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Erotic Feelings Towards Patients in the Psychotherapy Session: Investigating Their Relationship With the Characteristics of the Therapist, the Patient, and the Treatment

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Abstract

Experiencing erotic feelings towards a patient is a fairly common occurrence, not pathological per se, during phases of psychotherapy. This study aims to analyze associations between, on the one hand, the presence in therapists of romantic attraction (RA), sexual attraction (SA), or flirting behavior (FB) toward patients and, on the other hand, a series of characteristics of therapist, patient, and treatment. Between April and June 2022, 547 psychotherapists completed an online survey investigating their affective and behavioral responses toward their most recently treated patient. Compared to female therapists, males showed significantly higher prevalence of SA alone (p < .001) or in combination with RA (p < .01), FB (p < .01), or both (p < .05). Multivariate adjusted regression models showed that RA was associated with patient age ≤40 years (OR:39.49 for age 18–29; OR:28.44 for age 30–39), male sex (OR:10.40),

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and diagnosis of mood disorder (OR:14.08). Furthermore, RA was associated with intense countertransference feelings of tenderness towards the patient (OR:79.77) and hostility towards significant figures in their life (OR: 77.93). SA was associated with the therapist's male sex/gender (OR: 16.14), psychoanalytic orientation (OR:13.34), post-license experience ≤20 years (OR:6.12 for 1–9 years; OR:6.08 for 10–19 years). Lastly, FB was associated with the therapist's male sex/gender (OR:16.94).

Keywords
psychotherapy, erotic feelings, romantic attraction, sexual attraction, flirting behavior

The presence of therapists' erotic feelings toward patients (and vice versa) is as old as psychotherapy itself (Ellenberger, 1970). The term "erotic" is a bridge concept between "pleasant" and "sexual," therefore, erotic feelings can shift from loving to sexualized (Stefana, 2017a). It is significant that the concept of countertransference was introduced in regard to the erotic difficulties psychiatrist Carl Gustav Jung encountered in his psychoanalytic treatment of a twenty-year-old patient, which eventually resulted in sexual violation of therapeutic boundaries (Stefana, 2017b). Within the psychoanalytic world, during the early decades of the twentieth century there were rather frequent cases in which male psychoanalysts performed the "absolutely necessary" examination of the sex organs of female patients who requested psychoanalytic treatment, masturbating them during the sessions (Falzeder, 1994; Reich, 1967). In those years, various male analysts became sexually involved with patients or former patients, and some married them (Gabbard, 1995; Stefana, 2015).

Regrettably, despite the significant advances made in the last hundred years in the field of psychotherapy, both in terms of training to become a therapist (Klein et al., 2011) and ethical standards (Campbell et al., 2021), even today therapists' enactment of their own erotic fantasies and urges with patients is still a frequent issue (Clemens et al., 2021). Although the prevalence of sexual boundary violations is very difficult to measure accurately, pooled data indicate that more than 4% of professionals in the psychological sector surveyed admitted to having committed such a violation (Hook and Devereux, 2018). Because most prevalence estimates were derived from self-reports, it is likely that the true rate may be underestimated.

Some have speculated that to the generally long-lasting and emotionally intimate nature of therapeutic relationships and the type of issues addressed within them increase risk of sexual feelings and behaviors between a psychotherapist and their patient (Luepker, 1999; Steinberg et al., 2021). Consistent with this hypothesis, evidence shows that psychiatrists are more likely to present sexual boundary transgressions than physicians in other specialties (Brooks et al., 2012; Gulrajani, 2020; Melo et al., 2019). However, it must be noted that such a risk appears to be higher for those clinicians affected by lovesickness, masochistic surrender, psychotic disorders, or predatory psychopathy and paraphilias (Gabbard, 1999, 2016).

Many psychotherapists who become involved in sexual contacts with their patients fall into the categories of “lovesickness” or “masochistic surrender,” or both. Lovesickness could occur if a health professional – typically a professionally isolated middle-aged male practitioner – whose core problem is a narcissistic imbalance and who has a special need to be loved and idealized by their patients to enhance the therapist’s self-esteem (Celenza, 2007; Gabbard, 2016; Goldberg, 1994).

In contrast, masochistic surrender may occur with therapists who are deeply invested in their own suffering, have difficulty dealing with their own aggression, and have found considerable masochistic gratification in treating “difficult” or “impossible” patients. These clinicians tend to be intimidated and controlled by their clients. The therapist’s need to suffer can lead them inexorably down a self-destructive path to sexual misconducts (Cooper, 1993; Gabbard, 2016).

There are other patterns that also might be related to sexual behaviors in therapy. Predatory psychopathy includes both pure antisocial personality disorders and severe narcissistic personality disorders with marked antisocial traits. Sexual behavior in this context tends to be predatory and psychopathic. Although people affected by paraphilic disorders are not psychopathic predators by their own nature, mental health clinicians who act on their perverse impulses usually suffer from severe character pathology on the narcissistic-to-antisocial continuum. These clinicians are usually male with a lifetime history of predatory sexual behavior, while their victims are female patients. However, there are some cases in which male or female practitioners systematically seduce same-sex clients (Benowitz, 1995; Gabbard, 2016). Lastly, instances of becoming sexually involved with a patient purely due to a bona fide psychotic disorder are rare. Within these rare cases, a manic episode of bipolar disorder is usually involved in the clinician’s sense of omnipotence about their ability to cure through love or sexual relationships (Gabbard, 2016).

Experiencing erotic feelings toward a patient is not a rare occurrence (Garrett and Davis, 1998; Vesentini, Van Overmeire et al., 2022bVesentini, Van Overmeire, et al., 2022), nor is it pathological per se (Sonne and Jochai, 2014; Stefana et al., 2020), but it is challenging and potentially very dangerous (Hayes, 2014). When these feelings are triggered or fueled by a certain type of transference of the patient, they can become (if thought out, elaborated, and shared with colleagues, instead of being enacted with the patient) an important source of information about the patient’s intrapsychic and interpersonal dynamics. Unfortunately, there is still a reluctance among therapists to openly talk and discuss with each other these matters due to fear of being morally and professionally disapproved (Barnett, 2014; Garrett, 1999; Vesentini, Van Puyenbroeck et al., 2022b). This reticence is a problem because these feelings, particularly when intense, can negatively affect both the therapeutic relationship and the patient if they are not adequately managed. Silence about these feelings can develop into sexual banter or flirtation, which can sustain or intensify the erotic atmosphere in therapy (Gabbard et al., 2001). This could constitute the beginning of a “slippery slope” into sexual contact (Gutheil and Gabbard, 1993; Paul, 2015; Strasburger et al., 1992).

An erotic atmosphere in therapy can be sustained or intensified by sexual banter or flirtation (Gabbard et al., 2001). Flirtation typically involves seductive behaviors designed to stimulate the sexual interest of the patient, which include intrusive sexualized posture and gestures of the therapist, prolonged eye contact and gaze at the patient's body, comments on their appearance and attractiveness, and intrusive discourse about their sexual life and preferences. It must be underlined here that (a) therapists/patients in one culture may interpret a specific behavior as flirtation while others from a different cultural background may interpret it as non-flirtation (Di Mark et al., 2009), and (b) although flirting only sometimes steps onto a slippery slope into sexual contact (Simon, 1995, 1999), it always is unethical and unacceptable (Capawana, 2016; Crausman, 2004). Even when these enactments do not continue into sexual relations, they cause serious negative consequences in the patient (including deep feelings of confusion, humiliation, and disempowerment) (Hook and Devereux, 2018), as well as damaging their trust in the therapeutic relationship.

Sexual misconduct usually is the end result of a process that begins with the emergence of erotic emotions followed by a series of nonsexual boundary crossings and relatively minor boundary violations (Franke and Riecher-Rössler, 2021; Gutheil and Gabbard, 1993). This occurrence is particularly devastating for the patient and is associated with anger, cognitive dysfunction, emotional lability, feelings of emptiness, significantly impaired trusting capacity, guilt, social isolation, increased suicide attempts, and other sequelae (Aviv et al., 2006; Bouhoutsos et al., 1983; Pope and Vetter, 1991). Although most therapists with erotic feelings toward a patient reflect profoundly on these sentiments and believe that talking about them is important, only about a third actually disclose them with peers or supervisors. Instead, as a counter-reaction, they just tend to apply strict boundaries with that patient (Vesentini, et al., 2022b).

Until now, only a few studies have attempted to identify profiles or associations with demographic, clinical, and professional variables of clinicians who experienced and enacted erotic feelings toward the patient (Celenza, 1998; Halter et al., 2007; Vesentini et al., 2021a; Vesentini, et al., 2022b), and the results are only partially consistent.

In light of the above, this research report explores psychotherapist, patient, and treatment characteristics as protective or vulnerability factors for experiencing romantic and sexual attraction feelings and for enacting flirting behaviors.

Method

We undertook a secondary analysis of a survey that used a sample of licensed psychotherapists to develop a short self-report measure of the clinician's overall affective, cognitive, and behavioral experiences of the patient during any given session of individual psychotherapy, which is named the Clinician Affective REsponse (CARE) scale (Stefana et al., 2023).

Study Design

This cross-sectional online survey was conducted through Qualtrics between April and June 2022. The invitation to complete the survey was distributed by sending an electronic link through the mailing lists of psychotherapy professional associations and registers. A brief description of the purpose of the study and assurance of anonymity were given in the invitation email and more detailed on the first page. Participants were asked to select the last patient (≥ 18 years old) they saw in individual psychotherapy and complete a patient demographic and clinical data form and a therapist demographic and professional data form (i.e., variables listed in Table 1), as well as the questionnaire items.

The primary study, "Therapist In-Session Experience Survey" (Study #: 22–0356), was evaluated by the Office of Human Research Ethics at the University of North Carolina, Chapel Hill. It was exempted from further review on April 6, 2022.

Questionnaire

The initial item pool contained 116 items reflecting a wide range of affective, cognitive, and behavioral reactions that a therapist may experience during a "good" or "difficult" session. The items used a five-level Likert scale: "not at all," "a little," "somewhat," "a lot," and "very much." The following items were not included on the final CARE scale, as they did not load substantially on any of the three major factors retained there (Stefana et al., 2023). However, because of their clinical, they constitute the target variables of the present study:

How much did…
(1) I feel sexually aroused or attracted to them.
(2) I feel romantically attracted to them, like they would be my spouse or lover.
(3) I find myself flirting with them.

Response Rate

The response rate to take part into the study was 6%, which is consistent with expectations based on recent cross-sectional online surveys of health professionals (Li et al., 2017; Wanlass, 2019). It is worth noting that low response rates per se had little or no effect on bias (Fosnacht et al., 2017; Massey and Tourangeau, 2013).

Statistical Analyses

Categorical variables were reported as frequency rates and percentages, while continuous variables were expressed in terms of mean (*M*), standard deviation (*SD*), and range. Because we were interested in investigating the presence *versus* absence of romantic attraction feelings, sexual attraction feelings, and flirting enactments

Table 1. Therapists, patients, and treatments characteristics, and prevalence of romantic and sexual attraction.

Characteristics	Romantic attraction		Sexual attraction		Flirting behavior		Total sample
	No	Yes	No	Yes	No	Yes	Yes
Therapist age (years)							
30–39	58 (11%)	1 (6%)	55 (11%)	4 (11%)	58 (11%)	1 (7%)	59 (11%)
40–49	104 (20%)	2 (12%)	98 (19%)	8 (22%)	102 (19%)	4 (29%)	106 (19%)
50–59	133 (25%)	5 (29%)	127 (25%)	11 (31%)	135 (25%)	3 (21%)	138 (25%)
≥60	235 (44%)	9 (53%)	231 (45%)	13 (36%)	238 (45%)	6 (43%)	244 (45%)
Therapist sex/gender[a]							
Female	384 (72%)	5 (29%)	381 (75%)	8 (22%)	385 (72%)	4 (29%)	389 (71%)
Male	146 (28%)	12 (71%)	130 (25%)	28 (78%)	148 (28%)	10 (71%)	158 (29%)
Professional background							
Psychologist	159 (30%)	4 (23%)	149 (29%)	14 (39%)	160 (30%)	3 (21%)	163 (30%)
Psychiatrist	59 (11%)	3 (18%)	56 (11%)	6 (17%)	58 (11%)	4 (29%)	62 (11%)
Other	312 (59%)	10 (59%)	306 (60%)	16 (44%)	315 (59%)	7 (50%)	322 (59%)
Theoretical orientation							
Cognitive-behavioral	103 (19%)	1 (5.9%)	103 (20%)	1 (3%)	104 (19%)	0 (0%)	104 (19%)
Psycho-dynamic/analytic	177 (33%)	11 (64.7%)	162 (32%)	26 (72%)	179 (34%)	9 (64%)	188 (34%)
Eclectic	102 (19%)	1 (5.9%)	101 (20%)	2 (6%)	102 (19%)	1 (7%)	103 (19%)
Other	148 (28%)	4 (23.5%)	145 (28%)	7 (19%)	148 (28%)	4 (27%)	152 (28%)
Post-licensed experience							
1–9 years	101 (19%)	2 (12%)	94 (18%)	9 (25%)	98 (18%)	5 (36%)	103 (19%)
10–19 years	168 (32%)	4 (23%)	158 (31%)	14 (39%)	169 (32%)	3 (21%)	172 (31%)
≥20 years	261 (49%)	11 (65%)	259 (51%)	13 (36%)	266 (50%)	6 (43%)	272 (50%)
Time spent practicing therapy							
1–10 hours per week	80 (15%)	1 (6%)	79 (16%)	2 (5%)	79 (15%)	2 (14%)	81 (15%)

(continued)

Table 1. (continued)

Characteristics	Romantic attraction		Sexual attraction		Flirting behavior		Total sample
	No	Yes	No	Yes	No	Yes	Yes
11–20 hours per week	163 (31%)	5 (29%)	154 (30%)	14 (39%)	163 (30%)	5 (36%)	168 (31%)
≥21 hours per week	287 (54%)	11 (65%)	278 (54%)	20 (56%)	291 (55%)	7 (50%)	298 (54%)
Patient age (years)							
18–29	143 (27%)	5 (29%)	135 (27%)	13 (36%)	143 (27%)	5 (36%)	148 (27%)
30–39	143 (27%)	7 (41%)	139 (27%)	11 (31%)	145 (27%)	5 (36%)	150 (27%)
40–49	106 (20%)	3 (18%)	104 (20%)	5 (14%)	106 (20%)	3 (21%)	109 (20%)
≥50	138 (26%)	2 (12%)	133 (26%)	7 (19%)	139 (26%)	1 (7%)	140 (26%)
Patient sex							
Female	364 (69%)	7 (41%)	349 (68%)	22 (61%)	362 (68%)	9 (64%)	371 (68%)
Male	166 (31%)	10 (59%)	162 (32%)	14 (39%)	171 (32%)	5 (36%)	176 (32%)
Any psychiatric disorders							
Yes	435 (82%)	10 (59%)	418 (82%)	27 (75%)	437 (82%)	8 (57%)	445 (81%)
No	95 (18%)	7 (41%)	93 (18%)	9 (25%)	96 (18%)	6 (43%)	102 (19%)
Any anxiety disorders							
Yes	241 (45%)	5 (29%)	230 (45%)	16 (44%)	240 (45%)	6 (43%)	246 (45%)
No	289 (55%)	12 (71%)	281 (55%)	20 (56%)	293 (55%)	8 (57%)	301 (55%)
Any mood disorders							
Yes	151 (28%)	8 (47%)	146 (29%)	13 (36%)	156 (29%)	3 (21%)	159 (29%)
No	379 (72%)	9 (53%)	365 (71%)	23 (64%)	377 (71%)	11 (79%)	388 (71%)
Any personality disorder							
Yes	83 (16%)	2 (12%)	79 (15%)	6 (17%)	84 (16%)	1 (7%)	85 (15%)
No	447 (84%)	15 (88%)	432 (86%)	30 (83%)	449 (84%)	13 (93%)	462 (85%)

(continued)

Table 1. (continued)

Characteristics	Romantic attraction		Sexual attraction		Flirting behavior		Total sample
	No	Yes	No	Yes	No	Yes	Yes
GAF							
Mean (SD)	64.9 (14.2)	68.4 (13.7)	64.8 (14.2)	68.4 (13.5)	65.0 (14.2)	67.4 (13.6)	65.0 (14.2)
Range	7–98	35–85	7–98	26–90	7–98	50–86	7–98
CGI							
Normal, not at all ill	146 (28%)	9 (53%)	142 (28%)	13 (36%)	149 (28%)	6 (43%)	155 (28%)
Borderline mentally ill	69 (13%)	2 (12%)	67 (13%)	4 (11%)	70 (13%)	1 (7%)	71 (13%)
Mildly ill	150 (28%)	3 (17%)	142 (28%)	11 (31%)	148 (28%)	5 (36%)	153 (28%)
Moderately ill	134 (25%)	2 (12%)	130 (25%)	6 (17%)	135 (25%)	1 (7%)	136 (25%)
Markedly/Severely ill	31 (6%)	1 (6%)	30 (6%)	2 (5%)	31 (6%)	1 (7%)	32 (6%)
Therapy length							
0–3 months	105 (19%)	1 (6%)	102 (20%)	4 (11%)	104 (20%)	2 (14%)	106 (19%)
4–12 months	149 (28%)	7 (41%)	144 (28%)	12 (33%)	149 (28%)	7 (50%)	156 (29%)
13–24 months	96 (18%)	4 (24%)	91 (18%)	9 (25%)	98 (18%)	2 (14%)	100 (18%)
>24 months	180 (34%)	5 (29%)	174 (34%)	11 (31%)	182 (34%)	3 (22%)	185 (34%)
Session frequency							
<1 per week	189 (36%)	5 (29%)	188 (37%)	6 (17%)	190 (36%)	4 (29%)	194 (36%)
1 per week	270 (51%)	9 (53%)	256 (50%)	23 (64%)	273 (51%)	6 (42%)	279 (51%)
≥2 per week	71 (13%)	3 (18%)	67 (13%)	7 (19%)	70 (13%)	4 (29%)	74 (13%)
Session attendance							
In person	217 (41%)	9 (53%)	207 (40%)	19 (53%)	218 (41%)	8 (57%)	226 (41%)
Remote	313 (59%)	8 (47%)	304 (60%)	17 (47%)	315 (59%)	6 (43%)	321 (59%)

Note. a = there was perfect correspondence between sex and gender; CGI = Clinical Global Impression; GAF = Global Assessment of Functioning. Bold p-values indicate statistical significance.

regardless of the subjective evaluation of their intensity, these three target items were dichotomized as present or absent by grouping "a little", "somewhat," "a lot," and "very much" as one group (*versus* "not at all"). Relationships between each variable and the presence of feelings of romantic attraction and feelings of sexual attraction, as well as flirting enactments, were calculated by cross-table analysis, and their statistical significances were determined with the Chi-squared test (p-values <.05). Multinomial logistic regression models tested whether these associations remained significant after controlling for all the other variables listed in the table. The results are reported in terms of adjusted odd ratios (aORs) and related 95% confidence intervals (CIs). An OR greater than 1 means a higher likelihood of an occurrence of the investigated domain within the considered explanatory variable. In contrast, an OR smaller than 1 means a lower likelihood of an occurrence. The analyses were performed in R version 4.2.2 (R Foundation for Statistical Computing, Vienna, Austria).

Results

This study included 547 psychotherapists, having a professional background as psychologists (30%), psychiatrists (11%), and other professions (59%). Most were female (71%), had more than ten years of post-license experience (81%), and worked as a therapist for a minimum of 20 hours per week (55%). Table 1 presents details of the characteristics of psychotherapists, patients, and treatment format. Therapists' in-session subjective experiences theoretically related to the constructs investigated are reported in Table 2.

The prevalence of romantic attraction and sexual attraction feelings towards the last patient seen were respectively 3% and 7%, while the prevalence of flirting enactments was 3% (see Table 3 and Figure 1). Compared to female therapists, male therapists showed significantly higher prevalences of sexual attraction alone or in combination with romantic feelings, flirting behavior, or both.

Table 4 presents the results of the chi-squared analyses. Fifteen of the associations were significant $p < .05$, and 7 were significant $p < .001$. The strongest associations were with therapist sex/gender, feeling tenderness towards the patient, flattered by the patient, and therapeutic orientation, with effect sizes approaching what would be considered "medium-sized" using Cohen's (1988) benchmarks. Therapist sex and tender feelings were significantly associated with all three. The other statistically significant associations all had small effect sizes (e.g., phi <.10).

Multivariate adjusted regression models (Table 5) showed significantly higher odds of experiencing romantic attraction in therapists dealing with a patient younger than 40 years of age, while the odds were higher in the case of male sex of the patient, presence of a mood disorder in the patient, and especially the presence of very intense feelings of tenderness of the therapist toward the patient and hostility at significant figures in their life. Regarding the emotion of sexual attraction towards a patient, the probability of experiencing it was significantly higher in male clinicians and those with a psychoanalytic/psychodynamic orientation and fewer years of clinical experience

Table 2. Therapists' subjective experiences toward the patient experienced during the last therapy session, and prevalence of romantic attraction, sexual attraction, and flirting.

	Romantic attraction		Sexual attraction		Flirting behavior		Total sample
Therapist's experiences	No	Yes	No	Yes	No	Yes	*N* = 547
Flattered by the patient[a]							
Not at all–Somewhat	510 (96%)	14 (82%)	492 (96%)	32 (89%)	514 (96%)	10 (71%)	524 (96%)
A lot–Very much	20 (4%)	3 (18%)	19 (4%)	4 (11%)	19 (4%)	4 (29%)	23 (4%)
Tenderness towards the patient[b]							
Not at all–Somewhat	509 (96%)	10 (59%)	491 (96%)	28 (78%)	508 (95%)	11 (78.6%)	519 (95%)
A lot–Very much	21 (4%)	7 (41%)	20 (4%)	8 (22%)	25 (5%)	3 (21.4%)	28 (5%)
Wish to give the patient genuine love and care[c]							
Not at all–Somewhat	485 (92%)	13 (77%)	468 (92%)	30 (83%)	487 (91%)	11 (79%)	498 (91%)
A lot–Very much	45 (8%)	4 (23%)	43 (8%)	6 (17%)	46 (9%)	3 (21%)	49 (9%)
Hostility at significant figures in the patient's life[d]							
Not at all–Somewhat	511 (96%)	14 (82%)	493 (97%)	32 (89%)	512 (96%)	13 (93%)	525 (96%)
A lot–Very much	19 (4%)	3 (18%)	18 (3%)	4 (11%)	21 (4%)	1 (7%)	22 (4%)
Find it hard to emotionally understand the patient[e]							
Not at all–Somewhat	528 (99%)	16 (94%)	509 (99%)	35 (97%)	531 (99%)	13 (93%)	544 (99%)
A lot–Very much	2 (1%)	1 (6%)	2 (1%)	1 (3%)	2 (1%)	1 (7%)	3 (1%)

Note. [a] = the therapist felt flattered about something the patient said about their work or them.
[b] = the therapist felt tenderness towards the patient, more than they usually feel for their other patients.
[c] = the therapist wished they could give the patient the genuine love and care that the patient never received, needed, or deserved.
[d] = the therapist felt judgmental, resentful, or angry at emotionally significant figures in the patient's life.
[e] = the therapist found it hard to emotionally understand the patient's emotions, thoughts, and behaviors from their point of view. Bold p-values indicate statistical significance.

after license. Lastly, the presence of flirting enactments was associated only with the male sex of the therapist.

In addition, we examined if these behaviors were more likely to be reported in same-sex *versus* mixed-sex dyads. For all three –i.e., sexual attraction, romantic attraction, or flirting behavior – odds were significantly lower, *p*s<.001.

Discussion

This is one of the first studies to investigate the relationship between, on the one hand, the factors peculiar to each therapist-patient dyad (specifically, the demographic and professional characteristics of the therapist, the demographic and clinical characteristics of the patient, and the treatment characteristics) and, on the other hand, the presence of erotic feelings toward the patient.

We found that 41 out of 547 therapists surveyed experience romantic (3%) and/or sexual (7%) feelings toward the patient most recently seen. Considering that the sampling frame focused only on the feelings and behaviors towards the very last patients seen in psychotherapy (e.g., not the entire case load, or over the span of one's career), this suggests a relatively very high prevalence of erotic feelings among therapists. In fact, previous studies found that approximately 70–80% of therapists found at least one of their patients sexually attractive (Giovazolias and Davis, 2001; Vesentini, et al., 2022b), and about a quarter fantasize about a romantic relationship (Vesentini, et al., 2022b). The existing literature is consistent in indicating the importance of "peervision" and supervision when facing intense erotic feelings toward a patient (Celenza, 2007; Fisher, 2004; Gabbard, 2016; Nickell et al., 1995; Pope et al., 1993). However, only about 50–65% of therapists who experience those emotions openly discuss them with a colleague or supervisor (Giovazolias and Davis, 2001; Vesentini, et al., 2022b). This situation indicates the need within theoretical courses and supervisions to discuss more explicitly and frequently the natural occurrence of these feelings and impulses during phases of psychotherapy. Findings add weight to the description of clinical supervision as "an arena to promote mastery and demystify complicated erotic treatments and transference/countertransference enactments" (Bridges, 1998, p. 225). At the same time, teachers and supervisors should explain that enacting these impulses not only constitutes professional misconduct, but, more importantly, causes serious harm to the patient.

Regarding therapists' enactments, our findings show that 14 out of 547 (i.e., 3%) therapists surveyed reported flirting with their most recently treated patient. This number can be considered consistent with (unpublished) data from a recent survey of psychotherapy patients' perception of and reaction to their therapist during their most recent session (see Stefana et al., 2022a), in which 27 out of 701 (i.e., 4%) patients reported thinking that their therapist was sexually attracted by them. The discrepancy between the two percentages might be at least partly attributable to a misperception or projection on the part of patients. It should be underlined that, unlike experiencing romantic and sexual feelings toward the patient, flirting enactment represents an actual

Table 3. Descriptive statistics of the target items.

	Romantic attraction	Sexual attraction	Flirting behavior
Likert scale			
Not at all	530 (97%)	533 (97%)	511 (93%)
A little	10 (2%)	13 (2%)	29 (5%)
Somewhat	6 (1%)	6 (1%)	3 (1%)
A lot	1 (0%)	1 (0%)	3 (1%)
Very much	0 (0%)	1 (0%)	1 (0%)
Skew	6.8	5.8	8.6
Kurtosis	50.5	40.7	91.0

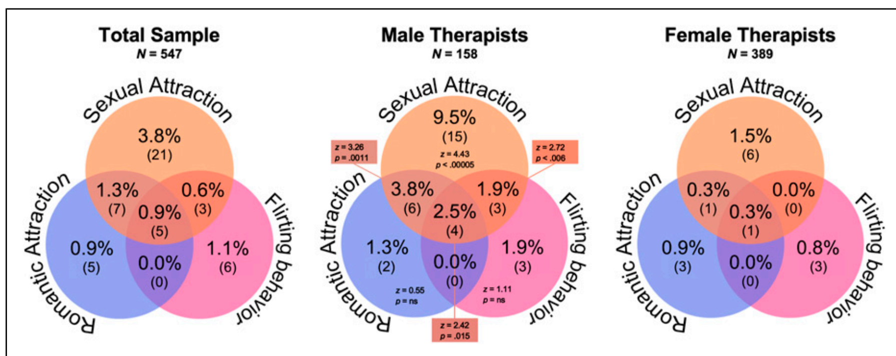

Figure 1. Relationships among romantic attraction, sexual attraction, and flirting behavior among therapists who reported any of these. *Note.* This is a subset.

sexual boundary violation (Hook and Devereux, 2018). In our sample, the presence of flirting enactments was associated with being a male therapist, which is consistent with the findings of studies on sexual misconduct in psychotherapists and healthcare professionals (Clemens et al., 2021; Hook and Devereux, 2018).

It is important to note that even when flirtation does not continue into sexual contacts, it causes serious negative mental health effects in the patient (Hook and Devereux, 2018) and damages trust in the therapist and the therapeutic relationship. It is precisely to avoid harming or exploiting a patient that more than nine out of ten therapists agree that flirting with a patient, although without further ulterior motives (we would like to add "conscious"), is an unacceptable intimate and informal behavior (Vesentini, et al., 2021b).

Consistent with a recent study (Vesentini, et al., 2022b), we also detected this gender imbalance for the experience of sexual feelings toward the patient. However, in contrast to that study, we found an increased probability of experiencing these feelings in psychoanalytically oriented therapists (*versus* no differences among the theoretical

Table 4. Associations between therapists, patients, and treatment features and romantic and sexual attraction.

Characteristics	Romantic attraction				Sexual attraction				Flirting behavior			
	χ^2	Phi	d.f.	*p*	χ^2	Phi	d.f.	*p*	χ^2	Phi	d.f.	*p*
Therapist age	1.31	—	3	.727	1.22	—	3	.748	.90	—	3	.827
Therapist sex/gender	12.80[a]	.15	1	**< .001**	42.30[a]	.28	1	**< .001**	10.6[a]	.14	1	**.001**
Professional background	.85	—	2	.654	3.40	—	2	.183	4.30	—	2	.117
Theoretical orientation	7.97	—	3	**.047**	26.00	—	3	**< .001**	7.52	—	3	.057
Post-licensed experience	1.61	—	2	.448	2.89	—	2	.235	2.77	—	2	.250
Time spent practicing therapy	1.29	—	2	.525	3.07	—	2	.215	.173	—	2	.917
Patient age	2.60	—	3	.457	2.58	—	3	.461	2.69	—	3	.443
Patient sex	4.52[a]	.09	1	**.034**	.50[a]	.03	1	.479	.00[a]	.00	1	1.000
Any psychiatric disorders	4.44[a]	.09	1	**.035**	.63[a]	.03	1	.429	**4.03**[a]	**.09**	**1**	**.045**
Any anxiety disorders	1.13[a]	.05	1	.288	.00[a]	.00	1	1.000	.00[a]	.00	1	1.000
Any mood disorders	1.93[a]	.06	1	.165	.59[a]	.03	1	.439	.12[a]	.01	1	.734
Any personality disorder	.01[a]	.00	1	.923	.00[a]	.00	1	1.000	.26[a]	.02	1	.614
GAF[b]	—	25	—	.316	—	.25	—	.143	—	.17		.531
CGI	5.65	—	4	.227	2.06	—	4	.724	3.61	—	4	.461
Therapy length	3.00	—	3	.392	2.75	—	3	.433	3.29	—	3	.348
Session frequency	.41	—	2	.813	6.09	—	2	**.048**	2.78	—	2	.249
Session attendance	.55[a]	.03	1	.460	1.61[a]	.05	1	.204	.89[a]	.04	1	.345
Flattered by the patient	4.80[a]	.09	1	**.028**	2.91[a]	.07	1	.088	15.4[a]	.17	1	**< .001**
Tenderness towards the patient	39.60[a]	.26	1	**< .001**	19.60[a]	.19	1	**< .001**	4.80[a]	.09	1	**.029**
Wish to give the patient genuine love and care	2.91[a]	.07	1	.088	1.89[a]	.06	1	.170	1.40[a]	.05	1	.238
Hostility at significant figures in the patient's life	5.19[a]	.10	1	**.023**	3.24[a]	.08	1	.071	.00[a]	.00	1	1.000
Find it hard to emotionally understand the patient	1.84[a]	.06	1	.175	.50[a]	.03	1	.480	2.41[a]	.07	1	.121

Note.[a]Pearson's Chi-squared test with Yates' continuity correction.
[b]Cohen's *d*instead of Phi.
Phi coefficients estimated for 1 *df* tests; phi ∼.1 small, phi ∼.3 medium, phi ∼ .5 large per Cohen's (1988) conventions. Multiple *df* variables unpacked in the multinomial logistic regression analyses (below).

Table 5. Incremental associations between therapists, patients, and treatment features and romantic and sexual attractions and flirting behavior based on multinomial regressions.

	Romantic attraction		Sexual attraction		Flirting behavior	
Characteristics	aOR (95%CI)	*p*	aOR (95%CI)	*p*	aOR (95%CI)	*p*
Therapist age (Ref. 30–39 years)						
40–49	.25 (.00–324.51)	.685	.60 (.10–3.88)	.585	2.91 (.09–538.58)	.603
50–59	5.94 (.04–22389.24)	.609	2.20 (.42–12.92)	.361	4.50 (.13–1007.29)	.477
≥60	8.31 (.05–36699.67)	.552	1.00 (.16–6.68)	.999	1.35 (.02–316.40)	.895
Therapist sex (Ref. Female)						
Male	7.72 (1.10–95.86)	.062	16.14 (5.59–55.37)	**<.001**	16.94 (2.55–205.58)	**.009**
Professional background (Ref. Psychologist)						
Psychiatrist	4.81 (.24–164.06)	.323	.63 (.15–2.44)	.507	19.95 (1.39–685.02)	.052
Other	1.02 (.12–9.92)	.984	.30 (.08–1.00)	.055	1.44 (.15–17.92)	.756
Theoretical orientation (Ref. Eclectic)						
Cognitive-behavioral	23.76 (.28–5086.67)	.180	.75 (.03–11.94)	.841	.00 (NA)	.992
Psycho-dynamic/analytic	31.23 (1.48–3171.71)	.067	13.34 (2.38–127.77)	**.009**	5.72 (.45–220.47)	.242
Other	6.10 (.15–682.81)	.375	4.05 (.59–41.91)	.186	1.45 (.08–55.70)	.812
Post-licensed experience (Ref. ≥20 years)						
1–9 years	.14 (.00–4.01)	.320	6.12 (1.13–35.79)	**.037**	2.35 (.12–42.46)	.556
10–19 years	1.74 (.15–18.54)	.639	6.08 (1.57–25.53)	**.010**	.77 (.06–8.37)	.831
Time spent practicing therapy (Ref. 1–10 hours per week)						
11–20 hours per week	6.27 (.35–257.69)	.253	2.15 (.41–16.68)	.397	1.31 (.09–20.11)	.839
≥21 hours per week	16.76 (.95–973.34)	.100	2.08 (.45–15.44)	.400	1.45 (.16–18.38)	.754

(continued)

Table 5. (continued)

Characteristics	Romantic attraction aOR (95%CI)	Romantic attraction *p*	Sexual attraction aOR (95%CI)	Sexual attraction *p*	Flirting behavior aOR (95%CI)	Flirting behavior *p*
Patient age (Ref. ≥50 years)						
18–29	39.49 (2.02–2103.16)	**.032**	2.19 (.56–9.63)	.268	31.93 (1.23–2698.59)	.071
30–39	28.44 (2.04–1195.43)	**.031**	2.18 (.53–9.63)	.285	38.07 (1.42–3103.02)	.057
40–49	4.68 (.16–172.04)	.357	.41 (.08–1.75)	.249	17.28 (.71–977.89)	.108
Patient sex (Ref. Female)						
Male	10.40 (1.26–149.62)	**.047**	.58 (.12–2.72)	.488	.71 (.11–3.98)	.704
Any psychiatric disorders (Ref. No)						
Yes	.06 (.00–.80)	.059	.67 (.31–1.55)	.314	.17 (.01–2.85)	.247
Any anxiety disorders (Ref. No)						
Yes	.52 (.05–4.66)	.553	2.34 (.80–7.36)	.129	7.28 (.75–135.91)	.124
Any mood disorders (Ref. No)						
Yes	14.08 (1.28–301.20)	**.048**	2.42 (.78–7.76)	.127	.80 (.07–6.49)	.840
Any personality disorder (Ref. No)						
Yes	.34 (.00–8.94)	.569	.82 (.21–2.83)	.763	.26 (.01–3.31)	.348
GAF (per 1 point increase)	1.04 (.97–1.13)	.314	1.03 (.99–1.09)	.201	1.01 (.95–1.10)	.837
CGI (Ref. Normal, not at all ill)						
Borderline mentally ill	.13 (.00–2.26)	.190	.40 (.07–1.98)	.277	.30 (.01–7.51)	.496
Mildly ill	.29 (.01–4.58)	.390	1.09 (.28–4.29)	.899	1.58 (.16–17.78)	.696
Moderately ill	.15 (.00–5.20)	.319	.60 (.10–3.31)	.564	.36 (.01–12.25)	.582
Markedly/Severely ill	1.75 (.01–269.27)	.834	.52 (.03–7.72)	.647	7.88 (.07–1175.17)	.380
Therapy length (Ref. 0–3 months)						
4–12 months	33.89 (1.19–7644.42)	.098	4.95 (1.05–30.15)	.057	4.94 (.37–232.24)	.294

(continued)

Table 5. (continued)

Characteristics	Romantic attraction		Sexual attraction		Flirting behavior	
	aOR (95%CI)	*p*	aOR (95%CI)	*p*	aOR (95%CI)	*p*
13–24 months	10.74 (.27–1970.19)	.267	4.26 (.75–29.21)	.114	.31 (.00–22.52)	.571
>24 months	18.87 (.50–4861.34)	.186	3.12 (.55–21.39)	.217	.76 (.03–49.54)	.880
Session frequency (Ref. < 1 per week)						
1 per week	.58 (.08–4.18)	.583	2.21 (.74–7.39)	.170	.22 (.02–1.83)	.178
≥2 per week	.08 (.00–1.82)	.175	1.70 (.34–8.51)	.510	2.82 (.21–45.99)	.440
Session attendance						
In person	1.00		1.00		1.00	
Remote	.18 (.02–1.11)	.083	.40 (.14–1.10)	.081	.30 (.04–1.61)	.181
Flattered by the patient (Ref. Not at all–Somewhat)						
A lot–Very much	18.17 (.24–1707.17)	.183	3.08 (.37–19.86)	.258	15.68 (.89–414.22)	.066
Tenderness towards the patient (Ref. Not at all–Somewhat)						
A lot–Very much	79.77 (6.56–2757.96)	**.003**	4.94 (.92–28.55)	.066	3.76 (.20–68.72)	.361
Wish to give the patient genuine love and care (Ref. Not at all–Somewhat)						
A lot–Very much	1.17 (.03–27.47)	.924	.84 (.15–3.80)	.827	3.10 (.29–27.65)	.309
Hostility at significant figures in the patient's life (Ref. Not at all–Somewhat)						
A lot–Very much	77.93 (3.42–5661.69)	**.015**	2.89 (.40–19.17)	.278	.64 (.01–21.15)	.823
Find it hard to emotionally understand the patient (Ref. Not at all–Somewhat)						
A lot–Very much	1208.57 (.02–981615129.40)	.618	59.65 (.46–5845.39)	.096	399.51 (.05–32992033.76)	.523

Note. OR = odds ratio. Bold *p*-values indicate statistical significance. All predictors from Table 3 entered simultaneously (22 variables), making this highly conservative as a test of incremental significance.

orientations in the prior study). The most probable explanation lies in the different study designs. While Vesentini and colleagues explored the intimate feelings and behaviors of the therapists toward former and current patients, we asked the clinicians to focus solely on the feelings and behaviors experienced toward the patient during the most recent therapy session conducted.

Further important and novel findings concern the associations between the presence of feelings of romantic attraction and the characteristics of both patients and therapists. Results indicated that dealing with a male patient increases the odds of experiencing romantic attraction, whereas dealing with a patient over 50 years of age was associated with significantly decreased odds. Additionally, dealing with a patient suffering from a mood disorder (83% of whom suffered from unipolar depression) increased the odds of feeling romantically attracted to them, consistent with a recent review indicating that patients with depression tend to evoke more positive feelings among mental health professionals than patients with other severe mental disorders (Stefana et al., 2022b). At the same time, the literature on emotional reactions towards patients with bipolar disorder is currently too limited to draw any conclusions (Stefana et al., 2022c).

Regarding the characteristics of the therapists, the odds ratios of very intense feelings (*vs* no or moderate feelings) of tenderness towards the patient and hostility at significant figures in their life were respectively 79.77 and 77.93, indicating that the odds of experiencing romantic attraction towards the patient were almost eighty times higher in those clinicians who experienced either of those intense feelings. It is possible that the recognition of a need for tenderness in the patient by the therapist (which probably was not received/provided by the attachment figures) elicits an internal tug that satisfies the need of the therapist to provide for what the patient needed. However, for reasons that may depend on the patient's projections into the therapist, the therapist's own unconscious mechanisms, or both, a kind of confusion of tongues (Ferenczi, 1988) gets triggered and thus the therapists experience romantic tenderness instead of solely "therapeutic tenderness." In this way, a repetition of trauma occurs in therapy: the patient does not receive what they really need. The role of the therapist is not to satisfy the patient's conscious or unconscious demands or to take care as a parent or partner should, but to respond to their growth needs for empathic understanding and care (Casement, 1990).

Three limitations of this study should be noted. First, it cannot be ruled out that some clinicians gave "socially desirable" responses. To the extent this bias was present, it would lead to systematic under-reporting, which would attenuate any associations. Second, the cross-sectional approach did not allow for a comprehensive exploration of factors that predict flirting enactments, nor for identification and analysis of slippery slope trajectories. Last, some therapists who experienced strong sexual or romantic attraction or high levels of flirting behavior may have dropped out because of discomfort with answering the survey or concern that they might somehow be identified from their responses (despite the guarantee of anonymity).

Conclusion

Experiencing romantic attraction and, especially, sexual attraction toward a patient in psychotherapy seems to be a common occurrence, while flirting with a patient is less common but still present. Male therapists appear to be at higher risk of feeling sexual attraction and enacting seductive behaviors during sessions. Feeling very intense tenderness toward the patient and hostility toward significant figures in their life was highly correlated with the presence of romantic feelings. As highlighted in previous literature, although erotic feelings are a normal part of many psychotherapy journeys, not recognizing or ignoring their existence and potential impact by not disclosing and discussing them with peers or supervisors can hurt both the patient and the therapeutic relationship, and it could facilitate the slippery slope towards boundary violations.

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