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Therapists' Anger, Hate, Fear, and Sexual Feelings: National Survey of Therapist Responses, Client Characteristics, Critical Events, Formal Complaints, and Training

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Therapists reported frequencies of experiencing 24 instances of feeling anger, hate, fear, and sexual attraction or arousal; encountering 16 client events (e.g., client orgasm, client disrobing, client suicide, client assault on therapist or third party); and engaging in 27 behaviors (e.g., avoiding clients with human immunodeficiency virus, kissing clients, massaging clients, using weapons or summoning police for protection from clients). Responses differed according to therapist gender (e.g., more male than female therapists experienced patient suicides and faced malpractice, ethics, or licensing complaints), client gender (e.g., more female than male clients were noticed as "physically attractive," hugged, and cradled in therapists' laps), and theoretical orientation. Many participants rated graduate training regarding anger, fear, and sexual arousal as inadequate.

Certain feelings—anger, hate, fear, and sexual attraction or arousal—may make many therapists uncomfortable, have been largely neglected in the research literature, and may not be adequately addressed in graduate training programs. The purpose of this article is to focus attention on these feelings and to present some relevant empirical data.

Anger and Hate

Although the early analytic view of countertransference encouraged exploration of the therapist's uncomfortable, negative, or taboo feelings, Winnicott (1949) pioneered the frank acknowledgment of a therapist's anger at and hatred of a patient. Illustrating his themes with what must have been difficult, perhaps courageous self-disclosures, he wrote that therapists "must not deny hate that really exists" (p. 70). The denial of hate led to "therapy that is adapted to the needs of the therapist rather than to the needs of the patient" (Winnicott, 1949, 74).

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Subsequent writers have explored the distinct but often interrelated feelings of anger and hate as they emerge with regard to such issues as child sex abuse (e.g., Boniello, 1990; MacCarthy, 1988), sexual assault of adults (e.g., Colao & Hunt, 1983), human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS; e.g., Boccellari & Dilley, 1989; Cummings, Rapaport, & Cummings, 1986), ethnicity (e.g., Calnek, 1970; Jackson, 1973), hospitalization for psychotherapeutic (e.g., Lakovics, 1985) or medical (e.g., Kucharski & Groves, 1976–77) reasons, the use of physical restraints in treatment settings (Hunter, 1989), and diagnostic labels such as borderline personality disorder (e.g., Nadelson, 1977; Reiser & Levenson, 1984).

The writings have tended to focus on three distinct themes. First, therapists may find it exceptionally difficult to acknowledge these feelings. As Boccellari and Dilley (1989) emphasized in their discussion of helping people who suffer from AIDS, "Negative or ambivalent feelings towards the patient, such as anger and resentment, can be particularly difficult for the caregiver to admit. Yet recognizing and accepting these feelings can result in a decrease in tension and feelings of guilt" (p. 197). Though sometimes hard to acknowledge, the occurrence of a wide range of such feelings among therapists is understandable; for example, working with those who face death through illness (e.g., people suffering from AIDS) can challenge the personal resources of even the most determined and committed caregiver (e.g., Trice, 1988).

Second, such feelings, when unacknowledged or inadequately addressed, may have devastating consequences. Reiser and Levenson (1984), for example, explore how diagnosing an individual as suffering from borderline personality disorder may in some instances fail to reflect accurately or even approximately the clinical status of the patient but instead serve to "express countertransference hate" (p. 1528).

Third, such feelings, when promptly acknowledged and adequately addressed, may, under certain circumstances, serve as a therapeutic resource. Epstein (1977), for example, described

how certain patients may benefit from the therapist's appropriate expression of anger within a firm context of friendliness, warmth, and respect. "By recognizing this anger and hate, the [therapist] can be honest. By appropriate expression of the anger, the [therapist] enables the patient to see ego boundaries for him- or herself and the [therapist]" (Epstein, 1977, p. 442).

Despite such discussions, however, the profession lacks research to help understand the extent to which therapists experience these feelings and the contexts (e.g., patient characteristics and behaviors, critical events in therapy) in which such feelings may occur.

Fear

Perhaps the most extensive literature on therapist fear focuses on fear of assaults. A recent review noted that "violence and assaultive behavior were not considered major problems by psychiatrists until the mid and late 1960s" (Rosenbaum, 1991, p. 115).

The research has tended to address the risk (i.e., the incidence or prevalence of actual assaults) rather than the fear of attacks by patients. An early survey of 100 psychiatrists, psychologists, and social workers working in an urban setting found that virtually one fourth (24%) reported having been assaulted by at least one patient in the previous 1-year period (Whitman, Armao, & Dent, 1976). A study of 99 nurses at a Veterans Administration medical center found that only 20% had never been assaulted by a patient (Lanza, 1985). A recent survey of 750 psychologists found that over one third (39.9%) reported having suffered at least one violent attack by a patient (Guy, Brown, & Poelstra, 1990).

The literature discussing therapist fear has focused not only on attacks by patients (e.g., Atkinson, 1991; Carney, 1977; Lion & Pasternak, 1973; Madden, 1977) but also on malpractice suits[1] (e.g., Brodsky, 1988), reporting child abuse (e.g., Pollak & Levy, 1989), helping older patients (e.g., Martindale, 1989), helping people suffering from HIV or AIDS (e.g., Baer, Hall, Holm, & Koehler, 1989; Cole & Adair, 1988; Goldblum & Moulton, 1989), and patient reactions to difficult or painful interpretations (e.g., Sinason, 1991). As with anger and hate, there are only meager research data about the extent to which therapists experience fear.

Sexual Feelings

As late as 1986, the topic of therapists' sexual attraction to their clients (distinct from but related to the topic of therapist–client sexual involvement) was absent from the nonpsychodynamic literature, nor were there any relevant research data (Pope, Keith-Spiegel, & Tabachnick, 1986). Research published that year revealed that "87% (95% of men, 76% of women) have been sexually attracted to their clients . . . and that . . . many (63%) feel guilty, anxious, or confused about the attraction" (Pope et al., 1986, p. 147).

The psychodynamic literature, however, has discussed the nature and occurrence of the therapist becoming sexually aroused during therapy sessions (e.g., Ganzarain & Buchele, 1986, 1988; Searles, 1959). Like Winnicott (1949), Searles illustrated his discussion with descriptions of his own experiences, emphasizing the difficulty of confronting his own responses (in this case, genital excitement during a therapy session): "I reacted to such feelings with considerable anxiety, guilt, and embarrassment" (1959, p. 183).

Therapists' Feelings, the Context, and Training

One facet of this survey is exploratory. It was designed to collect a broad range of baseline data about the degree to which therapists experience the kinds of feelings discussed in the previous sections, the contexts (e.g., client behaviors, therapist behaviors, and events in therapy) in which such feelings occur, and how therapists rate their graduate training with regard to these feelings.

A second facet involved specific research questions. Are such factors as therapist and client gender systematically related to (a) concerns about and actual occurrences of client suicide, (b) concerns about and actual occurrences of client violence, and (c) noticing that a client is physically attractive? Do the feelings and contextual experiences reflect coherent, underlying factors? If so, are these factors systematically related to (a) sexual involvement in therapy, (b) formal complaints against therapists, and (c) therapists' ratings of their training?

Method

A letter, questionnaire, and stamped, addressed envelope (for returning the questionnaire) were mailed to 300 men and 300 women randomly selected from Divisions 12 (Clinical Psychology), 17 (Counseling Psychology), 29 (Psychotherapy), and 42 (Psychologists in Independent Practice) of the American Psychological Association (APA) as listed in the *Membership Register* (APA, 1991).

In addition to asking the participant's age, gender, and theoretical orientation, the questionnaire contained four parts. Part 1 ("Your Feelings or Reactions With Adult Clients") contained 24 examples of feelings that a therapist might experience (see Table 1 for questionnaire items). Part 2 ("Your Adult Clients' Behaviors or Events") contained 16 examples of client behaviors or events that might occur in therapy with an adult client. Part 3 ("Your Actions or Reactions With Adult Clients") contained 27 examples of therapist behaviors.

Participants were asked to indicate the extent to which they had experienced each of the 24 feelings, encountered each of the 16 client behaviors or events, and engaged in each of the 27 actions or reactions for adult female clients. They were asked to make similar ratings for adult male clients. The rating codes were 0 = *never*, 1 = *rarely* (i.e., with 1–2% of their male or female clients), 2 = *sometimes* (3–19%), 3 = *often* (20%–50%), and 4 = *most* (51%–100%). The rating system was designed to provide some adjustment for the relative numbers of female and male clients: Participants were asked to indicate the percentage of their female clients with regard to whom they had experienced various feelings, behaviors, events, actions, or reactions and were asked to indicate the percentages of their male clients with regard to whom they had had such experiences.

The fourth part of the questionnaire asked participants to rate their graduate training with regard to three topics (i.e., fear, anger, and sex-

[1] In a general survey on a different topic, a large minority (45.9%) of psychologists reported "avoiding certain clients for fear of being sued" (Pope, Tabachnick, & Keith-Spiegel, 1987, p. 996).

(*text continues on page 146*)

Table 1
Percentage of Psychologists Responding in Each Category (N = 285)

Item	Rating									
	Female clients					Male clients				
	0	1	2	3	4	0	1	2	3	4
Part 1: Your Feelings or Reactions With Adult Clients										
1. Feeling afraid that a client may commit suicide (97.2)	1.8	37.5	55.8	4.6	0.0	6.3	49.5	39.3	2.8	0.0
2. Feeling afraid that a client may physically attack you (82.8)	48.8	48.1	2.8	0.0	0.0	16.1	66.3	15.1	0.4	0.0
3. Feeling afraid that a client may physically attack a third party (89.1)	23.2	59.3	16.1	0.7	0.0	8.4	50.5	37.5	1.4	0.0
4. Feeling afraid that a client may be physically attacked by a third party (79.3)	19.6	36.1	37.9	5.6	0.0	31.6	48.8	15.1	0.7	0.0
5. Feeling afraid that a client may engage in unsafe sex (88.4)	9.5	23.9	44.6	19.6	1.8	9.8	19.6	45.3	20.0	2.5
6. Feeling afraid that a client may need clinical resources that are unavailable (86.0)	10.5	24.9	44.2	17.2	1.4	10.9	27.0	42.1	14.4	1.8
7. Feeling afraid because a client's condition gets suddenly or seriously worse (90.9)	7.4	44.9	43.9	2.5	0.0	8.8	46.0	39.6	2.1	0.0
8. Feeling afraid that your colleagues may be critical of your work with a client (88.1)	11.2	50.5	33.3	4.2	0.0	11.6	48.8	33.7	3.5	0.0
9. Feeling afraid that a client may file a formal complaint against you (66.0)	35.8	55.1	7.7	0.7	0.0	5.6	41.3	10.0	36.1	5.8
10. Feeling afraid to work with a client who is HIV-positive (26.7)	76.8	14.7	3.5	1.8	0.0	69.1	20.0	4.9	1.8	4.2
11. Feeling so afraid about a client that it affects your eating, sleeping, or concentration (53.3)	48.8	42.5	8.1	0.4	0.0	21.8	54.4	19.6	2.8	0.0
12. Feeling angry with a client because he or she is verbally abusive toward you (80.7)	32.8	45.4	20.1	1.0	0.0	21.8	54.4	19.6	2.8	0.0
13. Feeling angry with a client because of his or her behavior toward a third party (82.5)	18.9	48.1	30.9	1.4	0.0	17.5	42.1	35.8	2.1	0.0
14. Feeling angry with a client because of late or unpaid therapy bills (82.5)	17.2	42.8	33.7	4.9	0.0	6.6	43.6	18.7	23.4	5.8
15. Feeling angry with a client because he or she is uncooperative with you (89.8)	9.1	49.8	38.6	2.1	0.0	11.2	48.4	36.1	2.1	0.0
16. Feeling angry with a client because he or she contacts you too often (86.7)	11.2	49.8	34.4	3.9	0.0	27.0	52.6	17.5	0.4	0.0
17. Feeling angry with a client because he or she is often late for or misses sessions (87.0)	11.2	51.9	33.3	2.8	0.0	14.7	51.9	28.4	2.5	0.0
18. Feeling angry with a client because he or she terminates suddenly (78.2)	21.1	52.6	25.3	0.7	0.0	22.5	53.0	20.7	1.8	0.0
19. Feeling angry with a client because he or she makes a suicide threat or attempt (64.9)	33.7	50.9	13.0	1.8	0.0	43.9	42.5	9.5	1.4	0.0
20. Feeling angry with a client because he or she makes too many demands (87.4)	10.5	47.4	36.1	4.9	0.0	18.9	52.6	23.2	2.5	0.0
21. Feeling so angry with a client you do something you later regret (45.6)	55.8	39.3	3.9	0.4	0.0	57.5	36.8	3.2	0.4	0.0
22. Feeling hatred toward a client (31.2)	70.5	24.9	3.5	0.4	0.0	68.4	24.9	3.9	0.4	0.0
23. Feeling sexually attracted to a client (87.3)	32.6	34.4	30.9	1.1	0.4	43.5	39.6	13.0	0.7	0.0
24. Feeling sexually aroused while in the presence of a client (57.9)	52.3	36.8	10.5	0.4	0.0	62.1	29.1	5.3	0.0	0.0
Part 2: Your Adult Clients' Behaviors or Events										
25. A client commits suicide (28.8)	82.8	15.4	1.1	0.0	0.4	76.1	20.7	0.4	0.0	0.0
26. A client physically attacks you (18.9)	88.4	10.5	0.4	0.0	0.4	85.6	10.9	0.7	0.0	0.4
27. A client physical attacks a third party (60.7)	54.7	36.5	7.4	0.7	0.0	38.9	46.3	10.2	1.1	0.4
28. A client files a complaint (e.g., malpractice, ethics, licensing) against you (11.6)	92.3	6.7	0.4	0.0	0.4	90.9	6.0	0.4	0.0	0.4
29. A client hugs you (89.1)	9.1	37.2	40.7	11.6	1.4	27.4	46.7	17.5	5.3	0.4
30. A client kisses you (24.2)	76.8	21.1	1.4	0.4	0.0	89.5	7.4	0.4	0.0	0.0
31. A client flirts with you (87.0)	29.1	43.5	24.6	1.8	0.0	39.3	42.1	15.1	0.4	0.0

32. A client tells you that he or she is sexually attracted to you (73.3)	36.5	45.6	14.4	2.8	0.4	50.9	33.0	12.3	1.1	0.0
33. During a session, a client strips down to his or her underwear (2.5)	98.9	1.1	0.0	0.0	0.0	95.4	1.8	0.4	0.0	0.0
34. During a session, a client is naked above the waist (2.5)	99.6	0.4	0.0	0.0	0.0	94.7	1.8	0.7	0.0	0.0
35. During a session, a client is naked below the waist (1.1)	99.6	0.4	0.0	0.0	0.0	96.1	1.1	0.0	0.0	0.0
36. A client touches his or her own genitals while in your presence (18.2)	93.7	5.6	0.7	0.0	0.0	80.0	15.4	2.1	0.0	0.0
37. A client touches your genitals (1.4)	98.9	1.1	0.0	0.0	0.0	97.2	0.4	0.0	0.0	0.0
38. A client seems to become sexually aroused while in your presence (48.4)	63.2	31.6	4.6	0.0	0.0	63.2	29.5	4.2	0.4	0.0
39. A client seems to have an orgasm while in your presence (3.2)	97.2	2.8	0.0	0.0	0.0	98.6	0.7	0.0	0.0	0.0
40. A client gives you a massage (1.8)	89.2	0.7	1.1	0.0	0.0	96.1	0.7	0.7	0.0	0.0
Part 3: Your Actions or Reactions With Adult Clients										
41. Avoiding treating a client because he or she is HIV-positive (4.2)	94.7	1.8	1.4	0.4	0.4	93.0	1.8	1.4	0.4	0.4
42. Telling a client that you are afraid of him or her (33.0)	84.6	15.1	0.4	0.0	0.0	66.0	30.2	1.8	0.0	0.0
43. Obtaining a weapon to protect yourself against a possible attack by a client (3.2)	99.3	0.7	0.0	0.0	0.0	94.7	3.2	0.0	0.0	0.0
44. Using a weapon to protect yourself against an attack by a client (0.4)	100.0	0.0	0.0	0.0	0.0	97.5	0.4	0.0	0.0	0.0
45. Summoning police or security personnel for your protection from a client (27.0)	88.4	10.9	0.4	0.0	0.0	72.6	24.2	1.1	0.0	0.0
46. Having fantasies reflecting fear that a client will physically attack you (50.9)	73.7	24.6	1.4	0.0	0.0	48.8	45.3	3.9	0.0	0.0
47. Telling a client that you are angry with him or her (77.9)	26.3	53.3	19.3	0.0	0.0	26.0	52.3	18.6	1.1	0.0
48. Raising your voice at a client because you are angry at him or her (57.2)	45.6	45.6	7.0	0.4	0.4	45.6	44.2	6.7	0.4	0.4
49. Having fantasies that reflect your anger at a client (63.5)	38.9	40.0	19.3	1.4	0.4	37.9	39.6	18.6	1.4	0.4
50. Telling a client that you care about him or her (91.9)	5.3	15.8	49.8	21.4	7.0	8.1	17.2	45.6	19.6	6.7
51. Holding a client's hand (60.4)	38.9	39.6	18.6	2.5	0.4	59.6	28.8	8.4	0.7	0.4
52. Hugging a client (81.1)	17.5	40.7	32.6	7.4	1.8	33.7	42.5	16.5	3.9	1.4
53. Kissing a client (5.6)	94.4	4.6	0.7	0.4	0.0	95.1	2.1	0.0	0.4	0.0
54. Lying down next to a client (0.4)	99.3	0.4	0.0	0.0	0.0	97.2	0.4	0.0	0.0	0.0
55. Lying on top of or underneath a client (0.4)	99.6	0.4	0.0	0.0	0.0	97.5	0.4	0.0	0.0	0.0
56. Cradling or otherwise holding a client in your lap (8.8)	90.5	7.7	1.1	0.4	0.0	94.0	2.5	0.7	0.0	0.0
57. Giving a massage to a client (2.8)	97.5	1.4	0.7	0.0	0.0	94.7	1.8	0.7	0.0	0.0
58. Flirting with a client (19.6)	85.3	13.4	1.1	0.0	0.0	86.7	9.1	1.4	0.0	0.0
59. Touching a client's genitals (0.0)	99.6	0.0	0.0	0.0	0.0	97.2	0.0	0.0	0.0	0.0
60. Experiencing an orgasm during a session (0.0)	100.0	0.0	0.0	0.0	0.0	97.5	0.0	0.0	0.0	0.0
61. Telling a sexual fantasy to a client (6.0)	95.1	4.2	0.4	0.4	0.0	92.6	4.6	0.4	0.0	0.0
62. Suggesting that a client tell you about his or her sexual fantasies (68.1)	32.6	29.7	31.6	7.0	1.8	31.9	28.8	28.1	7.0	1.8
63. Reassuring a client that having sexual feelings about a therapist is not uncommon (77.9)	27.7	31.6	27.0	11.2	2.5	33.0	31.9	22.8	7.7	2.1
64. Noticing that a client is physically attractive (95.8)	2.8	9.5	43.5	33.7	10.2	9.5	17.9	36.8	23.9	9.1
65. Telling a client that you find him or her physically atractive (38.9)	62.8	26.0	8.4	2.1	0.4	66.3	20.7	7.6	2.9	0.4
66. Telling a current client that you never engage in posttermination sex with clients (27.7)	75.4	14.4	5.3	2.1	1.8	79.3	10.5	3.9	1.4	1.8
67. Talking with a current client about sharing a sexual relationship after termination (2.1)	97.9	1.4	0.0	0.0	0.4	96.5	0.7	0.0	0.0	0.4

Note. Ratings are as follow: 0 = *never*, 1 = *rarely* (1%–2%), 2 = *sometimes* (3%–19%), 3 = *often* (20%–50%), 4 = *most* (51%–100%). Responses 0–4 sum to less than 100% due to missing data. Values in parentheses represent percentage of therapists responding *rarely* or more often, combined for female and male clients.

ual excitement) using the following ratings: virtually none, poor, adequate, good, or excellent.

Results

Characteristics of the Participants

Two hundred and eighty-five respondents (141 men, 141 women, and 3 who did not indicate gender) returned usable questionnaires. Respondents were almost equally divided between those who were 45 years old or under (140) and those who were over 45 (143), with two leaving this item blank.

Eighty-three (21.1%) respondents described their theoretical orientation as psychodynamic, 48 (16.6%) as eclectic, 35 (12.3%) as cognitive–behavioral, 15 (5.3%) as existential, 15 (5.3%) as interpersonal, 12 (4.2%) as systems, and 11 (3.9%) as behavioral. Thirty-four (11.9%) respondents listed diverse orientations that were grouped as "other," and 32 (11.2%) left this item blank.

Ratings of Feelings and Experiences

Table 1 shows participants' ratings for each of the 67 feelings and experiences with respect to female and male clients.

Client Suicide: Concerns and Occurrence

Therapist concerns with suicide were tested in a $2 \times 2 \times 2$ mixed between-between-within-subjects multivariate analysis of variance (MANOVA) on fears that a client may commit suicide and a client actually committing suicide.[2] Independent variables were therapist and client gender (between and within factors, respectively) and training, derived as a median split on the sum of the three training variables (evaluation of training with respect to fear, anger, and sex).

There was a significant multivariate effect of therapist gender, multivariate $F(2, 269) = 7.41$, $p < .05$, $\eta^2 = .05$. Although there was no difference expressed in fear of clients committing suicide, male therapists reported higher frequencies of clients actually committing suicide ($M = 0.30$ on a scale of 0 to 4) than did female therapists ($M = 0.12$), univariate $F(1, 270) = 14.36$, ($p < .025$).

Client gender also affected suicide concerns, multivariate $F(2, 169) = 30.27$, ($p < .05$, $\eta^2 = .18$), and showed small interaction effects with both therapist gender, multivariate $F(2, 169) = 5.16$, ($p < .05$, $\eta^2 = .04$), and training, multivariate $F(2, 169) = 4.48$ ($p < .05$, $\eta^2 = .03$). All effects relating to client gender were on fear of the client committing suicide. In general, there was greater fear for female clients ($M = 1.64$) than for male clients ($M = 1.39$). However, the discrepancy between fear of suicide for female and male clients was smaller for male therapists and for therapists who gave higher ratings to adequacy of their training.

Physical Attacks by Clients: Concerns and Occurrence

Therapist concerns with physical attacks were addressed in a parallel $2 \times 2 \times 2$ between-between-within-subjects MANOVA on four variables reflecting fears and experiences of clients attacking therapists and others: fear of client attacking the therapist, fear of client attacking a third party, actual attacks on the therapist, and actual attacks on a third party.

There were significant main effects of therapist gender, multivariate $F(4, 263) = 4.30$ ($p < .05$, $\eta^2 = .06$), and client gender, multivariate $F(4, 263) = 60.46$ ($p < .05$, $\eta^2 = .48$). Male therapists were more fearful that a client would attack a third party ($M = 1.26$) than were female therapists ($M = 1.02$), univariate $F(1, 266) = 12.06$ ($p < .01$).

Univariate differences between male and female clients were noted on three of the four variables: fear of attack on the therapist, fear of attack on a third party, and actual attacks on third parties. Male clients engendered greater fear of attack on the therapist ($M = 1.01$) than did female clients ($M = 0.53$), univariate $F(1, 266) = 171.33$ ($p < .01$). Male clients also engendered greater fear of attack on a third party ($M = 1.34$) than did female clients ($M = 0.94$), univariate $F(1, 266) = 109.15$ ($p < .01$). These latter fears seem understandable in that more attacks on a third party were reported for male clients (0.74) than for female clients (0.53), univariate $F(1, 266) = 34.18$ ($p < .01$). There were no statistically significant interactions.

Noticing That Clients Are Physically Attractive

A 2×2 mixed between-within-subjects analysis of variance (ANOVA) was performed on ratings of "noticing that a client is physically attractive." Independent variables were gender of therapist and gender of client. Although there was no statistically significant difference between the ratings of male and female therapists, client gender did make a difference, $F(1, 272) = 62.45$ ($p < .05$, partial $\eta^2 = .19$). On average, ratings for female clients were higher ($M = 2.40$) than for male clients ($M = 2.06$).

There was also a significant interaction between therapist and client gender in the ratings, $F(1, 272) = 74.02$ ($p < .05$, partial $\eta^2 = .21$). Female therapists noticed that male and female clients were attractive about equally often, whereas male therapists noticed that female clients were physically attractive more often than male clients.

Other Differences Due to Client Gender

A post hoc one-way within-subjects MANOVA explored differences between female and male clients in terms of several client and therapist experiences: telling the client the therapist finds him or her physically attractive, hugging or kissing a client, cradling a client in the therapist's lap, seeming to have a sexual orgasm in the presence of the therapist, holding hands, and flirting (multivariate $\alpha = .01$; univariate $\alpha = .0015$).

The multivariate effect of client gender was statistically significant, multivariate $F(7, 264) = 26.44$ ($\eta^2 = .41$). Women clients were more often the recipients of therapist hugging ($M = 1.35$) than were men ($M = 0.95$), univariate $F(1, 270) = 115.11$. They were also more likely to be cradled in the therapist's lap ($M = 0.11$) than were male clients ($M = 0.04$), univariate $F(1, 270) = 20.36$. Finally, they were more likely to have their hands held ($M = 0.85$) than were men ($M = 0.48$), univariate $F(1, 270) = 124.98$.

[2] Except where noted, all analyses were planned.

Factor Analysis of Feelings and Experiences

Fifty-three of the experiences were subjected to a factor analysis.[3] A composite score for each item was formed by summing the responses with respect to male and female clients. The analysis was based on 213 cases; 69 cases were missing data on one or more items (5 of the therapists dealt with female clients exclusively). Three cases were identified as multivariate outliers ($p < .001$) and were omitted from analysis.[4]

The principal factor analysis with varimax rotation yielded four factors, accounting for 66% of the total variance in the ratings. All four factors were internally consistent and well defined by the variables; the lowest of the squared multiple correlations for factors from variables was .781. The reverse, however, was not true. As seen in Table 2, communalities tended to be low. With a cutoff of .45 for interpretation of a factor loading, 15 of the items loaded on the first factor, interpreted as anger. The second factor, interpreted as sexual material, was defined by seven items. Four variables defined the third factor, interpreted as warmth, and six variables loaded on the fourth factor, interpreted as physical fear. Table 2 shows only those 32 variables (of the 53 analyzed) that loaded on at least one factor. Twenty-one of the variables loaded on none of the factors. Only one item was complex, loading on both factors 1 and 2: having fantasies that reflect anger toward a client.

Feelings and Experiences Related to Demographic Variables

A $2 \times 2 \times 2$ MANOVA was performed on the four factor scores as a function of gender, age group, and theoretical orientation (psychodynamic vs. all others). The only statistically significant effect was theoretical orientation, multivariate $F(4, 174) = 9.28$ ($p < .05$, $\eta^2 = .18$). Two of the four factors showed significant differences between psychodynamically oriented therapists and others: sexual material and warmth.

Psychodynamic therapists were more likely to experience the items in factor 2 (i.e., client flirting, client talking about sexual attraction to therapist, client touching his or her own genitals, client seeming to become sexually aroused, therapist having fantasies that reflect anger, therapist suggesting client tell about sexual fantasies and reassuring client about sexual feelings toward therapists) than were other therapists, univariate $F(1, 177) = 14.59$ ($p < .01$). For psychodynamically oriented therapists, the mean for the seven experiences was 1.85 (on a scale of 0 to 4), whereas the mean for the other therapists was 1.37.

Psychodynamically oriented therapists were less likely to experience items in factor 3 (i.e., hugging and being hugged by a client, holding a client's hand, and telling a client you care about her or him), univariate $F(1, 177) = 14.79$ ($p < .01$). The mean for psychodynamic therapists for those four items was 2.24, whereas the mean for the remaining therapists was 2.74.

Sexual Involvement in Therapy

Twenty-seven therapists (10 women and 17 men) were identified as experiencing sexual involvement in therapy.[5] Therapists were so defined if they answered anything other than "never" to questions about clients stripping to underwear, being naked above (female only) or below the waist, touching the therapists' genitals, therapists lying on top of or underneath a client, touching a client's genitals, telling a sexual fantasy to a client, or talking with a current client about sharing a sexual relationship after termination. A $2 \times 2 \times 2$ logit analysis on sexual involvement by gender and age of therapist showed no statistically significant relation.

A one-way MANOVA was performed to investigate differences between therapists who were and were not identified as sexually involved in their factor scores on anger, fear, sexual material, and warmth; their evaluation of their graduate training in dealing with sexual excitement; and their experience of having clients file complaints against them.

There was a significant difference between the two groups, multivariate $F(6, 197) = 6.30$ ($p < .05$, $\eta^2 = .16$). Among the six dependent variables, each evaluated at $\alpha = .008$, complaints and sexual material showed differences between groups, univariate $F(1, 202) = 15.96$ and 12.80, respectively.

The average rating for "a client files a complaint . . ." for therapists identified as sexually involved was 0.5, whereas for remaining therapists the average was 0.11. Therapists who were identified as sexually involved also showed higher ratings ($M = 2.23$) on the items defining the factor labeled *sexual material* (see Table 2) than did other therapists ($M = 1.45$); this finding is not surprising in light of the shared items.

Complaints Against Therapists

Because the overall rate of complaints was less than 10% for either female or male clients, most analyses of complaints used a dichotomized variable in which therapists were divided into those who had never had a complaint filed and those who had. A $2 \times 2 \times 2$ logit analysis of complaints by therapist gender and the dichotomized training variable (less than adequate, adequate or better) showed a significant relation between gender and complaints, $\chi^2(1, N = 281) = 7.63$ ($p < .05$). Although 17%

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[3] The remaining 14 behaviors were omitted from factor analysis because at least 95% of the responses to those items were "never." With so little variability, these items would not load on any factor, and attempts to include them created many outlying cases.

[4] The three outliers were men. One reported that most of his clients filed complaints, physically attacked him, and committed suicide, and probably miskeyed his responses. The second reported physical attacks sometimes by both male and female clients, massages sometimes given by both male and female clients, avoiding treating both male and female clients who are HIV-positive, and often kissing both male and female clients. The third outlier reported sometimes feeling angry with female clients who make suicide threats or attempts and rarely feeling so with male clients; sometimes he is given massages by female clients and rarely given them by male clients, while at the same time reporting no physical attacks by clients, no clients touching their own genitals, never avoiding treating clients who are HIV-positive, and never kissing a client.

[5] The term *sexual involvement in therapy* is used here *only* as a convenient summary label for the seven identified items; the term may have significantly different meanings or connotations when used elsewhere in the professional literature.

Table 2
Factor Loadings, Communalities (η^2), and Percentages of Variance for Principal Factors of Extraction and Varimax Rotation

Item	Factor loading	η^2
Factor 1. Anger (% of variance = 5.91)		
17. Feeling angry with a client because he or she is often late for or misses sessions	.67	.46
18. Feeling angry with a client because he or she terminates suddenly	.63	.40
12. Feeling angry with a client because he or she is verbally abusive toward you	.62	.49
13. Feeling angry with a client because of his or her behavior toward a third party	.60	.45
20. Feeling angry with a client because he or she makes too many demands	.58	.41
14. Feeling angry with a client because of late or unpaid therapy bills	.57	.34
15. Feeling angry with a client because he or she is uncooperative with you	.57	.36
22. Feeling hatred toward a client	.56	.40
8. Feeling afraid that your colleagues may be critical of your work with a client	.56	.34
21. Feeling so angry with a client you do something you later regret	.52	.29
49. Having fantasies that reflect your anger at a client	.51	.48
16. Feeling angry with a client because he or she contacts you too often	.48	.28
23. Feeling sexually attracted to a client	.47	.43
7. Feeling afraid because a client's condition gets suddenly or seriously worse	.46	.32
19. Feeling angry with a client because he or she makes a suicide threat or attempt	.45	.35
Factor 2. Sexual Material (% of variance = 4.46)		
32. A client tells you that he or she is sexually attracted to you	.69	.51
31. A client flirts with you	.67	.55
38. A client seems to become sexually aroused while in your presence	.66	.50
63. Reassuring a client that having sexual feelings about a therapist is not uncommon	.64	.43
62. Suggesting that a client tell you about his or her sexual fantasies	.61	.41
36. A client touches his or her own genitals while in your presence	.46	.24
49. Having fantasies that reflect your anger at a client	.45	.48
Factor 3. Warmth (% of variance = 3.36)		
52. Hugging a client	.81	.67
29. A client hugs you	.77	.62
50. Telling a client that you care about him or her	.61	.41
51. Holding a client's hand	.54	.32
Factor 4. Physical Fear (% of variance = 3.18)		
3. Feeling afraid that a client may physically attack a third party	.57	.38
45. Summoning police or security personnel for your protection from a client	.55	.33
2. Feeling afraid that a client may physically attack you	.50	.38
10. Feeling afraid to work with a client who is HIV-positive	.47	.29
27. A client physically attacks a third party	.47	.31
26. A client physically attacks you	.47	.29

of the male therapists had at least one complaint filed against them, only 6% of the female therapists did.

A one-way MANOVA was performed on scores for the four factors described in Table 2 as well as for experiences of client suicide. The independent variable was whether or not the therapist had a complaint filed. A significant multivariate relation was found, multivariate $F(5, 207) = 2.52$ ($p < .05$, $\eta^2 = .06$). The only variable significantly related to complaints was the factor score for physical fear, univariate $F(1, 211) = 7.22$ ($p < .01$). Therapists who had complaints filed against them were more fearful (mean of six variables contributing to factor 4 = 1.31) than were therapists who had never had complaints filed against them ($M = 1.01$).

To investigate the relation between complaints and client gender (a within-subjects variable), scores on complaints had to be treated as if continuous, despite the poor distribution. A one-way within-subjects ANOVA on complaints as a function of client gender showed no significant difference in complaints.

Evaluation of Training

Table 3 displays the responses to questions about the adequacy of graduate training programs in addressing fear, anger, and sexual excitement in therapy.

A post hoc one-way within-subjects ANOVA compared mean ratings on adequacy of three levels of training: anger, fear, and sexual excitement ($\alpha = .01$). The analysis showed that the difference in evaluation for the three types of training was statistically significant, $F(2, 540) = 27.00$ ($\eta^2 = .09$).

Ratings of training in the three areas showed strong positive correlations (i.e., the correlation between training ratings for fear and anger was .75, for fear and sex was .69, and for anger

Table 3
Evaluation of Graduate Training in Regard to Fear, Anger, and Sexual Excitement

Item	Percentage rating				
	Virtually none	Poor	Adequate	Good	Excellent
Fear	22.8	23.9	24.6	17.2	8.1
Anger	13.3	24.2	23.2	22.8	13.0
Sexual excitement	27.0	23.2	19.6	14.7	10.9

Note. Responses sum to less than 100% due to missing data.

and sex was .66), but no statistically reliable relations emerged (at $\alpha = .004$ to adjust for multiple testing) between evaluation of training and factor scores reflecting feelings and experiences in those areas.

A two-way MANOVA showed no differences in evaluation of graduate training in dealing with fear, anger, and sex as a function of theoretical orientation (psychodynamic vs. other) and age group. Neither age group nor theoretical orientation—either singly or in interaction—was reliably associated with evaluation of graduate training.

Discussion

Validity and Interpretation

Although participants were randomly selected from four APA divisions (12, 17, 29, and 42), the degree to which these results are genuinely representative of those divisions or of the close to 50,000 people (both APA and non-APA members) who are licensed to practice psychology (Dorken, Stapp, & VandenBos, 1986) is unknown.

Equally troublesome is the issue of self-report regarding sensitive topics, especially when some of the reporting involves retrospective evaluations—vulnerable to memory's imperfections (see Pope, 1990)—of training programs. As noted previously, research findings suggest that most psychologists may "feel guilty, anxious, or confused about [sexual] attraction [to clients]" (Pope et al., 1986, p. 147). For some, acknowledging to self or others that they have experienced such strongly negative feelings as "hate" toward those who have come to them for help may be extremely difficult, especially if their training has not encouraged them to recognize, accept, and examine such feelings. Prior research has demonstrated the extent to which "demand characteristics" (e.g., Barber, 1976; Orne, 1962) can influence research findings. More specifically, participants may tend to provide what they believe to be "socially approved" or "socially desirable" responses (e.g., Crowne & Marlowe, 1964; Edwards, 1982; Tanur, 1991).

Consequently, exceptional caution is warranted in interpreting these results, especially pending replication studies published in peer-reviewed journals. In light of such cautions and of space constraints, a few of the themes emerging from this survey are discussed in the following sections.

Feelings and Context

These findings suggest that therapists tend to experience fear, anger, and sexual feelings in the context of their work. Over 80% of the respondents reported experiencing each of the feelings—with nine exceptions—described in Part 1. The most widespread feeling was fear that a client would commit suicide, experienced by 97.2% of the participants (i.e., only one participant reported never feeling afraid that either a female or male client would commit suicide), followed by fear that a client would get worse (90.9%), anger at a client for being uncooperative (89.8%), and fear that a client will attack a third party (89.1%).

Participants reported that fear could exert debilitating effects on the therapist: Over half (53.3%) indicated having felt so afraid about a client that it affected their eating, sleeping, or concentration. Male clients engendered this type of debilitation for about 75% of the participants; about 50% of the therapists reported such fear with regard to female clients. Sometimes the fear focused (for more than 4 out of every 5 participants) on the lack of available clinical resources to meet a client's needs, sometimes (for 2 out of 3 participants) on the possibility that a client would file a complaint, and sometimes (for more than 4 out of 5 participants) on possible criticism by colleagues.

The least frequently reported feeling was fear of working with a client who was HIV-positive, reported by 20% of the respondents with regard to female clients and by 30.9% with regard to male clients. These findings are difficult to interpret because it is unclear whether those who did not report this fear were working with clients whom they knew to be infected with HIV. The second least frequently reported feeling was hatred, reported by slightly less than one third of the participants. Almost half (46%) reported feeling so angry with a client that they had done something that they later regretted. These were the only three items in Part 1 endorsed by less than half of the participants.

Over half (57.9%) of the participants reported experiencing sexual arousal while in the presence of a client. Almost half (47.7%) of the participants reported becoming sexually aroused during therapy sessions with female clients, whereas about a third (34.4%) reported arousal with male clients. Eighty-seven percent of the participants reported at least some sexual attraction to clients, consistent with previously reported national rates of 86.8% (Pope et al., 1986) and 87.5% (Pope, Tabachnick, & Keith-Spiegel, 1987). About two thirds (66.8%) of the participants reported sexual attraction to female clients; about one half (53.3%) to male clients.

The factor analysis revealed that when feelings were examined in conjunction with the other survey items (e.g., therapist and client behaviors), four well-defined and internally consistent factors emerged: anger, sexual material, warmth, and physical fear. Not surprisingly, the feelings tended to be related to the contextual items: All four factors spanned more than one of the three major parts of the questionnaire: therapist feelings and reactions, clients' behaviors or events, and actions or reactions with clients. So, for example, factor 4 shows that therapists who are physically fearful are those who reportedly have reason to be so, for instance, having experienced clients who have physically attacked.

Patient Suicide and Violence

These findings illustrate the violent and potentially lethal behaviors (e.g., suicide, assaults) that therapists must confront in their work. Over 18% reported having been physically attacked by at least one client; 58% reported that a male patient had attacked a third party, whereas 44.6% reported that a female patient had attacked a third party. About one fourth of the participants reported having fantasies that a female client will attack them; one half reported such fantasies about a male client. About one tenth reported summoning police or security personnel for protection from a female client; about one fourth reported making such calls for protection from a male client. Less than 4% reported obtaining a weapon for protection against a client, and none reported using a weapon for protection.

Over one fourth (28.8%) indicated that they had experienced at least one client suicide. About one out of six participants reported at least one female patient who committed suicide; about one out of five reported at least one male patient who took his life. Male therapists reported higher frequencies of patient suicide than did female therapists, a finding that might (or might not) be due to differing clientele. It is interesting that therapists tended to be more concerned about the possibility of suicide by female patients in light of the research indicating that male patients tend to have higher suicide rates (e.g., Bongar, 1991).

These violent or self-destructive events are likely to have understandably traumatic consequences for the therapist (e.g., Atkinson, 1991; Brown, 1987; Carney, 1977; Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989; Chemtob, Bauer, Hamada, Torigoe, & Kinney, 1988; Deutsch, 1984; Goldstein & Buongiorno, 1984; Henn, 1978; Lion & Pasternak, 1973; Madden, 1977). A study of 200 therapists who had recently lost a patient to suicide, for example, found not only intense feelings of grief, loss, and depression that anyone might experience after the death of someone he or she cared about but also feelings of guilt, inadequacy, self-blame, and fears of being sued, second-guessed, or scape-goated in the public press (Litman, 1965). A more recent study found that "trainees with patient suicides reported stress levels equivalent to that found in patient samples with bereavement and higher than that found with professional clinicians who had patient suicides" (Kleespies, Smith, & Becker, 1990, p. 257).

Attraction, Touching, Nudity, and Sexual Issues

Although clients' hugs, flirting, and statements of sexual attraction to the therapist are fairly frequent (over 50% of participants reported them for both female and male clients), clients' disrobing is exceptionally rare. Slightly over one third of the participants reported both male and female client (apparent) sexual arousal during sessions. Almost 3% of the participants reported that a female client seemed to have an orgasm while in the therapist's presence; 0.7% of participants reporting an apparent orgasm by a male client.

No participant reported touching a client's genitals or experiencing an orgasm during a session. Lying down on top of, next to, or underneath a client was exceedingly rare, as was giving a massage to a client. Over half reported hugging, over one fourth reported holding hands, and more than 1 in 10 reported flirting with regard to both female and male clients. Participants were also, according to their reports, more likely to notice that a female client is physically attractive. Some of these behaviors (e.g., hugging a client, kissing a client, client's disrobing) were explored in a prior survey, whose findings did not differ greatly from the current results (Pope et al., 1987).

The differential treatment of female clients is an important issue. In this survey, a higher percentage of female clients than male clients are noticed by their therapists as "physically attractive," are hugged by their therapists and are cradled or held in their therapists' laps. Such differences may be largely due to cultural sex roles and socialization (e.g., Bernay & Cantor, 1986; Brown & Ballou, 1992; Gilbert, 1987; Gutek, Cohen, & Konrad, 1990; Gutek, Morash, & Cohen, 1983; Hare-Mustin & Marecek, 1990; Herman, 1992; Kabacoff, Marwit, & Orlofsky, 1985; Tavris, 1992). They may also be related to the tendency for therapist–patient sexual contact to involve a higher proportion of female patients (e.g., Bates & Brodsky, 1989; Gabbard, 1989; Holroyd, 1983; Noel & Watterson, 1992; see also Pope & Feldman-Summers, 1992; Pope & Vasquez, 1991) and for sexual involvement between psychology graduate students (many of whom are learning to be therapists) and their professors or supervisors to involve a higher proportion (adjusting for gender imbalances among faculty and among students) of female students (Glaser & Thorpe, 1986; Pope, Levenson, & Schover, 1979; Robinson & Reid, 1985; Vasquez, 1992), especially in light of a research finding that sexual involvement as a student with one's graduate professors or supervisors is statistically related to subsequent sexual involvement as a professional (Pope et al., 1979). Such issues are in need of more detailed research to enable a better understanding of the nature and consequences of differential treatment of women in professional relationships. Holroyd and Brodsky (1980), for example, pioneered this kind of research, finding that the differential treatment of female and male clients with regard to nonerotic touch was systematically related to therapist–patient erotic involvement.

Complaints

Over 1 out of 10 (11.6%) participants reported that at least one client had filed a complaint (e.g., malpractice, licensing, or ethics) against him or her. The findings suggest that male therapists are at significantly greater risk for such complaints: Almost three times as many male therapists (17%) as female therapists (6%) reported that at least one client filed a formal complaint (e.g., malpractice, ethics, or licensing) against them. Not surprisingly, therapists who indicated some form of sexual or quasisexual involvement (i.e., client strips to underwear, client being naked above [female only] or below the waist or touching the therapists' genitals, or therapist lying on top of or underneath a client, touching a client's genitals, telling a sexual fantasy to a client, or talking with a current client about sharing a sexual relationship after termination) had a complaint rating that was over four times as large as the rating for those who did not report such involvement (rating of 0.5 vs. 0.11; see item number 28 in Table 1).

Training

Graduate training with regard to feelings can span a diverse range of formats: formal classes, seminars, case conferences, practica, field placements, and clinical supervision as well as the less formal learning opportunities (Pope, Sonne, & Holroyd, 1993). Respondents were asked to provide an overall rating for their graduate training in this regard. A large percentage of participants rated their graduate training as inadequate (i.e., nonexistent or poor) with regard to anger, fear, and sexual arousal (41%, 50%, & 65%, respectively).[6] Previous theory and research (e.g., Pope et al., 1986; Searles, 1965; Winnicott, 1949) suggest that such feelings may make both therapists and students uncomfortable. To the extent that such discomfort may lead to neglect of these issues in training programs, therapists-in-training may lack the support to develop the knowledge, resources, confidence, and skills to acknowledge, accept, and understand such feelings when they occur in the therapist's work. Feelings such as anger, hate, fear, sexual attraction, and sexual arousal provide exceptional opportunities for teaching —and research—that, as suggested by these findings, may yet be largely untapped.

In summary, the findings are a reminder of the intense, exciting, complex, stressful, and sometimes dangerous work that psychologists do, and that the responsibilities of that work are not the sort that can be carried out in an unfeeling manner. Acknowledging and trying to understand the feelings that come with the work may be an important part of the work itself.

[6] That evaluations of training do not differ according to theoretical orientation is somewhat surprising in light of the psychodynamic therapies' long history of writings emphasizing countertransference.

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