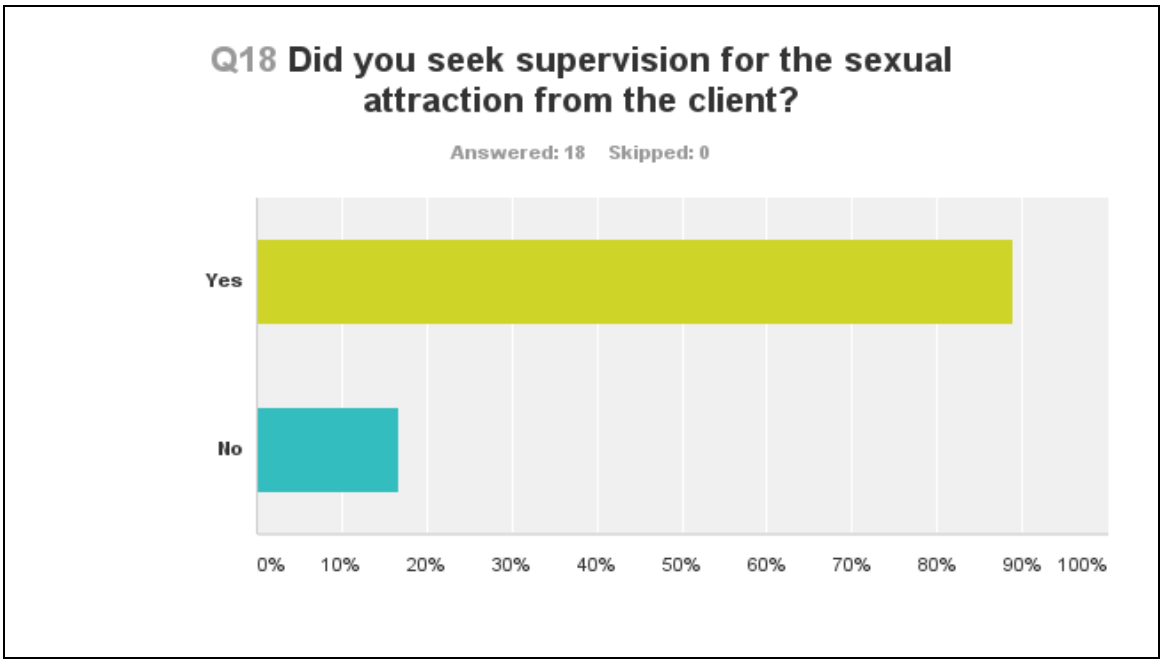
Graphic Representation of Participant Responses






Q10 I feel sexual attraction from clients affects the role of therapist and clients? Please explain
Answered: 18 Skipped: 0
Strongly Agree
Agree
Strongly Disagree
Disagree
Undecided
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%


Q21 Was the training you received helpful? If it was helpful please explain why?
Answered: 18 Skipped: 0
Yes
No
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%


Q18 Did you seek supervision for the sexual attraction from the client?
Answered: 18 Skipped: 0
Yes
No
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%