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Intimate attractions and sexual misconduct in the therapeutic relationship: Implications for socially just practice

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Abstract: Sexually intimate behavior between psychologists and their clients, supervisees, and students proposes a serious problem within psychology and related fields, although ethical codes related to this issue are contentious. Deleterious outcomes for those involved are often extensive and multifaceted. Additionally, clients from disenfranchised backgrounds may be at a heightened vulnerability to therapist exploitation due to increased power differentials. The discussion focuses on implications for training, supervision, and practice with regard to the therapeutic relationship and applications to minority populations. Recommendations are posited to help practitioners distinguish between sexual attractions and intimate behaviors and address them in ethical, socially just practice. Clients may also benefit from a deeper understanding of such issues.

Subjects: Counseling - Ethics; Cross-cultural Counseling; Personal Development; Practicum-Internship-Supervision

Keywords: sexual misconduct; exploitation; psychotherapy; social justice; boundaries

1. Introduction

Feelings of intimacy are inherent facets of many therapeutic encounters, and range dramatically depending on the particularities (Hayes, 2014). While such feelings are not necessarily sexual—and even in that case are not entirely problematic—they can carry significant weight for all parties involved. As an extreme, sexually intimate behavior between psychologists and their clients,

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PUBLIC INTEREST STATEMENT

Sexually intimate behavior between psychologists and their clients, supervisees, and students is a serious problem within psychology and related fields. There has been some disagreement in the ethical codes relating to these matters, in light of the array of negative outcomes for those involved. Additionally, clients from minority backgrounds may be at a greater vulnerability to therapist exploitation due to increased power differentials. The discussion focuses on implications for training, supervision, and practice with regard to the therapeutic relationship and applications to minority populations. Recommendations are suggested to help practitioners distinguish between sexual attractions and intimate behaviors and address them in ethical, socially just practice. Clients may also benefit from a deeper understanding of such issues.

supervisees, and students has notoriety as a serious problem within psychology and related fields. Overall perpetrator prevalence rates are 7–12% among general mental health practitioners in the United States (Celenza, 2007), encompassing approximately 2.5% of women and 9.4% of men (Pope, Keith-Spiegel, & Tabachnick, 1986; as cited in Koocher & Keith-Spiegel, 2008). Professionals who engage in this behavior are subject to ethical complaints, malpractice suits, and licensing board hearings (Pope et al., 1986), although ethical codes related to this issue are rather contentious (Gabbard, 1994). Additionally, deleterious outcomes for clients (Pope, 2001), as well as students, supervisees, and therapists (Koocher & Keith-Spiegel, 2008) are often extensive and multifaceted.

Although there has been some information promulgated about the incidence and consequences of therapist–client intimate contact over the past few decades, little has been present in the recent empirical base. Even less prevalent pertains to what has been documented regarding psychologists' sexual attractions to clients, a phenomenon that typically precedes the intimacy (Harris, 2001; Pope, Sonne, & Holroyd, 1993; Pope et al., 1986). Indeed, older estimates indicate that approximately 70–90% of clinicians have been attracted to one client, oftentimes more (Blanchard & Lichtenberg, 1998; Pope et al., 1986; Rodolfa et al., 1994). More recent studies indicated that 78% (Giovazolias & Davis, 2001) to 90% (Sonne & Jachai, 2014; in Hayes 2014) of those surveyed harbored such feelings. A preponderance of males has evidenced having intimate feelings, in comparison to females (Pope et al., 1986; Sehl, 1998). The extent to which psychotherapists are sexually attracted to clients, how they react to and handle such feelings, and the degree to which their training is adequate in this regard are important variables for consideration.

2. Legal precedents

Prohibition of sexual contact with one's clients dates back to the Hippocratic Oath, although the APA did not formally forbid it until 1977 (Pope et al., 1986). This was subsequent to three hallmark legal cases that implicated the reprehensible nature of the offense. In *Morra v. State Board of Examiners* (1973), the Kansas Supreme Court allowed for the revocation of a psychologist's license after he attempted to engage in sexual intimacies with his clients. A similar ruling occurred in *Cooper v. Board of Medical Examiners* (1975), as a result of sexual intimacies between a psychologist and clients.

Roy v. Hartogs (1975) was perhaps more representative of the current conception of therapist–client sexual misconduct, partially due to its inclusion of harm to clients. In this case, the plaintiff alleged that the defendant psychiatrist utilized sexual intercourse as a treatment technique for her sexual problems. She contended that her mental illness was exacerbated after the indiscretion; although, an appeals court only referenced practitioner malpractice, not client harm, in their ruling. Nonetheless, the notion of clients potentially becoming harmed or exploited due to sex with mental health providers was highly important in codifying ethical codes. Additionally, the feminist movement helped to dismiss the prevailing conception that women were merely acting out their sexual fantasies through these court cases, instead advocating for a more socially just approach.

3. Ethical guidelines

Several ethical codes of the American Psychological Association (APA) refer explicitly or indirectly to the issue of sexual encounters between therapists and individuals with whom they work in helping capacities (American Psychological Association, 2002, 2010).

3.02 Sexual Harassment. Sexual harassment is unwanted/offensive sexual solicitation, physical advances, or conduct that is sexual in nature, which may be deemed abusive to another party. Psychologists avoid sexually harassing those with whom they work.

3.04 Avoiding Harm. Psychologists take reasonable steps to avoid/minimize harming their clients, students, supervisees, research participants, and others.

3.05 Multiple Relationships. A multiple relationship occurs when a psychologist is in both a professional and additional role with another person, with a person associated with the person with whom

the psychologist has a professional relationship, or when he/she promises to enter into another relationship in the future with any of these persons. If such a dual relationship impairs objectivity and/or competence, or could potentially risk exploitation or harm to those who are served, the actions are deemed unethical.

3.08 Exploitative Relationships. Psychologists do not exploit persons over whom they have power/authority.

7.07 Sexual Relationships with Students and Supervisees. Psychologists do not engage in sexual relationships with those over whom they have evaluative authority.

10.01 Informed Consent to Therapy. This is pertinent to the nature of therapy, so that clients have realistic expectations; the therapeutic relationship is a professional one, which should be made explicit to clients at the outset.

10.05 Sexual Intimacies with Current Therapy Clients/Patients. Psychologists must not engage in sexual intimacies with current therapy clients.

10.06 Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients. Psychologists must not engage in sexual intimacies with relatives or significant others of current therapy clients.

10.07 Therapy with Former Sexual Partners. Psychologists must not conduct therapy with former sexual partners.

10.08 Sexual Intimacies with Former Therapy Clients/Patients. Psychologists must not engage in sexual intimacies with former therapy clients for at least two years after cessation or termination of therapy. After this interval, psychologists can potentially, albeit infrequently, become exempted from this principle if they demonstrate that no client exploitation occurred in the following areas: the amount of time that has passed since therapy terminated; the nature, duration, and intensity of the therapy; the circumstances of termination; the client's/patient's personal history; the client's/patient's current mental status; the likelihood of adverse impact on the client/patient; and any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a post-termination sexual or romantic relationship with the client/patient (American Psychological Association, 2002, 2010).

Ethical scholars have also addressed appropriate boundaries and multiple relationships with clients. For example, Kitchener (1988) offered three guidelines for differentiating between relationships that do and do not have a high probability of leading to harm. First, as expectations between roles become more incompatible, the potential for harm increases. Second, as the obligations associated with different roles become more divergent, the potential for loss of objectivity rises (e.g. clearer guidelines may be necessitated regarding former supervisory relationships (Avery & Gressard, 2000)). Third, to the extent that the prestige and power of the psychotherapist exceeds that of the client, the potential for exploitation is heightened. Indeed, as the risk for harm, loss of objectivity, and exploitation increase, so must the ethical guidelines prohibiting engagement in such relationships (Kitchener, 1988).

Furthermore, Gottlieb (1993) proposed a model for avoiding exploitative multiple relations that included three dimensions: power; duration of the relationship; and clarity of termination. Power can vary considerably across different persons and contexts, and refers to the discrepancy between the status, influence, and control of psychologist and his/her clients, students, and supervisees. Given the assumption that power increases over time and throughout the course of a relationship, the duration of the relationship in question is an important factor in assessing the potential for

exploitation. Clarity of termination refers to the specifics of the agreed-upon termination, and prospect of whether there will be further professional contact at a later time (Gottlieb, 1993).

Clearly, the issue of sexual misconduct and the implications of power differentials have manifestations not only in an individual psychotherapy context, but extend to group therapy, marital and family therapy, supervision, academia, and to persons who have outside relationships with one's clients. Nonetheless, the APA's dissemination of Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002, 2010) does not contain general guidelines for therapists who develop sexual attractions to their clients, or for those who consider disclosing these feelings to their clients (Fisher, 2004). Herein, one's discretion and professional training commonly contribute to the management of such feelings, rather than an explicit reliance on ethical codes. Whether the virtue ethic of prudence (Meara, Schmidt, & Day, 1996) and/or the quality of one's training (Blanchard & Lichtenberg, 1998) lead to beneficial outcomes in certain cases, however, can be quite ambiguous. In contrast, unpleasant effects have been observed among individuals involved in exploitative professional relationships.

4. Detrimental outcomes for individuals involved in sexual intimacies

Sexual contact between therapists and clients is unethical due to the power imbalance that permeates all aspects of the relationship, and because research has demonstrated that this form of sexual contact has ramifications for clients in the form of psychological damage (Sommers-Flanagan & Sommers-Flanagan, 2004). Pope (2001) documented the most common reactions that are frequently associated with therapist–client sex, articulating them as comparable to outcomes of incest or rape. These reactions are: ambivalence; cognitive dysfunction; emotional lability; emptiness and isolation; impaired ability to trust; guilt; increased suicidal risk; role reversal and boundary confusion; sexual confusion; and suppressed anger (Pope, 2001). A majority of clients surveyed reported sex with therapists as damaging; even those who found it pleasurable at first, eventually viewed it as exploitative (Koocher & Keith-Spiegel, 2008).

The ethical issues regarding sex between student and educator, and supervisee and supervisor, respectively, revolve more around the abuse of power and conflicts of interest (Koocher & Keith-Spiegel, 2008). Students and supervisees are vulnerable to those with evaluative authority and may thus feel coerced into pursuing an intimate relationship; here, power dynamics may influence sexual dynamics. Moreover, as a student's academic performance may become impaired or inhibited through sex with a professor, a supervisee's therapeutic work with clients can become compromised as a result of the inappropriate supervisory relationship. Negative emotional experiences can become apparent for students and supervisees, including fear, anger, a desire for vengeance, embarrassment, and guilt (Koocher & Keith-Spiegel, 2008).

A number of therapist consequences have also been documented in various domains. Risks to therapists encompass sanctions from professional organizations and licensing boards, criticism and ostracism from colleagues, and damage to the reputation of the field of psychology (Pope, Sonne, & Greene, 2006). Personally, offending clinicians may experience financial difficulties associated with legal fees, family conflict, and psychological problems related to the transgression (Koocher & Keith-Spiegel, 2008).

5. Specific multicultural and social justice considerations

Social justice implies responding to systemic inequalities that serve to marginalize and disenfranchise various groups of people, such that disadvantaged or marginalized groups may gain increased access to these tools of self-determination (Goodman et al., 2004). Power is inherently differential in therapy, with clients comprising the more vulnerable part of the alliance. From a feminist perspective, therapists are responsible for preventing potential abuse, harm, or victimization, and for acknowledging and attenuating power differentials within the therapeutic relationship (Brown, 2010). When power is shared in a collaborative manner, the client is enabled to feel empowered (Hill & Ballou, 1998).

Vera and Speight (2003) emphasize that research and teaching should have a more explicit focus on social justice issues in general, but this may also translate to multicultural and social justice issues in psychotherapy sexual attraction/contact. Indeed, prior research has focused on therapist-client sexual relationships, but the extent to which vulnerable populations are exploited herein is relatively understudied. It can be postulated that individuals from marginalized backgrounds and/or groups are at a heightened risk/level of vulnerability for sexual exploitation in therapy. These groups include—but are not limited to—mentally ill persons, minors, the elderly, childhood abuse survivors, disabled persons, racial/ethnic minority groups, impoverished people, LGBTQ individuals, women, and other marginalized and/or stigmatized populations.

Many individuals seek therapeutic support due to acute or chronic major mental illnesses. Persons may present as highly depressed, with severe anxiety, disoriented, in a dissociative state, and/or with emergent psychosis, among other presenting concerns (Zur, 2009). Due to the sensitive nature of these conditions, afflicted individuals may perceive themselves, and be consigned by clinicians, as vulnerable. Furthermore, clients who are hospitalized, imprisoned, or undergoing custody or sanity evaluations are likely to be highly reliant upon practitioners' impressions and recommendations (Zur, 2009). Such power dynamics may influence clients' and therapists' sexual dynamics, with little recourse for clients subject to solicitation.

Children and adolescents are a vulnerable population in that they often do not provide sole consent for treatment, and may therefore be more deferential to a mental health provider's authority. In a survey of psychologists, Bajt and Pope (1989) found that about 25% of respondents reported encountering instances of sexual intimacies between therapists and minors. Equally unsettling is the finding that approximately 5% of those exploited are minors at the time of the incidents (Pope & Vetter, 1991; as cited in Koocher & Keith-Spiegel, 2008). This topic, as well as that of sexual misconduct with elderly populations, is largely unaddressed in the literature, yet poses a significant issue for the field. There is considerable impetus for updated research and enhanced clinical awareness pertaining to victimization of persons at earlier and later stages of development. Moreover, topics of a sexual nature may be discussed within an adolescent's treatment, and awareness of such dimensions may be important in facilitating communication (Nissen-Lie & Stanicke, 2014; in Hayes, 2014).

Persons who were abused as children are also at an increased risk for victimization in therapy (Koocher & Keith-Spiegel, 2008), where they are prone to further traumatization. Furthermore, some disabled persons may have lower levels of sexual knowledge, experience, feelings, and needs (McCabe, 1999), which potentially puts them at risk for exploitation in therapy. In the context of historical systemic oppression, racial/ethnic minorities, persons with low socioeconomic statuses, and LGBTQ individuals are also vulnerable to a therapist's influence. If there is inadequate access to outside supportive resources, clients from these backgrounds may especially feel less supported, less confident in resisting a therapist, and be more susceptible to coercion.

Moreover, offending therapists are overwhelmingly male and victimized clients are predominantly female (Pope, 2001). Although female therapists account for a relatively low proportion of the prevalence, they engage in sexual boundary violations mostly with female clients (Celenza, 2007). Women may thus be more exploited in therapy (Koocher & Keith-Spiegel, 2008), again elucidating the importance of adopting feminist principles of acknowledging power imbalances and promoting empowerment (Brown, 2010).

Further, cultural differences in psychotherapy may contribute to an individual's (less clear) understanding of the nature and context of therapy. Therefore, it is the therapist's responsibility to fully inform clients of the limits of the therapeutic relationship and ensure that exploitation does not occur. Psychologists working with vulnerable clients, supervisees, and students need to be especially attuned to these issues and power differentials that exist, with an understanding that sexual misconduct can be especially damaging to people from socially marginalized groups. Adherence to a strong theoretical perspective may also provide a solid foundation in such cases. It is essential to be

mindful of the differences in love, attraction, sexuality, and relatedness that may exist between persons and cultures, as well as the potential for misunderstandings (Hayes, 2014). Utilizing an approach that emphasizes relational constructs (Nuttall, 2014) and/or the universal and individual elements of human experience as in existentialism (Berry, 2014) and multiculturalism may be fruitful. Acknowledging one's own values, biases, stressors, and strengths may help to mitigate the possibility of adverse outcomes (Barnett, 2014; in Hayes 2014).

It is evident that refraining from sexual contact with more vulnerable clients (and clients in general) is an ethical issue that cuts across the principles and standards. It also encompasses the virtue ethics of prudence, benevolence, integrity, and respect (Meara et al., 1996). Typically, minority groups are most likely to be uninsured, underinsured, underserved, and underrepresented in the national health care system (Satcher & Higginbotham, 2008), reflecting a pervasive social justice concern that may be exacerbated by issues of trust, conduct of psychologists, and abuse of power. A more in-depth focus of this issue is imperative in framing the future scope of the field of psychology, in terms of ethical, socially just practice.

6. Sexual attraction in the therapeutic relationship

A number of ethics scholars have commented on the paucity of data on sexual attraction in therapy, especially in the context of the ethical violation of actual sexual conduct (Koocher & Keith-Spiegel, 2008; Pope et al., 1986, 1993). Nonetheless, therapist sexual feelings to clients span an array of professional disciplines. The research that has documented the pervasiveness of this trend includes sport psychology (Stevens & Andersen, 2007), hypnotherapy (Adrian, 1996), counseling (Case & McMinn, 1997), and psychiatry (Bridges, 1998; Gorton, Samuel, & Zebrowski, 1996). Additionally, marriage and family therapy (Harris, 2001), social work (Sehl, 1998), and psychology (Berry & Worthington, 2001; Ladany et al., 1997; Pope, 2001) are helping professions prone to intimate attractions.

Sexual attraction in therapy is a normal occurrence that is not necessarily unethical, insofar as the attraction does not compromise objectivity or competence, and is not acted upon (Welfel, 2012). Some scholars have characterized it as inevitable (Barnett, 2014; in Hayes, 2014). Koocher and Keith-Spiegel (2008) described several alerts to problematic feelings, which could be any of the following: thinking about the person outside of the normal context; recurring thoughts or fantasies about intimacy with the client; satisfying personal wishes rather than focusing on therapeutic goals; wanting to touch the client; flirtatious behavior; or self-conscious grooming before certain appointments. Indeed, the slippery slope culminating in a sexual transgression is often intensified by unaddressed, unmitigated therapist feelings. Such feelings may be related not to the extreme instance (i.e. full sexual contact), but rather to ambiguity surrounding the subtle intricacies of fantasy, flirtation, and touch (Martin, Godfrey, Meekums, & Madill, 2011).

Several factors may contribute to therapists' attractions to clients. Pope (2001) delineated common characteristics of clients to whom approximately 5,000 psychotherapists were attracted, listed in order of descending occurrence. Physical attractiveness was the most frequent category, followed by a client being intellectually capable, sexual, vulnerable, having a positive personality, or showing kindness. Furthermore, therapists were attracted to clients who could fulfill the therapist's needs, were successful, behaved as a "good client," experienced a reciprocal attraction, or were independent. Within these dimensions, male therapists were significantly more likely to rate physical attractiveness as a sexually attractive quality, while female therapists were proportionately more likely to rate success as most important. Having an understanding of why a particular clinician may experience an individual client as attractive is important, in that it could help to decrease the potential for misconduct.

However, the very instance of having sexual feelings can be differentiated by therapist background and personality characteristics. Research has shown that some clinicians believed that sexual feelings were an indication of their enjoyment related to working with a client, as well as a

manifestation of enhanced empathy and attention (Ladany et al., 1997), leading to an overall positive impact on therapy (Giovazolias & Davis, 2001). Accordingly, approximately 50% of therapist respondents in one survey believed that their feelings of attraction benefited the therapeutic process (Rodolfa et al., 1994). In contrast, additional research has demonstrated that other clinicians experienced guilt, anxiety, shame, confusion, embarrassment, and a loss of objectivity (Ladany et al., 1997; Pope et al., 2006; Rodolfa et al., 1994) related to sexual feelings. In separate samplings of mental health professionals, a majority of respondents reported feeling guilty, anxious, and/or confused for attractions (Pope et al., 1986, 2006). Another estimate purported that negative outcomes were observed within the therapeutic relationship as a result (Rodolfa et al., 1994).

One reason for these negative emotions could be related to the historical trend of the profession to resist acknowledging sexual feelings and intimacies (Pope et al., 2006), dating back to psychoanalytic traditions (Pope et al., 1986). Sexual attraction is also more familiar to most persons, compared to actual romantic involvement with clients, and can feel more personal and less amenable to disclosure. Disclosure in itself can allow one to be subject to criticism, have their personal feelings exposed, and/or be considered inadequate by colleagues or peers, making it seem prohibitive (Celenza, 1998; Pope et al., 2006). Furthermore, the notion that an altruistic helper is sexually aroused by seemingly vulnerable clients can be threatening to the field of psychology, and can elicit negative perceptions of therapy. Religious (or other cultural) factors may also inhibit therapists from admitting sexual attraction due to an increase in distress and stigma (Case & McMinn, 1997).

Pope et al. (1986) elaborated upon therapists' feelings of sexual attraction from a psychodynamic perspective. Since countertransference represents the therapist's own transference (the sexual attraction), the therapist is purportedly involved in a distortion. This distortion is the diminishing of a "blank slate," and essentially viewing the client as a figure or conflict from the therapist's past (Pope et al., 1986). Because the countertransference is ostensibly an irrational response to the client's transference, the therapist is thought to be "mishandling" the transference. As a result, a therapist's attraction to a client becomes a therapeutic error and is considered shameful, likely accounting for the historical resistance to recognize these "taboo" issues in training/supervision (Fisher, 2004; Pope et al., 1986). Unrecognized or inappropriately managed sexual feelings on the part of the therapist can be detrimental to therapeutic outcomes, so one must learn to deal with these emotions effectively. Indeed, Giovazolias and Davis (2001) observed that while 39% of participants felt the aforementioned guilt, surprise, and shock for their feelings, 45% normalized their experiences in a more positive manner. The latter may lead to more in-depth understandings of transference, countertransference, and the actual therapist–client relationship (Gelso, Marmarosh, & Perez Rojas, 2014; in Hayes, 2014; Lotterman, 2014; in Hayes, 2014). The qualities that differentiate these individuals may be quite salient, and implications for training and practice thus follow.

7. Implications for training and practice

When therapists begin to develop sexual feelings for clients, they have a responsibility for ensuring they take appropriate steps to manage their feelings professionally and ethically. Trainees and recent graduates as well as eminent psychologists may be prone to both normal and more problematic feelings toward clients, and should take caution against feeling invulnerable to and disavowing such feelings. All practitioners should be especially contemplative of how their status, years of experience, and perceived level of competence may be implicated. Similarly, therapists must also evaluate their own multicultural backgrounds and values in relation to clients' identities, taking into account historical and systemic dynamics.

Multicultural counseling theories can inform clinicians' awareness of the power imbalances that exist when working with individuals from disenfranchised minority groups (Helms & Cook, 1999). Professionals must endeavor to not abuse the power they hold within these relationships and instead attempt to use this influence to secure resources and advocate for disadvantaged clients (American Psychological Association, 2003). Moreover, clinicians can adopt principles from feminist theory and therapy and strive to create an egalitarian alliance in which power is shared with clients

(Proctor, 2002), and where clients can thereby feel empowered within the context of therapy and beyond. Intimate contact should not be rationalized as a suitable way to share power with or empower the client, nor is it indicated in assisting clients with reaching therapeutic goals (Koocher & Keith-Spiegel, 2008).

Identification and management of sexual feelings is therefore essential in ethical practice, albeit in therapy, supervision, academia, or another related field. Training, consultation, supervision, continuing education, self-disclosure, personal therapy (Adrian, 1996), and termination/referral (Koocher & Keith-Spiegel, 2008) have all been described as singular or integrative methods to deal with attractions to students, supervisees, clients, or others. Case and McMinn (1997) purport that introspection/reflection, in particular, might increase the practitioner's distress, or lead to rationalizations to engage in sexual behaviors with a client, and should thus be ancillary.

A highly significant implication for training and practice is to cultivate effective means for self-care to promote emotional well-being (Celenza, 2007). This is essential to continually preparing oneself to work with others in a helping capacity and reduce stress associated with burnout. Self-care behaviors can include being a client in one's own psychotherapy, engaging in personal hobbies/activities, meditation, and exercise, among others. Hayes, Gelso, and Hummel (2011) alluded to five therapist attributes that can be beneficial in managing reactions to clients and foster positive therapy outcomes: self-insight, self-integration, anxiety management, empathy, and theoretical conceptualization of the case.

It also seems useful for professionals to monitor colleagues' engagement with self-care practices, questionable therapeutic/supervisory dynamics, and power dynamics present among different relationships.

Accordingly, consultation and supervision are other important venues in which the motivations behind psychologists' sexual attractions, ways to moderate them (Celenza, 1998; Welfel, 2012), and the relationships between sexual dynamics, power dynamics, and social justice can be discussed. Despite the likely benefits of seeking consultation, estimates have suggested that 60% (Rodolfa et al., 1994) to 73% (Giovazolias & Davis, 2001) of therapists with sexual feelings toward clients tend to take the initiative of doing so. As such, Ladany et al. (1997) recommend that supervisors commence conversations, normalize feelings, and provide opportunities for exploration in a safe environment. Paxton, Lovett, and Riggs (2001) suggest that those in supervising roles (or consulting roles) model appropriate behaviors, entailing an understanding that sexual feelings toward clients should be expected. Additionally, it is of paramount importance to distinguish sexual feelings from sexual misconduct (Fisher, 2004; Welfel, 2012) and to understand power imbalances inherent in the therapeutic relationship, particularly those involving clients from historically underserved backgrounds.

Self-disclosure is a typical occurrence in many therapeutic alliances, if appropriate and judicious. However, self-disclosure pertaining to sexual attraction is dramatically more contentious. Although actual instances vary based on the gender configuration of the therapy dyad, five to ten percent of therapists—most of whom were men—have disclosed an attraction (Fisher, 2004). Interestingly, about 75% of counselors in one study reported that clients have disclosed feelings of attraction to them (Sonne & Jachai, 2014; in Hayes, 2014). In all cases, the therapist's disclosure should have a treatment rationale, and client welfare must be kept at the foremost consideration.

One benefit to disclosing an intimate attraction is that it probably does not engender or contribute to more serious sexual boundary transgressions (Gabbard, 1994). Pope et al. (1993) indicated that self-disclosing has implications for treatment, such that one can have feelings but not act on them (i.e. modeling, containing affect). Further, some who disclosed had significantly improved therapeutic outcomes (Giovazolias & Davis, 2001). However, it appears that direct, explicit disclosures of sexual feelings may constitute harm to clients, or otherwise be confusing (Fisher, 2004). These discussions are also contraindicated for vulnerable populations, where clients may feel coerced into

acquiescing to the therapist's desires due to power imbalances. For instance, persons with sexual abuse histories (or those with less perceived power in therapeutic relationship) may be more likely to engage in sexual behaviors with therapists, presumably to a greater extent if therapist self-disclosure occurs (Fisher, 2004). Moreover, Goodyear and Shumate's (1996) study revealed that such situations were perceived to be less therapeutic, with a less competent clinician employing the disclosures. Overall, most psychologists considered self-disclosing too personal and therefore unethical behavior (Fisher, 2004; Pope et al., 1986). It is likely optimal to avoid doing so, as a standard.

Moreover, Pope et al. (1993) recommend that if clients disclose an attraction, the therapist should be especially cautious about revealing a mutual appeal. A rationale for this is reflected in the study conducted by Goodyear and Shumate (1996), which suggested that client expressions of romantic interest in therapists should be conceptualized as manifestations of a client's level of distress. Management of this transference can be attained through giving attention to the issue, and normalizing the feelings as being in the context of an intense therapeutic relationship (Koocher & Keith-Spiegel, 2008; Welfel, 2012).

With regard to training, practicum experiences and coursework generally have not focused on sexual attraction to clients, or trainees have found it unhelpful (Blanchard & Lichtenberg, 1998). Relatedly, Pope et al. (1993) advocated for safe-learning environments to facilitate therapists' comfort with acknowledging and expressing sexual feelings toward clients. Criteria that define safe-learning environments are: safety; understanding the task; respect; openness; encouragement; appropriate privacy; acceptance; sensitivity; frankness; and support (Pope et al., 1993). These environments have applicability in a variety of areas, such as peer supervision groups, formal classes, seminars, case conferences, practice, and field placements, among others, where feelings can be expressed through writing or discussion. Accordingly, graduate programs have a responsibility to employ content-specific training with regard to sexual feelings, sexual attraction, self-disclosure (pros and cons), and professional boundaries early and often during training (Fisher, 2004; Paxton et al., 2001). Lending credence to this form of training—after a six-session pilot course on sexual feelings and boundary maintenance in the treatment setting, participants in one study demonstrated increased knowledge and comfort regarding boundary and countertransference issues (Gorton et al., 1996).

8. Revisiting the APA ethical codes

The APA ethical codes (American Psychological Association, 2002, 2010) convey that sexual contact with former clients is prohibited, except under extremely unusual circumstances. This exception is meant to address accidental meetings two (2) years after a brief and non-intensive (or, non-transference-based) treatment (Welfel, 2012). Despite the extraordinary instance in which this is acceptable, 11% of counselors surveyed in Akamatsu's (1988) sample admitted to having had sexual contact with former clients, with the majority of respondents deeming the behavior unethical. In actuality, the effects of sexual intimacies between clinicians and clients during or subsequent to treatment may be quite injurious, resembling a form of sexual abuse (Pope, 1988).

Having two years as an infrequent, but *potential*, option may cause therapists to contemplate this during therapy. Since there is a possibility, it is difficult to dismiss it completely from clinicians' thoughts, possibly inciting misguided intentions, a focused therapy, or an abrupt end to treatment. The counselor may refrain from utilizing beneficial interventions or other treatment approaches due to the ethical guidelines of necessitating a limited relationship prior to post-termination sexual contact. Although, having entertained the thought of sexual intimacies with clients during therapy should preclude the involvement in the future, as per the ethical guidelines. Moreover, clients may feel inhibited in therapy if they know there is a possibility of eventual sexual contact (Gabbard, 1994; Koocher & Keith-Spiegel, 2008), perhaps exacerbating any concurrent sentiments of uncertainty or resistance. Thus, even if therapy was fully terminated with no recommendation for a follow-up, and

there has been no social contact for the appropriate amount of years (Gonsiorek & Brown, 1989), the prospect of the intimate relationship can be distracting or overwhelming during therapy.

Considering the relatively arbitrary APA requirement of two years, with somewhat vague standards, Gabbard (1994) contends that the codes should not include an exception to the rule for a drastically uncharacteristic case, and would instead suggest a complete prohibition. The main rationale for this is the potential for harm to clients who were involved in sexual relationships with their therapists (Pope, 1988). Therefore, allowing contact, albeit in the future, is still potentially increasing any damage that clients could experience as a result, essentially defying non-maleficence; it could also disrupt previous therapeutic gains. In particular, clients from various minority groups may feel more vulnerable to a psychologist's influence and exert less agency in resisting relationships after therapy has concluded. The potential for exploitation and harm in these instances is likely compounded. Consequently, Vasquez (1991) advocates for the position that counselors should not engage in sexual relationships with current or former clients, to minimize any risks to the provider, the consumer, and the profession.

The relationship between therapists and their clients are quite complex to assess, as they contain elements of professional, transference, and perspective-oriented relationships. It is also arduous to ascertain whether the client had the assertiveness to refuse sexual behavior, the client's emotional involvement in counseling, and the power dynamics of the particular relationship. The question of whether this is a real attraction may then emerge. For those who recognize transference reactions, the "attraction" in therapy is supposedly a manifestation of transference/countertransference dynamics creating the illusion of romance; there is no reliable measure of transference or resolution thereof (Gabbard, 1994). Furthermore, with the obligation for continued professional involvement, such as disability inquiries, insurance claims, or questions about chart notes, entering into a sexual relationship—even after therapy—can be problematic. It is compelling to consider that the implications of therapy can evolve later in life, and that confidentiality may be threatened in such relationships (Welfel, 2012).

With regard to brief consultations, prompt smoking cessations, etc., proponents of the two-year rule (or advocates of decreasing these) might contend that sexual activity is permissible. Although there are some merits to their claims that therapy was not intensive or transference was not apparent, the power disparity still existed, and was likely magnified for clients representing disempowered or marginalized statuses. Essentially, the therapist is unable to relinquish his/her influence over the client, as the nature of the helping relationship consigns each to a "helper/helpee" role (Committee on Women in Psychology, 1989; Gabbard, 1994). Regardless, the duration of treatment is probably immaterial even in these situations, because the power imbalance was established at the outset of the relationship. It would be useful to assess psychologists' views on the current ethical code and potential modifications.

The disadvantageous effect on the reputation of the profession stems from the notion that clients are being harmed or otherwise exploited by counselors (Pope et al., 2006). Consequently, more people are hesitant to enter or re-enter counseling due to feeling violated or distressed. Individuals from minority backgrounds are already underserved and underrepresented in therapy (Satcher & Higginbotham, 2008), and these issues of trust, conduct of psychologists, and abuse of power are potentially implicated. Thus, it is helpful to employ beneficence with vulnerable clients, provide psychoeducation, be collaborative and empowering, and engage in preventative measures for therapists, namely with the prohibition discussed here. Additionally, state laws differ, and clients can bring legal action to clinicians for malpractice/incompetence. This could particularly dissuade counselors from engaging in such acts if in conjunction with a prohibition—for all clients, regardless of timeframe—from the professional associations.

9. Conclusion

Being sexually attracted to clients, supervisees, and students is not necessarily an ethical violation; crossing the boundary to sexual contact is, however, a serious infraction. Clients from vulnerable populations may have less power in the therapeutic relationship, and may thus experience greater difficulty and distress when faced with a situation involving sexual misconduct. Such instances are likely to discourage individuals from pursuing therapeutic services and compound any existing problems. However, research is limited with regard to sexual attraction and misconduct involving persons from minority or underserved backgrounds. Additional research is necessary to delineate approximations of current prevalence rates—specifically with a focus on clients who may be at greater risk for exploitation—as well as perceptions of psychologists pertaining to current ethical codes. Socially, just psychologists and other mental health service providers need to engage in self-care and be cognizant of their feelings, motivations, and actions, with the welfare of those with whom they work kept paramount.

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