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Swimming upstream : navigating the complexities of erotic transference

Stacey A. Spilly
Smith College

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ABSTRACT

The focus of this study is to examine therapists' subjective experience of erotic transference and determine what clinical skills and techniques are useful for managing such encounters. The purpose of the study is to answer the following questions using qualitative interviews: How do clinicians' reactions to erotic transference impact the therapeutic relationship? Also, how do clinicians formulate and symbolize aspects of the erotic transference?

The participants were thirteen clinicians who practiced some form of therapy in the Bay Area of California. The sample included psychiatrists, marriage and family therapists, PhD psychologists, and clinical social workers. Given this subject matter is still taboo for some clinicians, I interviewed therapists from mixed backgrounds and mixed theoretical orientations; thus my sample was diverse and includes different types of clinical dyads.

The findings evoked different countertransference responses depending on the degree of intensity of the erotic transference. Additionally, the level of psychopathology corresponded to the intensity of the erotic transference. Most of the clinicians went to a supervisor or peer group to help manage erotic dynamics, as the majority did not receive any formal training around working with erotic dynamics; all reported the process of consultation was extremely helpful. Those clinicians who practiced therapy in managed care settings were constrained by working within a time-limited model that did not allow

for exploration of the erotic transference. In cases where erotic feelings were reciprocal, clinicians were reluctant to seek consultation and experienced higher levels of anxiety and discomfort.

SWIMMING UPSTREAM:

NAVIGATING THE COMPLEXITIES OF EROTIC TRANSFERENCE

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Stacey Spilly

Smith College School for Social Work
Northampton, Massachusetts 01063

2008

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CHAPTER I

INTRODUCTION

The subject of erotic transference has generated a growing body of interest by clinicians in the mental health field as well as popular culture at large. From Tony Soprano of "The Soprano's" to Laura from the very popular Israeli-based HBO series "In Treatment" (as well entering the storylines of major motion pictures), erotic transference is creating quite a stir. This level of attention by the media reflects the public's growing imagination of erotic dynamics happening behind closed doors in the therapist's office. It is a positive development in way of revealing the prevalence of erotic dynamics and getting people exposed to the fact that even in therapy, when people are generally at their most vulnerable, the place of the erotic is always a possibility. Thus, the normalization of this phenomenon is helping to lesson the taboo and promote discussion around this important clinical issue. However, public attention to erotic dynamics has also sensationalized the place of the erotic and as a result, misrepresented these scenarios in some cases. As in the movie "The Departed", the portrayal of the erotic transference by William "Billy" Costigan Jr. ensued quite quickly into a sexual relationship. What's aggravating about these scenarios is that early boundary crossings seem to easily slide into a sexual boundary violations, where the therapist may return the erotic invitation and act-out the patient's fantasy or wish for a relationship. While empirical studies reveal therapist attraction to patients is commonplace, acting-out this desire is not widespread,

refuting the "spin" by popular culture. Review of a small base of literature on therapist

self-disclosure of erotic feelings found that, "Most therapists across mental health

disciplines, roughly between 70% and 90% of clinicians, have been attracted to at least

one client" (Fisher, 2004, p. 106). However, few therapists self-disclose sexual

attraction: "Across mental health disciplines, roughly between 5% and 25% have ever

disclosed sexual attraction to a client, although most figures hover around 5% to 10%"

(Fisher, 2004, p. 108). Notably, of those therapists who did disclose feelings of sexual

attraction to their patients, they were significantly more likely to be men (Fisher, 2004).

Moreover, while the majority of therapists view feelings of sexual attraction as ethical,

few therapists act-out these feelings: "The rate of therapists' sexual involvement with

clients ranges from about 2% to 10% and appears to be on the decline" (Fisher, 2004, p.

106). Thus, this study was undertaken in part to demystify the place of the erotic from

the popular imagination and open-up the discussion with clinicians from multiple

backgrounds to understand what technical skills and factors are critical to effective

handling of erotic dynamics. As Freud indicated in his classic 1915 paper on

"transference-love", these are fundamental dynamics that happen in varying degrees of

development and intensity. Crucial to managing such affairs safely and securely depends

on the therapist's ability to help guide the patient through the erotic landscape, integrating

raw experience and transforming it into rich understanding about both patient and

therapist. Thus, the potential for growth and self-knowledge to come out of the erotic

transference begs for further study into such rich material. As Person (1985) states,

transferences "remain both goldmine and minefield" (as cited in Bridges, 1994, p. 425);

especially when erotic feelings are concerned because of the intensity of feelings

involved. Therefore, it remains the therapist's task to make room for erotic manifestations and restore the value to understanding the complexity of the erotic transference.

Erotic encounters are culturally positioned, gender informed, and socially constructed interactions that do not happen in a vacuum. Thus they are not flat, one-dimensional, nor static in nature. Rather, they represent a dynamic movement in the therapy relationship that signals clues about the manifest meaning assigned to such intimate transactions. In addition, they are contextually placed and unique to the particular dyad involved. According to contemporary writers in this area, the erotic transference does not exist in isolation, rather it is co-created with the therapist; thus a collaborative approach that acknowledges the real relationship between parties is paramount. Only by bringing erotic issues to the fore can we work to de-pathologize its presence and adopt a broadened theoretical understanding to unravel the manifold layers of symbolic meaning embedded in the erotic matrix.

This research attempts to break through the sexual barrier to stimulate discussion and thought into sexualized dynamics without self-consciousness, thereby gaining an understanding of the potential harms and risks in mismanaging these encounters in the therapeutic space. Certainly in cases where erotic desire or loving feelings are reciprocated by the therapist, the margin of error is small and requires skill to maintain appropriate and flexible boundaries. However, specific training on how to safely address erotic transference and countertransference continues to remain absent in most counseling curricula programs, potentially leaving clinicians without the skills and tools to effectively manage these issues within the therapeutic dyad. Furthermore, the traditional

psychoanalytic emphasis on clinicians' objectivity hindered open acknowledgement into the types of reactions therapists have to their clients' eroticized transferences. More recently, the concept of countertransference and use of the therapist's self has become an integral component to the treatment process. Specifically, relational and intersubjective schools have moved from a traditional one-person psychology with an emphasis on neutrality to a two-person model with a focus on the intersubjective field as a co-constructed phenomenon. The present study will use a qualitative interviews to investigate thirteen (13) therapists' reactions to clients' erotic transference and perceived outcomes on the therapeutic relationship.

The two-person dyad inevitably creates interpersonal dynamics in the here-and now that stem from unresolved past and present experiences. These reenactments are happening at both subtle and more pronounced levels of awareness and requires careful attunement to the shifting nuances in the room. This interweaving of subjectivities creates a complex picture where a client's regressive acting-out is brought to the foreground. It is this interplay of subjectivities in the room that fosters erotic transference to surface and invite recognition.

Consequently, the focus of this study is to examine therapist's subjective experience of eroticized transference to help elucidate the clinical skills and techniques useful to managing such encounters. Conversely, this study will also devote attention to the concept of nondisclosure of erotic countertransference: When do clinicians intentionally decline to self-disclose reciprocal feelings of love or erotic desire and for what reasons? Moreover, how does that impact the working alliance in the therapeutic relationship? Because this topic is still taboo for some clinicians, shedding light on this

subject can enhance the professional development of social workers because it has the potential to destigmatize erotic manifestations and generate more open discussion about these fundamental dynamics. The investigation of these issues will expand upon the skills necessary to appropriately address this issue within the therapeutic encounter and avoid committing professional violations and misconduct.

CHAPTER II

LITERATURE REVIEW

This study researched the concepts of self-disclosure, countertransference, and transference. It begins with a general overview on self-disclosure and its impact on therapeutic dynamics. The bulk of the research will center on erotic transference, especially in regards to its meaning and function within the therapeutic dyad. The review will be divided into theoretical and empirical literature to examine conceptually as well as empirically the erotic matrix between patient and therapist.

Self-disclosure: Empirical Studies

Farber and Hall (2002) suggest an alternative way to research the phenomenon of self-disclosure by focusing on patient disclosure. The authors shifted away from previous studies of self-disclosure that tended to focus on the influence of therapist's self-disclosure on the patient's tendency to reciprocate as well as the impact of therapist disclosure on therapeutic outcome. This study used a quantitative method that made use of an existing self-report measure (The Disclosure-to-Therapist-Inventory-Revised) to standardize the questionnaire; the sample consisted of 147 current psychotherapy patients (45 men, 102 women). Results were investigated to determine the relationship of disclosure in therapy along several factors: client gender, shame-proneness, and strength of the therapeutic alliance. No significant differences were found in overall degree of disclosure as a function of patient gender or shame-proneness; however, disclosure was

positively correlated with the perceived strength of the therapeutic alliance. The study did not focus on the relationship between patient disclosure and outcome.

Because patients were found to withhold disclosure of sexual and procreative issues, the authors concluded this trend reflected some of the basic taboos in our society. Moreover, the lack of extensive discussion of sexual and/or procreative issues may reflect either deeply held cultural ideas regarding appropriate sexual behavior or ideas regarding the domain of what should be spoken about, even to one's therapist. To bridge this gap, efforts were taken to normalize material deemed taboo by one's culture: "Freud exhorted therapists and patients alike to treat sexual issues with the same degree of maturity and dispassionate observation that they would any other important issue" (Farber and Hall, 2002, p. 366). To explain why patients withheld disclosure of certain issues, Hill et al. (1993) found that patients are likely to withhold material in therapy because of feelings of shame or insecurity (as cited in Farber and Hall, 2002).

Indeed, many authors (Broucek, 1991; Hill, Thompson, Cogar, and Denman, 1993; Livingston and Farber, 1996; Wurmser, 1981) substantiate that *shame* [italics added] poses a significant obstacle to Freud's (1913/1958) "fundamental rule," that the patient must disclose every thought that comes to awareness: "Shame, including the fear of exposure, is an inexorable aspect of psychotherapeutic treatment, inevitably affecting the focus and depth of what is discussed" (Farber and Hall, 2002, p. 360). Thus patients' shame limits the scope of feelings or thoughts deemed suitable for exploration in therapy. This raises the concept of what Kelly (1998) refers to as "secrets" that patients may refrain from disclosing fully to their therapist; most often these secrets reflected either relationship difficulties or sexual issues (as cited in Farber and Hall, 2002). In sum,

Farber and Hall did not explore how these factors (i.e. client gender, shame-proneness, and strength of the therapeutic alliance) impact the outcome of therapy. In addition, it is limited by virtue of doing quantitative work: it does not allow exploration of participants' judgments; instead, it uses their interpretation of meaning for self-disclosure as fact. Conversely, the current study will use a qualitative research design to allow for greater depth into participants' responses to patients' disclosure of erotic transference and will address how factors such as patient gender, shame-proneness, and strength of the therapeutic alliance, impact the handling of erotic issues in the therapeutic arena. Moreover, it will add to the discussion of how shame figures into disclosure patterns of erotic feelings.

Anderson and Mandall (1989) examined the pattern and extent of self-disclosure among therapists, namely professional social workers in the state of Oregon. The research was carried out using a fixed method research design to address the use of self-disclosure in a population. This method produced a detailed picture of a conceptually defined phenomenon in a specific context. The data for the study was collected by means of a mailed survey; hence it relied on self-reports rather than direct observation. The questions used for the survey were taken from a review of literature, indicating a deductive style of methodology. In addition, the researchers made use an existing tool, the Jourard Self-Disclosure Questionnaire, to standardize the questions used for the study. In sum, the authors concluded that self-disclosure is widely used by social workers yet used less often by clinicians with a psychodynamic orientation (Anderson and Mandall, 1989). They also found respondents adhered to the principles governing when to use self-disclosure as was shown in the literature. However, the response

choices on the survey did not include alternate reasons for using self-disclosure that were not predicted or anticipated from the review of literature, thus such findings were "invisible" to the study. The current study will address this gap. Specifically, it will measure from the therapists' perspective the effects of patient disclosure of erotic feelings on the treatment relationship. The sample will include clinicians from various disciplines to evaluate how different theoretical styles manage erotic dynamics differently. Thus, results will span across theoretical orientations and practice approaches to understand erotic feelings from different clinical perspectives.

Hanson (2005) investigated from the clients' perspective whether or not the effects of therapist disclosure and non-disclosure were considered helpful or unhelpful. Eighteen people (sixteen women and two men), currently in therapy, were surveyed. Qualitative interviews were conducted using open-ended and exploratory questions to gather participants' information. This method allowed for a variety of perceived effects of therapist self-disclosure. Responses from participants were grouped in categories suggested by the literature. These included: strengthening the therapeutic alliance; fostering a more egalitarian relationship; or advancing client autonomy; modeling or skills training; validating reality; facilitating client insight or learning; catharsis; support, reinforcement and validation of client; and the right to make informed decisions. In addition, it addressed the role of attachment in the therapeutic relationship and the potential for helpful disclosures to counteract past hurts, including previous failures of attachment. Clients' perceptions were rated according to helpfulness/unhelpfulness of the disclosure/nondisclosure. Disclosure was defined broadly to include interactions that revealed personal information about him/herself (self-revealing statements) and reactions

or responses to the client as they arise in session (self-involving responses). It used a Grounded Theory method of qualitative analysis, which added flexibility to the interview process by allowing for the emergence of new categories and also the suggestion of relationships between them. Two new categories emerged from the data: transitioning and moral solidarity, these categories did not fit in the pre-determined categories and were considered new findings. Specifically, *transitioning* referred to small-talk used by therapists to make a transition into and/or out of sessions. Such revelations effectively broke the ice, put clients at ease, and gave a sense of the therapist's humanity. Additionally, therapists who revealed moral solidarity with a stigmatized identity (gay; incest survivor) was found to be helpful if disclosed sooner rather than later in the therapeutic process. Two colleagues were used to code some of the incidents to protect against researcher bias, which is a common danger when doing qualitative work. To ensure her bias did not alter results, she was careful to ask for experiences that reflected a range of effects, both positive and negative, for both disclosure and nondisclosure. The results corroborated the literature citing the greatest effects of disclosure and non-disclosure are on the alliance, with skill level being a mitigating factor. The author refers to Gutheil and Gabbard (1993) who posit that psychoanalytic literature on the topic of non-disclosure regarded it "either as a default position of the traditional framework or as an ethical requirement" (as cited in Hanson, 2005, p. 97). This reinforces the therapist's position of neutrality since, as Meiselman (1990) found, "disclosures were believed to cause alliance ruptures as a result of decreasing trust or safety or to cause clients to 'manage' the relationship by becoming the therapist's caretaker" (as cited in Hanson, 2005, p. 97). Coady and Marziali (1994) report, "Empirical studies of the therapeutic

alliance found that the alliance was impaired when clients' needs were thwarted," by therapists' refusal to self-disclose when sensitive issues are raised, such as religious beliefs, sexual orientation, or abortion (as cited in Hanson, 2005, p. 97). Additionally, Ackerman and Hilsenroth found that the alliance is weakened when "therapists rigidly used transference interpretations and were unwilling to acknowledge the real relationship with their clients" (as cited in Hanson, 2005, p. 97). Alternately, the current study will address the impact of erotic dynamics on the alliance and treatment relationship. In turn, it will evaluate the role of the therapeutic relationship in handling erotic feelings.

Specific to cross-cultural dyads, Burkard et al. (2006) investigated the use of self-disclosure and the effect of such disclosures on cross-cultural counseling processes. A study conducted by Hill and Knox (2002) found that therapist self-disclosure is an infrequently used intervention, comprising "an average 3.5%…of all therapist interventions" (as cited in Burkard et al, 2006, p. 15). Most studies support positive effects of therapist self-disclosure: "clients reported having more insight"; "perceived therapists as more real and human"; "helped clients feel reassured and normal"; and some clients reported, "liking their therapists more" when they self-disclose (Burkard et al, 2006, p. 16). This study used qualitative research to examine more fully the concept of self-disclosure from the therapist's perspective. It interviewed eleven European American therapists about their use and the effect of self-disclosure with clients who were of a race different from their own. The author identified three themes evident in the conceptual literature regarding the use of therapist self-disclosure in cross-cultural therapy: 1) The concept of cultural mistrust; 2) a demonstration of therapists' sensitivity and skills in working with cultural and racial issues in therapy; and 3) to model

appropriate in-session behavior and help form a productive working alliance (Burkard et al, 2006). The authors suggest areas for future inquiry: understanding factors that may interfere with the transfer of knowledge in cross-cultural counseling and identifying skills important to cross-cultural work. The current study will investigate whether or not cultural factors play a significant role in determining therapists' reactions to the erotic transference.

Self-disclosure: Theoretical Literature

From a contextual perspective, Geller (2003) uses a two-stage decision-making model to consider therapist self-disclosure from a style and internalization perspective. This model incorporates a dual focus on the interaction between intentional self-disclosures and the expressive styles from which they surface and in which they are embedded. This approach emphasizes having an awareness of contextual factors that influence one's choices about "when, what, and how to say something personal about myself to a patient." (Geller, 2003, p. 542). In addition, timing is of utmost importance when considering when to self-disclose and treatment goals should be given priority beforehand. Moreover, interpersonal skills are critical to effectively maximize the therapeutic potential of intentional use of self-disclosure. In addition, the author stresses having knowledge of a patient's sense of limits before opting to self-disclose requires skill and experience. Indeed, using self-disclosure sparingly is a good general rule for therapists. This article expanded the view of personal disclosures to include visual and nonverbal disclosures. With a broadened view of self-disclosure, "The creation of meaning through the symbolization of experience can occur in any medium of channel of communication" (Geller, 2003, p. 545). In addition, it deemed self-disclosure a form of

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communication in its own right, equal in importance to other therapeutic tools such as clarifications, interpretations, and questions (Geller, 2003). Ultimately, discretion paid to the alliance, while simultaneously keeping a focus on the therapeutic goals of treatment and phase of treatment, can refine and inform therapists' understanding of the technical use of self-disclosure.

Fisher (2004) gives practical advice for how to negotiate erotic entanglements by providing a review of the literature that investigates prevalence rates of therapists' disclosures of loving and/or sexual feelings and measures their impact on resolving the erotic transference-countertransference dynamics. Fisher, in his position as a male psychotherapist, warns against the explicit use of self-disclosure of attraction and states a need for adequate consideration of other interventions. The author cites a good guiding principle for disclosures: "Avoid explicit, direct disclosure while subtly acknowledging the strong feelings that were present in the therapeutic relationship" (Fisher, 2004, p. 111). This advice is a difficult task to carry out effectively, as Gabbard (1994) noted, the margin of error is much too small to justify making a direct disclosure, even when there is a sound theoretical basis and an ethical boundary states explicitly that no sexual activity would ever take place, there is no way to control for how the patient receives the disclosure (as cited in Fisher, 2004). Review of a small base of literature on therapist self-disclosure of erotic feelings found that, "Most therapists across mental health disciplines, roughly between 70% and 90% of clinicians, have been attracted to at least one client" (Fisher, 2004, p. 106). However, few therapists self-disclose sexual attraction: "Across mental health disciplines, roughly between 5% and 25% have ever disclosed sexual attraction to a client, although most figures hover around 5% to 10%"

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(Fisher, 2004, p. 108). Notably, of those therapists who did disclose feelings of sexual attraction to their patients, they were significantly more likely to be men (Fisher, 2004). Given this evidence of gender differences in perception of interactions and in initiating quasi-sexual behavior, female clients are treated differently, particularly by male therapists. Fisher considers the possibility: "there may be something about male therapists' needs that are being expressed in these disclosures, which suggests they are not acting in the clients' best interests" (Fisher, 2004, p. 117). The recommendations given by Fisher as a result of his research on therapist self-disclosure of sexual feelings has expanded the knowledge around this ethical dilemma. While the current research focuses attention on therapists' reactions to patient disclosure of sexual feelings, in some instances reciprocal feelings may represent a significant clinical issue as well. Thus, this article provides useful guidelines for managing these situations safely and ethically.

The majority of therapists viewed feelings of sexual attraction as ethical; conversely, few therapists act-out these feelings: "The rate of therapists' sexual involvement with clients ranges from about 2% to 10% and appears to be on the decline" (Fisher, 2004, p. 106). In a dated study on sexual contact in therapy, Bouhoutsos et al (1983) found 92 percent of sexual intimacy reported between therapist and patient occurred in dyads composed of female patients and male therapists (p. 188). In addition, the majority of sexual relationships with male patients (58%) also involved male therapists (Bouhoutsos et al, 1983, p. 188). In addition, many therapists question the ethics and competence of disclosing attraction to clients. Fisher reinforces a good general rule for therapists to keep in mind when making a disclosure: "To take care that it is only

the client's needs that are being met, and to avoid or minimize the potential for harm to the client" (Fisher, 2004, p. 117).

Searles (1959), albeit a dated reference but still an important consideration, believed frank discussion of erotic feelings may benefit patients with psychosis and warned against direct disclosure of such feelings to neurotic patients (as cited in Fisher, 2004). Specifically, Searles believed loving feelings might be used to help resolve patients' conflicts about incest and raise otherwise low self-esteem levels (as cited in Fisher, 2004). However, in terms of incest, making direct disclosures in this context are incredibly complicated to formulate, yet alone control for how the patient takes in and experiences the disclosure. Such patients with a sexual trauma history may become re-traumatized by therapists' sexual or loving disclosures. Therefore, therapists must remain cognizant of how certain vulnerabilities impact and shape erotic transference-countertransference dynamics.

In the area of erotic transference, Rachman and colleagues Kennedy and Yard (2005) relate patients' disclosure of erotic transference in the psychoanalytic situation to manifest from earlier sexual trauma. They propose that the emergence of the erotic transference is an enactment that occurs between therapist and client; this enactment is an indication of an earlier childhood experience. Moreover, they highlight the value of enactments that is contained in the unconscious communication that the erotic transference represents. "It is through the expression of the erotic transference that the analysand attempts to master the original trauma" (A. WM. Rachman et al, 2005, p. 185). Critical to this process is the analyst's emotional reaction to the erotic transference; this

requires careful exploration to derive meaning behind the enactment, while maintenance of appropriate boundaries is upheld.

In addition, the authors state that historically, disclosure of erotic transference in the clinical encounter was viewed as a negative development in the analytic relationship. "The one-person psychology of traditional analysis has focused on blaming the analyst for the development of an erotic transference." (A. WM. Rachman et al, 2005, p. 183). In essence, psychoanalysts of the past avoided erotic transference, if one could, and encouraged the attitude and philosophy of neutrality. This neutrality spoke to a taboo concerning emotional and interpersonal engagement. "Emotional and interpersonal distance was institutionalized as the "correct" analytic posture." (A. WM. Rachman et al, 2005, p. 183).

Moreover, the lack of attention to the significance of erotic transference contributed to the de-emphasis of the role of trauma in the development of psychopathology. The authors derive their theoretical ideas from Sandor Ferenczi's Confusion of Tongues paradigm (1933) to generate their hypothesis: "An erotic transference is an enactment in the here-and-now of the psychoanalytic situation of a childhood seduction, or sexual trauma" (WM. Rachman et al, 2005, p. 184). Case examples were used to illustrate their ideas. Ferenzi's Confusion of Tongues paradigm endorsed Freud's original seduction hypothesis that emotional disturbance could be related to childhood sexual trauma (WM. Rachman et al, 2005). In short, his ideas expressed in the Confusion of Tongues paradigm describe how a victim of incest processes the sexual trauma. This publication stirred a controversy by turning away from Freud's classical view that erotic transference originated from an unanalyzed negative

countertransference reaction. Freud's view reflected a one-person psychology where the Oedipal conflict existed as the primary explanation for human behavior, whether neurotic or perverse. Thus, Ferenzi proposed an alternate explanation for the development of the erotic transference.

Furthermore, Ferenzi believed the erotic transference contained split-off elements of the sexual trauma that manifest in the actual behavior of the clinical situation. Hence, it is the therapist's job to tease out and assist the patient in finding meaning to the split-off elements embedded in the eroticized dynamics. The emotional reaction of the therapist, conscious or unconscious, helps co-create the unfolding of the enactment in real time (A. W.M. Rachman et al, 2005). If one responds with anxiety for example, the therapist may downplay or ignore the sexual seduction, thereby assuming the role of "parental bystander" who overlooks the abusive experience. Alternatively, if the sexual or loving feelings are mutual, the therapist may deprive the client of his or her need to uncover the sexual trauma free of emotional entanglements. "Rather than recovering his or her voice, the individual is re-traumatized, encouraging splitting and dissociation" (A. W.M. Rachman et al, 2005, p. 185). In sum, this article shifted the belief of erotic transference as a negative development to a useful clinical tool that symbolically represents past and present self and object relations. In addition, it illustrated how the therapist's response (or lack of response) to erotic transference has various implications in clinical encounter.

Book (1995) highlighted technical and countertransferential difficulties that may interfere with the therapist's identifying and addressing the erotic transference. He specifically focused on three related issues: (1) theoretical and technical problems in

identifying and managing erotic transference; (2) latent meanings of erotic transference; and (3) some countertransferential issues in dealing with the erotic transference. This article is written from the perspective of a male therapist treating a female patient in psychotherapy or psychoanalysis, given that most cases of exploitation involve a male therapist with a female patient (Book, 1995). The author defines the term "erotic transference" as: "Any transference in which the patient's fantasies contain elements that are primarily reverential, romantic, intimate, sensual, or sexual" (Book, 1995, p. 505). The author makes the proposition that erotic transference is avoided or mismanaged in cases where: (1) the therapist is naïve and unable to identify or actively denies, the existence of transference; (2) the therapist has unresolved countertransferential problems; (3) the therapist is psychopathic, repeat offender, and/or consciously prey on female patients [in the case of male therapist-female patient dyad]; and (4) the psychotic therapist who sexually exploits patients because of delusional demands (Book, 1995).

In addition, his belief that self-disclosing therapists blur the boundary between patient and therapist and "inappropriately encourage unnecessary intimacy" may be appropriate in cases involving erotic transference/ countertransference dynamics (Book, 1995, p. 506). Whereas contemporary studies reveal that therapist self-disclosure is more widely used (albeit judiciously) and accepted as an appropriate technique, in certain situations it may result in more harm than benefit.

In working with the erotic transference, the author recommends that therapists examine the latent meaning and function of the erotic transference, rather than accept the disclosure of erotic transference as reality. Thus, it is the therapist's job to explore and uncover what is represented in the erotic transference while staying attuned to his/her

countertransference responses and attempt to use these in the service of empathic understanding (Book, 1995). To be sure, this recommendation is well taken and clearly an important distinction. Additionally, he asserts: "The erotic transference—the existence of reverential, sensual, or sexual feelings toward the therapist may represent significant but overlooked pre-oedipal issues, oedipal issues, hostile issues, or selfobject issues that must be identified for treatment to be helpful" (Book, 1995, p. 508).

Thus, patient disclosure of erotic transference may signal the existence of another disguised transference. Similarly, the same holds true for clinicians who experience sexual feelings for their patient. For example, in some cases erotic countertransference can mask identification with the patient, especially when vulnerabilities are shared: "When the therapist's issues closely resemble a piece of the patient's history or on the surface match a patient's issues, sexualized countertransference may serve to protect primarily the therapist and secondarily the patient from discovering painful material…" (Bridges, 1994, p. 428). In this way, sexual feelings can serve to inhibit actualizing other painful/unsettling material in both patient and therapist. Thus, both parties may develop sexual/loving feelings to avoid or deny going deeper and working with core developmental issues that factor into erotic dynamics happening in therapy.

In sum, self-disclosure can be a powerful intervention when used skillfully to facilitate growth and development in the therapeutic relationship. One approach to measure the level of frustration the patient can tolerate is to pretest before an initial self-disclosure. Indeed, managing a patient's disclosure of love or erotic desire is a challenging and complex process. In situations where erotic feelings are reciprocal, it is important that self-disclosure of erotic countertransference be personal but not

exhibitionist. Careful attention must be paid to the inherent risks involved in openly and honestly reciprocating expressions of love. Because it's a slippery slope, misuse of erotic self-disclosure can lead to professional violations and misconduct. Indeed, the margin of error is small for the therapist to speak to erotic tension in the analytic treatment. The difficulty lies in managing such feelings with skill and technique.

<p align="center">*Countertransference: Theoretical Literature*</p>

The historical evolution of theoretical discourse on countertransference transformed its use into valuable clinical phenomena. Gabbard (1999) reviewed the literature discussing countertransference theory and technique. Starting with Freud, countertransference was regarded as essentially "an obstacle to overcome" (as cited in Gabbard, 1999, p.1) . This narrow view of countertransference was expanded by Paula Heimann in 1950: "The analyst's total emotional response to the patient is not simply an obstacle or hindrance based on the analyst's own past, but an important tool in understanding the patient's unconscious" (as cited in Gabbard, 1999, p. 2). While this new broadened perspective saw countertransference as useful information, it did not endorse the analyst to communicate his or her feelings to the patient.

In addition, D. W. Winnicott (1949) added an objective component to countertransference in which the therapist reacted to the patient in the same way that everyone else did (as cited in Gabbard, 1999). This viewpoint is helpful to bear in mind when sitting with patients who evoke certain strong reactions. This theoretical shift regarded countertransference as a technique to understand interpersonal dynamics of the patient from a broader context, where patterns that unfold in the therapeutic relationship are replicated in other contexts outside of the therapeutic encounter.

Contemporary theoreticians acknowledge countertransference as a *jointly created* phenomenon, where the subjectivity of the therapist both influences and informs the creation of countertransference. Thus, this co-creation of interwoven subjectivities recognizes a two-person psychology where both patient and therapist imbue the therapeutic space with distinctive characteristics. More specifically Gabbard (1995) notes, "The patient draws the therapist into playing a role that reflects the patient's internal world, but the specific dimensions of that role are colored by the therapist's own personality" (as cited in Gabbard, 1999, p. 3). In essence, the clinician is 'hooked' (a term used by Gabbard to explain the process of projective identification) to participate in the patient's world through a series of enactments that disavow the therapist from the traditional position of neutrality or objective blank slate.

Countertransference enactments involve a 'subtle interlocking' of the transference and countertransference (Mann, 1997). This phenomenon is distinguished from projective identification in that therapists may interpret intrapsychic meaning of an interaction differently in response to the same material from the same patient. Gabbard (1989) clarifies these terms:

> Theoretically, *splitting* [italics added] among therapists is caused by projection of idealized self and object representations to some therapists, and devalued self and object representations to other therapists (Gabbard, 1989). *Projective identification* [italics added] is considered the vehicle that converts intrapsyhic splitting into interpersonal splitting (as cited in Rossberg et al, 2007, p. 229).

More specifically, a therapist's own conflicts and internal self and object representations determine the final shape of the countertransference response (Gabbard, 1999). In addition, Gabbard (1999) refers to the common ground in psychoanalysis that now regards *intersubjectivity* as the crucial element in the analytic process. Bollas (1987)

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writes: "In order to find the patient we must look for him within ourselves. This process inevitably points to the fact that there are 'two patients' within the session and therefore two complementary sources of free association" (as cited in Mann, 1997, p.70).

Racker (1968) divided the therapist's reactions into two distinctive types: concordant and complimentary countertransferences (as cited in Gabbard, 1999). The former involves an empathic attunement to the patient, meaning the therapist identifies with a self representation within the patient. The latter involves the therapist's identification with an internal object representation of the patient, an instance Racker believed may activate the therapist's own conflicts by the patient's projections (as cited in Gabbard, 1999).

In sum, the idea of countertransference as a joint creation helps the clinician remain vigilant to patterns of interaction that manifest within a shared common ground. This shift in thinking to a broadened connotation of countertransference by contemporary theorists opens the interpretative field to include *nonverbal correlates*, such as tensing of the muscles, changes in breathing, or shifts in body posture (Gabbard, 1999). These nonverbal cues can also be a tool to help understand how particular patients influence behavior and emotions that may lodge in the body and inevitably shape the analytic space in meaningful ways.

Jaffe (1986) speaks to the technical use and definition of countertransference reactions: "Countertransference reactions, experienced as thoughts, feelings, associations, and fantasies, provide valuable clues regarding the patient's conflicts, developmental vulnerabilities, and object relations" (as cited in Bridges, 1994, p. 429). Additionally, Jaffe (1986) suggests clinicians employ a "loosening of self-other boundaries and give

full sway to primary-process modes of listening in the service of gaining needed information about the patient's subjective experience" (as cited in Bridges, 1994, p.429). Thus, all phenomena in the clinical encounter inform and shape countertransference reactions in meaningful and complex ways.

Basically, all therapeutic interactions are open to interpretation and clinical dyads ascribe meaning to phenomena differently. Interpersonal and intrapersonal dynamics coexist in the clinical encounter creating "a certain margin of psychic realities in the analytic couple that brings affective vitality to the analytic endeavor" (Cornell, 2007, p. 53). Moreover, Ferenczi (1998 [1932]) describes an interpenetration of subjectivities where subject and object intermingle and form an intersubjective whole:

> The emotions of the analyst combine with the ideas of the analysand, and the ideas of the analyst (representational images) combines with the emotions of the analysand; in this way the otherwise lifeless images become events, and the empty emotional tumult acquires an intellectual content (as cited in Cornell, 2007, p. 53).

This suggests there's a third space, or analytic third, inhabited and co-created by therapist and patient, that takes form and becomes a distinct entity made up of characteristics belonging to both participants. In this way, dynamics unfolding in the therapeutic encounter are unique and representative of the particular clinical dyad.

Countertransference: Empirical Study

Rossberg et al (2007) conducted an empirical study that measured countertransference reactions toward patients with personality disorders. Sandler and colleagues (1992) links the relevance of this research to the current study. Specifically, Sandler et al (1992) found patients with more primitive pathology express an extreme form of erotic transference referred to by Blum (1973) as "eroticized transference",

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which "corresponds to a severe disturbance of the sense of reality, is indicative of the severity of the illness, and is usually manifest in borderline cases or in cases of ambulatory schizophrenia" (as cited in Koo, 2001, p. 29).

Rossberg et al (2007) surveyed a total of 11 therapists who filled out the Feeling Word Checklist-58 (FWC-58), for 71 patients admitted to a day treatment program. The patients were diagnosed with the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II). The results showed that patients with cluster A + B Personality Disorders (mainly Borderline Personality Disorder) evoked more negative and less positive countertransference reactions than those with cluster C Personality Disorders (mainly Avoidant Personality Disorder). The instrument used to measure countertransference reactions, the Feeling Word Checklist-58 (FWC-58), groups responses into 7 clinically meaningful dimensions. There are 2 positive subscales named *important* (empathic, caring, and enthusiastic), and *confident* (relaxed, objective, and calm), and 5 negative subscales named *rejected* (disliked, disparaged, and stupid), *on guard* (anxious, cautious, and threatened), *bored* (aloof, indifferent, and empty), *overwhelmed* (surprised, confused, and invaded), and *inadequate* (sad, distressed, and helpless). These countertransference subscales are useful to the present study by providing a standardized means to group clinicians' reactions to erotic transference into positive or negative evaluative categories. Because the sample was small, it did not compare to what extent the therapists' experience and level of training influenced the reported coutertransference reactions. The current study explored if these variables account for comparatively different results. Additionally, the results of this study illustrate that therapists' countertransference reactions can be used as important clinical

tools, if the therapists are able to recognize and use insight about their feelings in a meaningful way. One way to recognize and sort out various dynamics is the practice of dualism; this self-reflective process helps evaluate to what extent action and reaction, inner and outer, past and present relationships shape and inform dynamics co-created between therapist and patient. Tracking is a technique that helps foster this dual state of awareness.

Erotic transference

Erotic transference is inevitably emotionally difficult to address and represents a variety of dynamic and defensive meanings. Freud (1915/1959), in "Observations on Transference Love," concluded the quality of love expressed in the clinical encounter is similar to the type of love expressed in everyday life (as cited in Lijtmaer, 2004). The primary distinction between the two types of love was that love directed toward the therapist was closely associated with resistance (Lijtmaer, 2004). In other words, resistance represented a defense against the analysis and served as a disguise to mask other painful experiences. Freud (1915/1959) believed "a subgroup of these patients were untreatable because they concretely needed to actualize the transference" (as cited in Lijtmaer, 2004, p. 484). Freud delineated certain common factors, which make a person more susceptible to developing an erotic transference. These include: "Sexual seduction in childhood while in the oedipal phase; instinctual over-stimulation combined with parental deprivation in terms of lack of appropriate protection and support; intense masturbatory conflicts; and family toleration of incestuous/homosexual behavior" (Lijtmaer, 2004, p. 484).

In 1973, Blum changed this idea with the publication, "The Concept of Eroticized Transference", which reflected a range of responses from the patient with one end labeled "erotic" transference (positive expressions based in affection that were analyzable); conversely, the other end of the continuum of feelings defined erotic transference as "an intense, vivid, irrational, erotic preoccupation with the analyst, characterized by overt, seemingly ego-syntonic demands for love and sexual fulfillment from the analyst" (Blum, 1973, p. 63). In the clinical encounter, Blum's view is that the seduction pattern gets replayed in order to master the trauma. This is similar to enactments, where unfulfilled needs, wishes, or desires are replicated with the therapist being seduced in a sense, to play a role that reflects the patient's internal world. To help clarify the meaning of erotic, Mann (1997) suggests it includes: "All sexual and sensual feelings or fantasies a person may have. It should not be identified solely with attraction or sexual arousal as it may also include anxiety or the excitement generated by the revolting" (Mann, 1997, p. 6). This more open-ended view of the erotic speaks to the complexity and layers of meaning embedded in the erotic transference. Mann (1997) highlights the general tendency of writers regarded the erotic transference as a negative therapeutic reaction and considered it a resistance. In this way, the bulk of the early literature reflects a striking lack of analytic curiosity towards exploration and investigation. This creates an oversimplification of the phenomenon, thus limiting the therapist's capacity to understand various meanings and nuances of the erotic transference.

Clinical accounts of erotic transference consist of subjective experiences out of which various investigators try to make sense; thus there are no reliable, objective reports on this complex subject (Mann, 1997). Thus, there is a high degree of variance as

authors from different theoretical orientations suggest reasons for its occurrence. Mann

(2003) claims that "to see the erotic as essentially fabricated and as a resistance is more

often an indication of resistance in the therapist rather than in what is happening in the

patient" (as cited in Rouholamin, 2007, p. 184). This approach acknowledges a two-

person psychology where the therapist's own unconscious wishes and fantasies play a

significant role in the co-creation of erotic transference-countertransference dynamics.

Lijtmaer (2004) uses her own clinical examples to elucidate the variety of erotic

manifestations that may exist in clinical dyads. She states that the presence of erotic

material within the therapeutic relationship pose "special treatment challenges that may

not respond well to the interpretative effects of the therapist." On the more pathological

side of the spectrum, Akhtar (1996) categorizes certain behavior as "malignant erotic

transference" which can be described in four aspects:

> (1) predominance of hostility over love in the seemingly erotic overtures; (2)
> intense coercion of the analyst to indulge in actual actions; (3) inconsolability in
> response to the analyst's depriving stance, and (4) the absence of erotic
> countertransference in the analyst, who experiences such "erotic" demands as
> intrusive, desperately controlling, and hostile (as cited in Litjmaer, 2004, p. 492).

Such erotic overtures may cause the therapist to resist working through such complex

material and may evoke particular countertransference anxieties that Chiesa (2003) states

range from "anxiety, fear, confusion, surprise, gratification, disgust, condemnation,

attraction and a wish to reciprocate may all be elicited" (as cited in Rouholamin, 2007, p.

185).

To help manage the effects of the erotic transference, Rouholamin (2007)

explores the importance of the psychotherapeutic "frame" as a container for the erotic

transference to maintain boundaries and structure to the professional nature of the

therapeutic relationship. The frame, first coined by Milner in 1952, is used to differentiate the therapeutic relationship from any other relationship between two people. In this way, it provides a structure to the clinical encounter and demarcates rules to govern the unfolding dynamics between therapist and patient. It is particularly important, according to Mann (1997), that the therapist's subjective reactions to the erotic transference are, "neither repressed or denied, but subjected to the rigors of analytic thought, it can be utilized to the patient's advantage" (as cited in Rouholamin, 2007, p. 185). Furthermore, May (1986) recommends containment of sexual feelings in psychotherapy to manage the anxiety "without spilling over into action, or withdraw in disgust or alarm" (as cited in Bridges, 1994, p. 425).

Additionally, gender factors into countertransference reactions differently depending on the particular configuration of the clinical dyad (i.e. same-sex and cross-sex dyads). Flax and White (1998) in their position as two female (heterosexual) psychoanalysts, discuss how gender figures into the erotic transference/ countertransference matrix using case examples to support their arguments. As transference is no longer seen as primarily the patient's early years in reenactment, many authors recognize that the therapist brings his/her own transference to the situation and ultimately, influence the process of treatment in distinct ways (Flax and White, 1998). As early as 1936, Bibring indicated that therapy proceeds differently depending on whether or not the therapist is male or female (as cited in Flax and White, 1998). A review of the literature shows that little attention has been paid to the *subjective experience* of the female analyst (Flax and White, 1998). Specifically, the literature lacks a detailed description of the therapist's countertransference to the patient's erotic

transference (Flax and White, 1998). There exists some controversy in the literature regarding whether or not male patients develop strong erotic transferences to female therapists. The authors propose that female therapists may inhibit the full unfolding of erotic transferences in male patients for various reasons. For example, female therapists may fear being seen as seductive, or feel discomfort with the normative power pattern this dyad dictates. To counteract such unease in the female therapist, they suggest the "erotic spell" be maintained to allow the full unfolding of the transference; for this to occur, "both involvement and detachment are central to this process" (Flax and White, 1998, p. 5). Integral to carrying out this task, the therapist must allow for immersion in the transference while maintaining their analytic observing capacity, thus providing structure as well as flexibility to the therapeutic frame. This approach allows for a not-knowing clinical stance to lead the process of exploration: "If we do not immerse ourselves in the process we cannot fully know it, and if we lose the "as if" quality we are of no help to the patient" (Flax and White, 1998, p. 11). To clarify, the "as if" quality of the therapist refers to a clinical stance of therapist that is both involved and detached or stated more simply, in it and out of it at the same time. Gabbard (1994) corroborates this view poignantly: "Only by tiptoeing on the edge of that abyss can we fully appreciate the internal world of the patient and its impact on us" (p. 1103). In sum, the authors call for an exploration of developmental issues, gender representations, and fantasies of both participants in response to erotic feelings to help flesh out the unique construction of the particular dyad.

In certain cases, the therapist's subjective reactions to the erotic transference may elicit sexual and loving feelings toward the patient. Depending on the intensity of the

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response, the general agreement among authors recommend the therapist seek consultation with peers and mentors capable of warm and compassionate guidance. If feelings are left unresolved, sexual stimulation in the countertransference can lead to a variety of outcomes: therapists' misconduct (most extreme example), therapeutic impasses, shame and isolation, therapists' withdrawal or overinvestment in the treatment process (Bridges, 1994). In addition, specialized trainings or one's own personal therapy can help alleviate the shame and isolation that therapists may associate with the conscious recognition of feelings of attraction in the therapeutic field. Seeking out these support networks can reduce the likelihood of engaging in destructive behavioral enactments (Bridges, 1994).

Bridges (1994) expands upon early writers' attempt to normalize sexual feelings and erotic longings that arise in the treatment relationship to both destigmative the phenomenon of erotic transference and offer guidance on the technical use of such feelings. In navigating erotic dynamics, Havens (1993) states the success of treatment depends in part on the *attitude* [italics added] we take toward new phenomena we discover in ourselves as well as our patients: "Therapists do well to maintain an open mind about where the exploration of sexual feelings will take them" (as cited in Bridges, 1994, p. 427). Maintaining an open mind adds space to the clinical encounter so that subtleties are identified, contained, and insight can follow.

To assist the therapist in navigating this often affectively loaded area, Gray (2000) suggests the development of erotic transference speaks to the level of care and love the patient received as a child: "Keeping this in mind can help the therapist to understand both the need of a firm frame, and to appreciate how much the person who feels that they

never had enough care may long for more than the therapy gives" (as cited in Rouhoulamin, 2007, p. 183). Moreover, according to Jung (1946), "this is the purpose of the erotic connection; it deepens the patient's capacity for relatedness" (as cited in Schaverien, 1999, p. 17).

In certain cases, erotic countertransference can prevent identification with the patient, especially when vulnerabilities are shared: "When the therapist's issues closely resemble a piece of the patient's history or on the surface match a patient's issues, sexualized countertransference may serve to protect primarily the therapist and secondarily the patient from discovering painful material…" (Bridges, 1994, p. 428).

To incorporate such countertransference reactions into useful clinical formulations and assign meaning to particular dynamics happening in the treatment process, Gorkin (1987) recommends "sinking but not drowning in the sexualized countertransference" (as cited in Bridges, 1994, p. 429).

These recommendations help structure a clinical stance to arrive at direct interventions to manage sexual feelings. Bridges (1994) suggests consultation before the therapist attempts the following interventions: "deepening explorations, verbal clarifications, personal disclosure, and perhaps limit setting" (Bridges, 1994, p. 429). In cases of reciprocal erotic transference/countertransference reactions, clinicians risk acting inappropriately when faced with sexual dilemmas.

Davies (1994) opens up the professional literature on erotic countertransference by reflecting on her own parallel processes happening in the psychoanalytic encounter. Davies makes use of her own bodily states of awareness to understand more fully the erotic subtexts happening in the clinical encounter. Stating she had no other honest

alternative, she disclosed her erotic countertransference to both recover from an impasse

and enable her patient to move into an area of inquiry that had been previously

dissociated. Davies asserts that from a relational model of psychoanalysis, this level of

involvement and revelation on the part of the therapist may represent a therapeutic

alternative. Thus, within a two-person model of psychoanalysis, the therapist takes a

more active role, where meaning is mutually constructed and the interaction is between

two actively engaged participants.

> We assume-indeed, we rely upon, the hope that the analyst and together will
> become enmeshed in complicated reenactments of early, unformulated
> experiences with significant others that can shed light upon the patient's current
> interpersonal and intrapsychic difficulties by reopening in the analytic
> relationship prematurely foreclosed areas of experience (Davies, 1994, p. 156).

Additionally, Davies brings somatic experience into the foreground with cognitive

processes. This clinical approach effectively bridges the divide between mind and body

and expands the clinical focus to incorporate bodily states of awareness when processing

and interpreting stimuli:

> Here the analyst must communicate to the patient that the body, dreaded though it
> may have become, also creates and interprets meaning, responding to such
> meaning even before these processes can be cognitively encoded. Only if both
> participants listen to the language of shifting physical sensation can the necessary
> process of symbolization proceed and the gulf between somatic experience and
> expressible cognitive operations be bridged (Davies, 1994, p. 169).

This holistic approach broadens the clinical stance and invites acknowledgement and

integration of clinicians' subjective experience to happen within and across various

realms of knowing. This approach creatively transforms the therapist into a

dimensionally integrated whole object within which the patient can integrate split off

part-objects represented in the erotic transference. The term *part-object* stems from

Object Relations Theory that describes object representations from a person's intrapsychic world that have fragmented; hence, the good and bad aspects are split-off from one another.

In sum, making a direct disclosure of shared erotic feelings in the therapeutic arena is certainly a challenging task and fraught with risk. Thus, "safer" alternatives that are more exploratory of the erotic transference may prove less daunting and protect against ethical transgressions.

Indeed, acting-out sexual feelings seriously compromises clinicians' professional stance and violates the American Psychological Association (2002) "do no harm" Ethics Code for psychologists. Avoiding harm is also cited under the section on Human Relations (American Psychological Association, 2002, Section 3.04): "Psychologist take reasonable steps to avoid harming their clients/patients…and to minimize harm where it is foreseeable and unavoidable" (p. 1065). Such issues are increasingly addressed in legislation and all professional societies stipulate sexual behavior with patients is unethical (Bridges, 1994). Specifically, Appelbaum (1990) warns of the consequences of sexual liaisons between therapist and patient: "Some states allow malpractice suits for sex with a former patient, prohibiting sexual contact from six months to two years after therapy ends" (as cited in Bridges, 1994, p.430). Ultimately, sorting out sexual feelings responsibly requires clinical sophistication, personal maturity, and affective tolerance of intense emotional states.

Coughlin (1998), an MSW social work student at Smith College, conducted an empirical study on therapist's subjective experience of erotic transference and investigated what clinical skills and techniques are useful in managing such feelings. She

interviewed six social workers from the Boston metropolitan area. All six of her subjects were women who worked with clients in either private practice or some combination of agency work and private practice. All of her participants were from Western-European ancestry and two identified themselves as lesbians.

Coughlin's study is distinguished from the current study in that her sample included only social workers; thus her results can more easily generalize and speak to the implications for social work practice than the current study. In addition, the current literature review presented a general overview of self-disclosure and incorporated empirical studies to shed light on prevalence rates of erotic manifestations in the treatment relationship. Coughlin's study did not use any empirical studies to support her research nor did she reference any specific clinical tools to help manage erotic dynamics.

In addition, this study has several limitations to which the current study hopes to improve upon. To begin with, Coughlin's sample was small: consisting of six participants. To obtain a more varied sample, the current study broadened the selection criteria of participants to include clinicians from various training backgrounds (i.e. social workers, psychologists, marriage and family therapists, and psychiatrists). In addition, Coughlin's sample was homogenous, using only female therapists from Western-European ancestry; this outcome might have been used to her advantage if her discussion examined how this salient characteristic factored into her results. However, there was no discussion regarding the significance of this factor. Moreover, the author referred to dyads generally; she did not include any demographics that distinguished the parties of the treatment relationship, such as race, gender and sexual orientation. Including this information can shed light on how certain factors influence and shape the expression and

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handling of erotic transference. Additionally, knowing this information would help acquaint the reader as well as provide information into whether or not similarities and/or differences in the treatment dyad constrain (i.e. inhibit) or enhance (i.e. promote) the development and management of erotic dynamics.

Notably, none of her participants reported a reciprocal erotic transference-countertransference exchange: What factors contributed to this finding? Does this finding represent the taboo against openly disclosing erotic countertransference? Were there ethical dilemmas or other factors, such as race, gender, or culture, constraining open acknowledgement of sexual and/or loving feelings toward patients? Comparatively, how will this outcome compare to the current study? I wonder, is erotic countertransference regarded differently today?

Additionally, I wondered about Coughlin's experience as a participant/observer; how did her subjectivity as a female graduate student doing research factor into her results? What were her biases and how did these influence her discussion? Why did she choose this topic and what did she gain from the experience? I will discuss these issues in the current study.

Additionally, the studies differ geographically. How will results vary according to location (i.e. West Coast versus East Coast)? Are there significant differences between outcome measures when factoring in theoretical orientations and/or degree type, gender and sexual orientations in the dyad?

Lastly, none of the participant clinicians in the Coughlin study reported having any formal training on managing erotic transference. This is a serious gap that needs to be addressed in the curriculum of graduate training programs. In the following section,

the current study will address this lack of knowledge in the literature review and discussion chapters by highlighting clinical techniques useful for acknowledging and working competently with such dynamics.

Techniques and skills to manage erotic transference

Well-established technical guidelines were first addressed by Freud in 1915. In his observations of "transference-love", Freud suggested the best approach is abstinence, "according to which the analysts should neither reject nor satisfy, but only interpret, the patient's wishes" (as cited in Koo, 2001, p. 31). It is within this liminal place that fantasy and indulgence can play. Critical to this process progressing safely requires the therapist maintain his/her observing capacity and clinical frame. In some cases, the therapist may need to clarify the terms of the treatment relationship by emphasizing, "the work remain exclusively within the domain of fantasy and words" (Koo, 2001, p. 31).

Additionally, Swartz (1969) suggests that the therapist pay attention to associations and the patient's general behavior during the initial interview; this information may warn the therapist about the potential for developing an erotic transference (as cited in Koo, 2001, p. 32). Moreover, the nature and sequence of material can provide important clues that a patient may be on his/her way to eroticizing the transference. Keeping close watch of one's own way of relating can avoid sexualizing the treatment; thus "avoid speech, manner, conduct, office, and hour arrangements that could potentiate a sexualized relationship" (Koo, 2001, p. 32). Certainly, efforts may be carried out more rigorously with some patients where limits and boundaries serve to protect and structure the treatment relationship.

In terms of the clinical stance of the therapist, Kumin (1985) recommends the therapist accept the patient's sexual desire without seductiveness or avoidance (as cited in Koo, 2001, p. 32). Due to the inherent complexity embedded in the erotic transference, Gabbard (1994) suggests the optimal technical approach depends on the therapist's ability to recover his or her bearings in order to do the critical work:

> The analyst must achieve a proper balance between sympathetic identification, without which one cannot understand the patient, and objectivity, without which one cannot do the professional work. Achieving this balance, as well as a certain level of comfort with the countertransference feelings, permits the analyst to derive the correct interpretation to reduce the patient's sexual desire and resistance (as cited in Koo, 2001, p. 32).

Rappaport (1956) recommends the therapist be watchful for any blind spots in his or her consciousness. To assist this process, individual therapy or consultation with peers or mentors can help the therapist identify hidden material and integrate unsettling feeling states.

Furthermore, many authors (Freud, Rappaport, and Swartz) emphasize the necessity of constant reality testing in the treatment (as cited in Koo, 2001, p. 32). Gabbard states the "as if" nature of therapy is lost in eroticized transference; thus it falls on the therapist "to restore the sense that the patient's feelings are both real (i.e. new feelings associated with the analytic relationship) and not real (i.e. displaced feelings from an old object relationship)" (as cited in Koo, 2001, p. 32). Therefore, the therapist helps to model this dual state of awareness by exploring dynamics happening in real time and interpreting the enactments. In this way, the interpersonal and intrapersonal coalesce and shed insight on significant self and object representations.

When such efforts fall short, the therapy may reach an impasse or derail all together. "Difficulties in the development and management of transference reactions are one of the most frequent causes for patients' changing analysts" (Koo, 2001, p. 32). However, transferring the patient may be a disservice to the patient. Rappaport (1956) believes that "sending the patient away, even to another analyst, only serves to add one more traumatic experience to those of childhood and will not guarantee that the patient will not again eroticize the new analytic relationship" (as cited in Koo, 2001, p. 32). Thus, transferring the patient should be considered a last resort. Rather, therapists are encouraged to seek help with such transference difficulties by way of consultation and/or individual therapy. Additionally, exploring this consideration with the patient in a collaborative, exploratory way can help alleviate the potential of injury.

In sum, a review of the literature found that competent handling of the erotic transference requires a contemporary psychoanalytic approach that incorporates a relational framework. This approach acknowledges a two-person psychology where manifestations of the transference/ countertransference matrix influence and shape dynamics co-created in the therapeutic space. This perspective may help foster feelings of connection, trust, and safety between participants, thereby strengthening the therapeutic alliance to competently handle erotic dynamics.

This process is assisted by finding a "therapeutic middle ground" (Gabbard, 1994; Fitzpatrick, 1999), neither avoiding or silencing nor confusing or seducing the patient (as cited in Fisher, 2004, p. 111). Widening the clinical stance of the therapist allows for the "as if" nature of therapy to fully evolve, while maintaining the clinical structure and therapeutic frame. Careful attention is paid to the psychosomatic component in

assessment and treatment of the erotic transference, noting the nonverbal correlates communicated in the clinical encounter, while tolerating the strong affect will serve as a road map for the therapist and patient to navigate through the erotic matrix. Indeed, erotic transference is a clinical issue infused with great power and potential if examined with a broadened perspective that acknowledges the complex interaction and reaction between patients' sexual feelings and therapists' sexual feelings.

CHAPTER III

METHODOLOGY

The focus of this study is to examine therapists' subjective experience of erotic transference and determine what clinical skills and techniques are useful for managing such encounters. Conversely, this study will also devote attention to the concept of nondisclosure of erotic transference/countertransference: When do clinicians intentionally decline to self-disclose reciprocal feelings of love or erotic desire and for what reasons? Moreover, how does this nondisclosure impact the working alliance in the therapeutic relationship? The purpose of the study is to answer the following questions: How do clinicians' reactions to erotic transference impact the therapeutic relationship? Also, how do clinicians formulate and explain aspects of the erotic transference?

Design and Rationale

In order to answer these questions, I conducted a qualitative, inductive, exploratory study. The qualitative model focuses on narration and the words used to describe events, recollections, opinions, feelings, meanings and strategies. The unstructured nature of qualitative research allows participants to disclose information in an open manner without limitations and broadens the scope of collected information. Since a dearth of empirical research exists on this study question, I used flexible methods, the emphasis of which is the discovery of new phenomena. In order to fully investigate this phenomenological territory, I used induction, a process whereby data collection and

analysis precedes theory. In addition, the analysis of data was also informed by existing theory. In congruence with flexible methods research, I recorded clinicians' responses using semi-structured and open-ended interviews, with an effort to make interviews as pointed as possible. Given that I've conducted a flexible method study with a small sample, I relied on replication logic rather than sampling representiveness (Anastas, 1999) for the validity of my findings. Replication logic helped add credibility and ability to generalize my findings by demonstrating that the same findings will occur in a different situation.

This study is useful to the professional development of social workers because it has the potential to destigmatize erotic transference and generate more open discussion about these fundamental dynamics. The investigation of these issues will enhance clinicians' skills and knowledge base, while at the same time preventing professional violations and misconduct. The research will be used for the MSW Thesis, presentation, and possibly future publication.

The Characteristics of the Participants

The participants were thirteen clinicians who practiced some form of therapy in the Bay Area of California. Given that this subject matter is still a taboo for some clinicians, I interviewed therapists from mixed backgrounds and mixed theoretical orientations; thus I strived for a balanced sample that's diverse. Specifically, I made a concerted effort to recruit a diverse sample that includes both mixed and same-sex gendered dyads in the case example(s) of erotic transference. To accomplish this task, I advertised my study by posting flyers in diverse settings and used a snowball sample.

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Selection of Participants

Individuals who indicated interest in participating in this study needed to meet all of the following criteria: 1) clinicians must have at least one year or more of post-graduate experience; 2) they have had professional experience with a client's expression of erotic transference, 3) the client did not have a formal thought disorder, 4) the participant is over the age of 21 and fluent in English. In addition, the participants had read and signed the informed consent form prior to carrying out an hour-long, individual interview with this researcher in their office. Participants retained a copy of the informed consent form while the original was secured in a locked drawer after obtaining their signature.

Because this topic is still taboo for most clinicians, this researcher felt it could result in a limited sample. To prevent against this possibility, this study included clinicians of various types: Clinical Social Workers, Marriage and Family Therapists, Psychologists, and Psychiatrists. The sample included three social workers, six marriage and family therapists, two PhD psychologists, and two psychiatrists.

The Recruitment Process

Subjects were gathered using a snowball method where a few qualifying participants were located, interviewed, and asked to identify other clinicians that may be interested in being a participant. More specifically, I approached colleagues individually, informed them about my study, and asked them if they knew of someone (who fits my criteria) that might like to participate. Generally, this researcher screened colleagues for referrals saying, "I'm doing my thesis on clinicians reactions to erotic transference and to collect data on this topic, I'll be interviewing clinicians of various disciplines who are

fluent in English, have one year post-graduate experience, and are interested in contributing knowledge to better manage loving and sexual feelings in the therapeutic space." This nonrandom method was used in addition to posting flyers in Bay Area community psychotherapy clinics such as the San Francisco Psychotherapy Training Center, California Pacific Medical Center, Psychoanalytic Institute of Northern California, and New Leaf (see Appendix A). Notably, the participants were either referred to me or approached me individually and expressed interest in the topic; I received no responses from the hundred or so flyers I circulated in various agencies and clinics around the Bay Area.

Individuals who agreed to participate in this study and met the stipulated selection criteria were scheduled for an interview. Interviews were conducted in participants' office. The screening process happened over the phone prior to scheduling the interview to ensure the clinician met the stipulated criteria. Specifically, the screening asked the prospective participant if they have had at least one year of post-graduate clinical experience; have they had professional experience with a client's expression of erotic transference; did this particular client have a formal thought disorder, and is the participant over the age of 21 and fluent in English. In addition, the participants read and signed an informed consent form (see Appendix B) prior to carrying out an hour-long individual interview with this researcher. Participants were either mailed or emailed as an attachment the informed consent form and handed over the signed copy at the time of interview; one copy was given for their own records. The informed consent described the focus of the study, the risks and benefits of their participation, and the federal regulations that will be upheld to protect their confidentiality. Once this researcher received the

signed consent, it was locked in a secure file. The clinician was then called to schedule the interview.

The Interview Process

Interviews were held with different therapists in different settings working with diverse populations, in both public and private settings. All of the interviews were conducted face-to-face in their office.

The interview began by asking certain demographic questions about the patient's degree, length of time in clinical practice, client population (if any), theoretical orientation, and sexual orientation (optional) in order to gain insight into the dynamics that unfolded in the clinical dyad and build rapport. The formal interview started with broad questions that eventually became more pointed. The interview centered on one case example of erotic transference in order to explore the particular dynamics shared between therapist and client in greater detail; this approach allowed for succinct and intimate information to unfold. Specifically, it addressed clinicians' countertransference reactions to elicit how the erotic feelings were managed within the clinical encounter. The questions were guided using a questionnaire (see Appendix C). The whole process took approximately one hour.

During the interviews, I recorded narrative data by tape recording. The clinician was informed before I started (as well as turned off) the tape recorder. Minimal notes were taken to document affect, behavior, and body language in real time.

The audiotapes from these interviews were labeled with a numeric code to preserve the confidentiality of the participants and later transcribed. This researcher

transcribed each word, as well as noting pauses, or other nonverbal responses, contained in the interviews.

Data Analysis

Interviews were divided into sections such as demographics, erotic transference, and countertransference reactions. The data analysis involved identification of salient themes and patterns within each area. This was done by underlining key words and noting similar (and some distinct) experiences as well. This process allowed for identification of core categories developed within and across the interviews.

Demographics of the Participants

The participants reflected a broad range of clinicians who offer some type of therapy on an individual basis. The sample included three social workers, six marriage and family therapists, two PhD psychologists, and two psychiatrists (both received psychodynamic training in addition to pharmacotherapy); in addition, one participant is a certified psychoanalyst. All of the participants were licensed and either worked in private and/ or managed care settings. All participants disclosed their sexual orientation resulting in four gay women, four gay men, three straight women, and two straight men. The following table (found on the next page) illustrates the demographics of the participants.

Table 1: Demographics of Sample

Gender	n	% totals
Women	7	54%
Men	6	46%
Transgender	0	0

Race

	n	% totals
American Indian or Alaska Native	0	0
Black or African American	0	0
Native Hawaiian or other Pacific Islander	0	0
White	9	69%
Hispanic or Latino	2	15%
Asian	1	8%
Other	1	8%

Sexual Orientation

	n	% totals
Heterosexual	5	38%
Gay/Lesbian	8	62%
Bisexual	0	0
Other	0	0

Language

	n	% totals
English	10	80%
Spanish	2	15%
French	0	0
Other	1	8%

Degree

	n	% totals
Clinical Social Worker	3	23%
Marriage and Family Therapist	6	46%
Psychologist	2	15%
Psychiatrist	2	15%

Years Practicing

	n	% totals
(2-6)	3	23%
(8-12)	4	31%
(13-17)	3	23%
(18+)	3	23%

Practice Context

	n	% totals
Private Practice	5	38%
Managed Care	4	31%
Combination of Private and Managed Care	4	31%

Primary Theoretical Orientation*

	n	% totals
Psychodynamic (Object Relations, Ego Psych., Self, Relational)	9	69%
Psychoanalytic	1	8%
Cognitive Behavioral Therapy	3	23%

*some participants identified with more than one orientation

CHAPTER IV

FINDINGS

"I made a decision in that kind of in-between place that I was going to remain steady…and keep breathing" (Participant #3)

This study used a qualitative approach to explore clinicians' reactions to erotic transference in the therapeutic space. The recruitment process used a snowball sampling method to identify potential participants. Upon meeting the criteria for the study, participants were interviewed using a semi-structured, exploratory, interview guide. All of the interviews were conducted face-to-face and transcribed by this researcher.

The findings reported in this chapter are drawn from a diverse sample consisting of thirteen (13) participants. Outreach efforts included flyers and recruitment letters that circulated among various clinics and agencies located throughout the Bay Area. Notably, this method yielded no responses. Indeed, this response rate may reflect a persistent unwillingness to discuss this topic openly that continues to this day. Given the failure of this method to recruit participants, colleagues who had heard about this research project and who had limited interaction with this researcher, agreed to participate. As a result, the bulk of participants had some connection to this researcher, evidenced by the word-of-mouth referral process and/or the professional tie allowed participants to become open, in a sense vulnerable, to discuss intimate disclosures in the therapeutic field. As one participant stated when thinking over whether or not to participate, "I have everything to lose and nothing to gain," alluding to the persistent taboo nature of this research topic.

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Other participants were gathered by referrals from other clinicians known to this researcher.

The findings are broken down into sections to highlight key areas that emerged from the interviews. These sections start broadly and become more specific as the chapter progresses. The areas highlighted include: description of the participants; presenting issues of the clients; definitions of erotic transference; therapists' countertransference reactions and its impact on the treatment dynamics; factors that complicating management of erotic entanglements; symbolic meanings of erotic transference; and participants' response to this study.

Theoretical Orientation

While theoretical orientations varied, the majority (ten participants) used psychodynamic principles in their clinical work, under half (six participants) used Cognitive Behavioral Therapy (CBT) when appropriate, and three participants worked more holistically and mentioned Hakomi training as a significant clinical influence. Other clinicians incorporated object relations, self psychology, humanistic, gestalt, family systems, and relational therapy. Length of time in clinical practice ranged from two and a half to over twenty years, with one participant who had twenty-eight years of experience. All of the participants reported having little or no prior training in their graduate program on erotic transference. Over two-thirds of the thirteen participants (ten participants) specifically sought consultation from peers and/or clinical supervisor to address the erotic transference. Many expressed going to someone they knew they could trust and whom they had an established relationship with; this seemed a critical factor

when seeking consultation to address these issues. All the clinicians who sought

consultation found it helpful.

> #3 (lesbian therapist, straight male client):
> It was really good to talk with someone about that [the loving/romantic feelings between them]. But I went to the person who I felt could understand, who knows me really well, and is non-judgmental. I didn't go to the person who I felt would have a reaction to that. She really kind of helped me understand more of what happened.

> #6 (female therapist, female supervisor):
> The supervision and consultation that I have gotten really have helped me manage that [erotic transference] stuff. I don't even remember that school helped me with this [erotic transference] at all. I've been working with the same consultant…she's had a great influence on holding that and just sort of sitting patiently with that and allowing what will unfold to unfold, and you know, obviously with boundaries.

Etiology of the erotic transference:
Client Characteristics

While clients' diagnostic issues varied, all of the participants reported their client

struggled with some form of relationship issues. In addition, two case examples revealed

deprivation of parental, phase-appropriate protection and support, namely abuse and

neglect. Two other examples revealed preoccupation with sexual matters, in fantasy or

acting-out behavior. One participant revealed a client's history where the line between

fantasy and reality was blurred so that both realms seemed coalesce.

> #12 (straight female client, straight male client):
> They [fantasies] were not acted-out. Well, if they were acted-out, it would be more like in a business negotiation where to get a contract you play the submissive role. That would typically be accompanied in his mind by a sexual fantasy that was a bit of the same, but these were not things that happened in real life.

In all, the case examples indicated real life frustrations with early life relationships,

which Saul (1962) found to be a key factor in the development of erotic transference.

#2 (straight female therapist, straight male client):
He was doing some very blatant sexual acting out, which is part of what we would talk about in the therapy, but he also had clinical depression…I believe he had some trauma history, but he was provocative from day one. I think it may have been sexual trauma of some sort but I don't remember the details of it.

#8 (gay male therapist, gay male client):
He came to see me for relational problems. He had a string of relationships, all with very similar type of people in which he was hoping for much more. The people he was having relationships with were more in the moment.

In some cases, there was Axis II pathology, such as borderline, dependent, narcissistic, or

avoidant personality disorder.

#11 (gay male therapist, gay male client):
A lot of Axis II. He wasn't actually borderliney; he was more avoidant and a little dependent.

#1 (lesbian therapist, lesbian client):
She was someone very borderline and that's not a diagnosis I tend to use or definitely do not use lightly.

#9 (straight male therapist, straight female client):
She came in for bipolar disorder, relationship, and family issues. We figured out diagnostically what was going on…I think she was more Axis II now that I'm thinking about it.

Description of the erotic transference:
Romantic/ Loving Feelings

Some participants claimed the erotic transference felt more

romantic and loving rather than sexual in nature. These situations lacked a direct, explicit

sexual overture and seemed to speak to a level of trust, identification, and/ or connection

within the clinical dyad. Moreover, the clients' romantic and/ or loving feelings tended

to develop gradually and ebb and flow throughout the treatment relationship. They also

were palpably felt and sensed in the room by the clinician, who tolerated the erotic

transference and allowed for its full development. This response seemed to regard the

erotic transference as a mutual sharing of intimacy and connection between client and

therapist.

> #10 (straight female client, straight male client):
> He and I were similar in age, I was a few years older than him. And he had talked about some of the relationships that he's had with 'girls', that was his term: "You know, I've had a lot of relationships with girls, but they haven't gone very well." He seemed at times a little emotionally younger than his age, and I felt that, yeah, he could potentially develop some kind of crush on me or something, and I'll be able to deal with that if it happens.

> #7 (gay male therapist, straight female client):
> I think the sexual and/ or erotic transference if you will, that was what started from this, but I think in terms of loving feelings, I think that persisted throughout the course of the therapy and one of the reasons why the termination was so dramatic…because that had kind of extended and had been progressing, while the sexual feelings had not progressed.

> #3 (lesbian therapist, straight male client):
> There has not been any overt expression of love; it doesn't feel erotic, more intimacy, feelings of safety. He has very few friends; he has very little intimacy in his life. So there's something about the two of us being together, especially my being a woman, and the level of intimacy over the years and the depth of the work more recently…the intimacy is in the room. It doesn't go unnoticed.

> #1 (lesbian therapist, lesbian client):
> She described it was more love feelings, like 'crush' feelings.

One participant reported the romantic/ loving aspect to the erotic transference made it

"easier" to work with and make sense of clinically. In addition, some clinician

participants reported that the absence of erotic countertransference assisted in working

with the erotic transference by allowing them to feel comfortable.

> #6 (lesbian therapist, lesbian client):
> I think it's always easier if I don't have an erotic countertransference, and I didn't, so that always helps me like, "Okay, I don't have to be dealing with my own stuff around this.

> #3 (lesbian therapist, straight male client):
> If I felt more of a sexual energy, my natural boundaries would come up differently. Right? So again, I'm not sure if and when that happens, and given

now we've made room [for the erotic feelings] and the boundaries have shifted [by embracing in session]—I'm not sure what's going to happen. If I feel it's more eroticized, I'm going to have a different feeling about it.

#7 (gay male therapist, straight female client):
So when she brought them [erotic fantasies] in, initially I probably saw them as an opportunity and I wasn't particularly threatened by this because I'm homosexual and she's heterosexual—there clearly was no sexual tension from my part— whether from her part there was some kind of sexualized context, it's hard to say. I don't know if she knew whether or not I was gay, I didn't disclose that to her; so it felt very comfortable for me to discuss it with her…because there wasn't any of that sexual tension in the room.

#5 (gay male therapist, gay male client):
For me it was, this is the clinical situation. I have had people who I've felt my own attraction, but with him that was not there. And I really tried to approach it from a very clinical perspective; I was thankful I hadn't found him attractive. If one of the people I had found attractive had done that [exposed his genitalia] to me…god only knows how I would react!!!"

Slippery Slope

#12 (straight female therapist, straight male client):
There's this description, at least from the point of view of sexual boundary violations, that these things occur on a slippery slope.

Some clinicians reported they sensed it in the room, indicating an evolutionary view of erotic transference as a slippery slope that will inevitably surface at some point in the treatment relationship. This position of balancing on an edge of a slippery slope invoked a variety of feelings in the therapist including anxiety or fear that if erotic transference-countertransference dynamics escalated, they may slide and loosen the treatment structure of the clinical dyad. Thus, noting the signs and cues of erotic transference became an important developmental task of the therapist and affected the handling of it in the clinical arena.

#1 (lesbian therapist, lesbian client):
Before she brought it up, I don't think I was anticipating it but the intensity was already there. She started having projections and feelings and ideas about me

outside the sessions. So it wasn't a surprise that she was thinking about me and cooking up stuff, but I wasn't anticipating the intensity of the feelings. So when she brought it up, it wasn't really a stretch for me to guess that."

#3 (lesbian therapist, straight male client):
It's [erotic feelings] in the air. It hasn't fully manifested yet but there almost isn't any way around it. If the intimacy and love in the room is really growing, which it is, and he wants to get connected to all parts of himself and wants to be sexual again with women, I don't know how that's [erotic transference] not going to happen in here. And I think on some level, I'm trying to prepare myself for that. And also try and normalize it for myself in whatever kind of discomfort I have—it kind of seems inevitable."

#12 (straight female therapist, straight male client):
I wouldn't say it was revealed [disclosed] in the way that you're talking about it. This was a man who spent a great deal of time in fantasy life about various kinds of sexual liaisons. So the only difference was, this was about me. I'm not saying that was a small difference; I didn't actually feel like it was a revelation at all. I thought, "Okay, he's gotten to the point where he's talking about the fantasies I'm in; he feels safe enough to do that."

In certain cases, this slippery slope phenomenon may start to give way when

clinicians' personal issues (i.e. experience level, interactive style, relationship status)

factor into one's ability to maintain a professional relationship with clear boundaries.

#2 (straight female therapist, straight male client):
I was single at the time and not sure I could work with this guy.

#4 (straight male therapist, straight female client):
For some reason my caseload right now has twenty-six to thirty year old women. And they come in talking about relationship issues and well, in my mind I'm thinking sex would be more interesting with you—with this person. It's been happening a lot ever since sex with my wife has become more stressful.

#8 (gay male therapist, gay male client):
I think that because of my experience now I probably would have dealt with it more naturally. And also too because of who I am today, I'm in a committed relationship and in a completely different place in my life and also too in my development as a professional, so I think because of those factors it probably would have been more natural to address it in the moment. But then again, these are things that sometimes in the moment you don't know necessarily what to do with it.

#9 (straight male therapist, straight female client):
Because you know I was single at the time, and I'm still single, but umm…I think I let that, in this case, get in the way. In many other cases I don't…I don't let that go. In this case it did because she was so overt about it; she's the only patient who made such a direct overture, it was a very direct overture. Other patients, they might have been attracted to me but it was never spoken about, this was quite overtly spoken about.

In some cases, clinicians feared being blamed for the erotic transference

and worried if there clinical style might have been seductive or overly casual.

#10 (straight female therapist, straight male client):
At the time my personal life and when we look at when therapist's cross that line and they get sexual with them it's usually when therapist's have some problems personally in their life. My personal life was a mess: I had recently gotten divorced and was starting to see someone who was also dating someone else…so it was this very dim, quiet kind of setting, in comes this attractive guy who is really thinking about me and very sweet to me and I was like, "Oh god, this is terrible; I cannot be having these feelings for one of my patients. In comparison to the guy I'm dating who's being an asshole." So I was really paying attention to that and thankfully I had a supervisor I could talk openly with about this stuff with.

#5 (gay male therapist, gay male client):
I've often wondered what I've done to kind of stir up the permission to expose one self. And admittedly, I am a more interactive kind of person and I'm not a blank screen. I add a lot of humor to my work and I get the feedback from some patients that I am too interactive for them and that's fine…I appreciate that. And then others will say that's why they come to me because they don't want the blank screen. But it lends itself to some danger because they have told me, they would like it if we could be friends, but they're respectful of the boundaries; that's where my boundaries get real clear. I don't necessarily disclose a lot, although I will, not in the same way that they are disclosing to me, although I will [disclose] more so than an analytically-oriented therapist would and I think that might have led to some of these outcomes. But certainly I'm not doing anything to promote that and I am very clear about my professional ethics and my responsibilities with that. So I've wondered if in fact, my more casual style sort have led to that or could have led to that [exposure of genitalia].

Erotic Countertransference

I remember those Paul Newman eyes; I also remember he was
the last patient I saw the day of the '89 earthquake—he left my office and 5
minutes later the earthquake happened. I was like,

"Oh my god, the earth moved!"#2 (straight female therapist, straight male client)

When feelings are reciprocal, erotic countertransference adds a new twist to erotic

dynamics stirred between therapist and client. As participant #2 (straight female

therapist, straight male client) commented:

> It stirred stuff up, but nothing that felt unmanageable—I was clear on the
> boundaries and I was comfortable that I didn't respond at that point because I
> didn't feel like I could use it in a way that could be helpful to him. So it didn't
> feel like much to work through particularly. I kept working with him on the
> relationship issues but I don't feel like that took away from my ability to do that.

In these situations, the margin of error is small for the clinician to openly disclose mutual

feelings of attraction. Most turned to a colleague, supervisor, or mentor to seek guidance

and work through the erotic countertransference; this often was accompanied with some

shame but also curiosity and desire to understand what was playing out or being enacted

in the treatment dyad. One participant opted not to seek consultation because of alleged

financial costs and time constraints, thus leaving this person without guidance for

managing complex erotic dynamics.

> #9 (straight male therapist, straight female client):
> One of my sexual fantasies is to have a woman use her beauty and take power in
> that and get what she wants from me and for me to lose power and give it to her.
> So when she said, "I will give you sex for payment," that was coming up for me
> and as a professional, I had to be very cognizant not to go there. As an individual,
> I didn't really address it. I wasn't in therapy at the time, I am now but I wasn't
> then, so it wasn't like I was talking about this with a therapist. I wasn't talking
> about it with anyone frankly. This is the first time I actually thought about a lot of
> this stuff. So I wasn't addressing it.

This participant stated feeling "abused" by the persistent, enduring, extreme form of

erotic transference that seems to pull from the therapist a certain response: to gratify the

clients' erotic fantasies and/or wishes to sexualize the therapy relationship.

Many seemed unsure what would happen and worried the erotic transference may spiral out of control. This feeling of fear influenced how they managed it, some decided not to explore it because it felt dangerous. Others felt too vulnerable to explore it in a way that would be productive and helpful for the client, so they left it alone.

> #9 (straight male therapist, straight female client):
> It was very confusing for me because I felt almost abused, (laughs) now that I'm thinking about this. And maybe this is my problem, I felt like my boundaries were not strong enough so I was just glad to kind of end it because it just wasn't working and she kept pushing it. I guess with another type of boundary I might have been better able to deal with that. But this one was tough for me, particularly in that time in my life.

> #2 (straight female therapist, straight male client):
> The message was: if you don't have something constructive you can give to your client—don't say anything! And I couldn't untangle my own stuff to say anything that I considered helpful, so I just listened. And that was fine and that was the only time it came up directly with him. Perhaps if I had responded he would have done something more with it—but I just felt like I couldn't go there nor wanted to go there because it just felt too vulnerable to me. So I didn't do anything with it."

> #4 (straight male therapist, straight female client):
> Most patients come in and they're vulnerable you know; for them to have those [erotic] feelings is one thing but then for you to have that [erotic] countertransference…just for me it's unethical…it's not even that it's unethical, it's just not right…it's immoral.

This countertransference reaction usually led to a stalemate in the therapeutic relationship or wish for the dissolution of treatment. The direct disclosure of loving and/or sexual feelings toward the therapist seemed to have altered the therapeutic alliance in a way that could not be undone.

> #2 (straight female therapist, straight male client):
> He got all bent out of shape…that I was too sexually repressed to handle his sexual issues. So he fired me…*oh, thank god* [italics added] did he fire me.

#4 (straight male therapist, gay male client):
It's almost like I don't care anymore as much. At the back of my mind I want to tell him, "There's no medical necessity for you to continue treatment here, we can talk about finding you someone on the outside." But that feeling is even stronger now, not because of the context of his comment [client stated various times he was physically attracted to him], but it has changed our relationship.

#10 (straight female therapist, straight male client):
I was a little more guarded with him. Like maybe if I were to see him again, because it's a residential community, I would probably be less likely just to be casual and friendly.

Some stated the graphic or explicit nature to the erotic transference felt dangerous

or evoked feelings of disgust and fear.

#7 (gay male therapist, gay male client):
The other thing is that…I don't want to say it felt scary to address it with him but it almost had a stalker like quality to it and I think there was a part of me that was very uncomfortable about that particular gift [soap that had been used by his client]. And so I think I was just avoiding it, I think it was pure avoidance behavior on some level as well…I think that probably mostly I was avoiding it but I was avoiding it for different reasons…and so then you start to wonder what is this soap all about, so if I accept this soap, which I did, what does that mean? Does he see that in some sexualized fashion or is that some kind of proxy for sex for him, or something. I have no idea. So I think that was another reason I avoided it because I didn't really want to know.

#11 (gay male therapist, gay male client):
Yeah, I thought he was a little creepy after that. He had no legal history, no prior incidents like this that I was aware of. I think it would have been very difficult to explore the issue of why he did this [stalking]. I think it would have been of value for him to do it but I don't know that I would necessarily want to do it, to explore the issue further.

#12 (straight female therapist, straight male client):
For me, I wanted to back up because I was a little bit afraid. Not for any good reason, part of how I work is that I picture as much as I can what my patient is telling me in my mind's eye. Given that he would have the [sexually aggressive] fantasy and then I would be having a fantasy at the same time to try and understand it. There's a time delay because he's saying it then I'm imagining it; it wasn't so comfortable for me.

#4 (straight male therapist, gay male client):

Part of it, I feel like I might be attacked. Not physically, but verbally and emotionally attacked. And part of it is my own issues, wanting to be accepted…it was like cutting it off and not really addressing it and then it came up and was cut-off again. I think with another patient it would be easier discussing it. I think with him I don't feel very safe discussing it. There's some mistrust…my countertransference. I just don't trust it [exploring the erotic transference].

Many participants stated feeling "flattered" by the erotic nature of the transference. This was a common initial response that seemed to pass as more details of the erotic transference emerged. In addition, some participants revealed they were mutually aroused by the erotic material; similar to feelings of flattery, this response was not sustaining but generally came up as a initial countertransference reaction.

#12 (straight female therapist, straight male client):
I think it's fair to say that when a patient begins to talk about something sexual, even if it doesn't involve the analyst, usually when it does it can be somewhat arousing as well.

Safeguarding the treatment relationship:
Boundaries and Ethics

Ideally, the therapeutic relationship is a protected space where dynamics occurring in the therapeutic encounter shed insight on relational patterns happening outside of therapy. In order for this to happen, boundaries and ethics provide a structure for the therapy to unfold safely. Some sensed it was not safe to explore the erotic transference and setting the boundary effectively closed down its development and full expression.

#2 (straight female therapist, straight male client):
You needed to put a limit on it and let him know it was inappropriate. And to tell you the truth, if he was having sexual fantasies about me, I didn't want to know. Maybe that's slacking on my part, but I just didn't want to know.

#4 (straight male therapist, gay male client):
It was always about: "Thank you, I'm flattered." But with him I felt like I just had to cut it off and set the boundary.

#9 (straight male therapist, straight female client):
She wanted me to sit on the couch and kind of go there, start a relationship in the session and I told her, "I couldn't do that; that would get in the way of our therapeutic relationship.

#10 (straight female therapist, straight male client):
There was a part of me that was like, "Oh Shit, now I need to give him the therapy never included sex little workbook that you get from the Board of Psychology" so it was kind of awkward then to segue way into, "Well, you know we are processing how this is for you and the difficulty you had with women and communicating emotionally; this may be some progress for you and by the way I'm legally required and ethically required to give you this brochure and I think it was okay because then we talked about our relationship was not going to become sexual and we made that pretty clear and I do think it's important that we talk about this and that you do have the experience of being able to share something with a woman and have the emotional reactions that you have around it and also know that the relationship is going to stay as it is, it's not then going to then turn into something sexual…it was more uncomfortable for him than me it was for me, for sure.

Most participants asserted a boundary of some sort when confronted with an explicit

erotic disclosure. Some felt they had asserted the boundary prematurely and revisited the

issue subsequently for exploration.

#8 (gay male therapist, gay male client):
The points that I highlighted the first time I addressed it I said something like, "You know therapists and clients are not allowed to have personal relationships." And I did some brief description about why that is and I kind of left it at that. I think it had to do more with my own personal discomfort in the moment and also to want to get beyond the moment. One of things my supervisor said, "Well, at some point, you might want to revisit how you feel about it."…So those were the things we addressed in the second session.

Often the client exhibited vulnerability when making the verbal or non-verbal disclosure

of erotic transference.

#10 (straight female therapist, straight male client):
Gradually over the course of a few weeks, we got to this point where he very, with a great deal of embarrassment, admitted that he was attracted to me. He had a hard time looking at me, he was laughing out loud in the session when he was saying it. He was clearly very uncomfortable.

#8 (gay male therapist, gay male client):
Well, first he was embarrassed and then he sort of felt like, "Maybe I made a mistake in telling you this and maybe I should end therapy." So I acknowledged those feelings for him and commented how uncomfortable it must be for him to acknowledge that especially knowing there wasn't a possibility of moving forward in any type of relationship.

Two participants mentioned they did not differentiate the erotic transference from other types of transference; they were treated equally and given the same amount of attention. Thus, it was not "privileged" nor was it given "special" attention.

#12 (straight female therapist, straight male client):
I didn't address it [the erotic transference]. I just talked about it like any other fantasy. I don't privilege erotic fantasy or any other kind of fantasy…I tried to understand the fantasy with him, which is what I would do with any fantasy. I think when I was a younger clinician, I might have said something like: "Well, just to be clear that's not going to happen." But that really takes a big sledgehammer to the fantasy and the purpose of the fantasy being brought to treatment is for understanding…a big purpose, not the only purpose. So I just treated it like any fantasy.

#1 (lesbian therapist, lesbian client):
How do you treat someone so severely borderline is what informed me, other than something special about the erotic transference. It was all about the shame for her.

Others alluded to other types of transference co-occurring with the erotic transference, such as idealizing, maternal, or paternal transference.

#6 (lesbian therapist, lesbian client):
I can't really say what came first [the erotic transference or idealizing transference], for her it was so much the beginning of the work together that maybe even the way I held that boundary for her around the erotic transference that it helped the idealizing part. The way that I was able to welcome those feelings, I think for her my boundaries were firmer, like I wasn't going to respond to her like, "Oh, okay, we're going to have a sexual relationship." But that I continued to be loving and available…there was a lot of push/ pull stuff in her life and a lot drama developed around these feelings for her with other people and that there was no drama but just a consistent, loving presence that said, "It's okay to have those feelings and we can make room for them." I think that probably fueled

her idealizing transference; she felt so accepted and not ashamed and that those feelings could surface and go underground and surface and go underground and there was no drama around it.

#9 (straight male therapist, straight female client):
I was very aware of her putting me up on a pedestal or her putting me up in the expert position and giving me a lot of power and I was conscious not to abuse that power. I don't think that's true of all patients but in her case it was, that she put me up here."

#7 (gay male therapist, straight female client):
I'm trying to think specifically how we addressed the erotic transference piece; I think it was wrapped up with all the other transference pieces. She would talk about it fairly freely, it wasn't anything that was graphic in nature that felt to me it was entering any kind of psychotic transference, but definitely she was willing to talk about it and it came very easily for her.

Sexually explicit

The extreme side of the spectrum of erotic transference included sexually explicit and graphic disclosures that tended to invoke feelings of discomfort in the therapist. This response usually was coupled with feeling intruded upon or in one case, abused. Clarifying the boundaries between therapist and client became a critical task to preserve the therapeutic relationship.

#5 (gay male therapist, gay male client):
This was a violation of my boundaries [client exposed himself in therapy]. I tried not to be punitive with him; I just wanted him to know that this was not going to go on any further. I could handle him telling me he was disrobing and we would talk about all that and the repercussions of that and the legalities of that and the meaning of all that. But it made me personally uncomfortable that he would do that [exposing his genitalia]; it was sort of violating of me but I didn't try to be punitive with him in that regard.

#9 (straight male therapist, straight female client):
It was very confusing for me because I felt almost abused [by the intensity of erotic transference] now that I'm thinking about this. And maybe this is my problem…I felt like my boundaries were not strong enough so I was just glad to kind of end it because it just wasn't working and she kept pushing it. I guess with another type of boundary I might have been better able to deal with that. But this one was tough for me, particularly in that time in my life.

#7 (gay male therapist, straight female client):
You would have to hear her say those things in order to understand what I mean exactly, there's a certain way, a certain energy that she puts into it. I think if most patients said that their husbands were 'well hung' then it wouldn't bother me at all. But there was something about the inflection and the look on her face and the way that she communicates it that makes me a little uncomfortable with her. And maybe that is part of the erotic transference that I'm picking up, because usually that kind of language doesn't make me uncomfortable.

#11 (gay male therapist, gay male client):
My clinical supervisor recommended discussion and termination [as a result of the stalking]. She was very sensitive to these issues because she had quite a few such incidents and had actually been assaulted, so she had recommended I file a restraining order, which I did. I saw him again to discuss it and to terminate. I saw him two more times after I saw him outside my apartment. I raised the issue that I had seen him. He was a little taken aback. He said it was harmless, that he was just a little curious about my life, things like that. I don't know if that was right thing to do to terminate and file a restraining order. It seemed a little extreme to file a restraining order, but I did what I was told.

Some spoke of a graphic and extreme form of erotic transference that felt

exhibitionistic. One participant described it as a separate "problem" that was distinct

from the erotic transference.

#5 (gay male therapist, gay male client):
The erection?? That act [of exposing oneself] didn't happen again. The discussion about sex in his life was an ongoing thing. The whole exposure thing in a lot of ways that's a separate thing to me. It's a different problem in some ways that just…you know, there are people who are exhibitionists; I tried to work with him around exhibitionism as well. Because clearly he had been doing that. So not only did I want to get some discussion around this event [exposure] in our session but how to deal with exhibitionism in general in his life.

#2 (straight female therapist, straight male client):
It felt provocative and exhibitionistic. It felt like he was trying to provoke something in me and I didn't want to bite that bait. But when he directly said something—that was when I confronted it…and prior to that, I just thought about it.

#7 (gay male therapist, gay male client):
Yeah, kind of exhibitionistic in a way. I mean bringing in an open bar of soap that had been used…that's fairly exhibitionistic.

In one case there was exposure of genitalia, which resulted in increased vigilance to clarify the boundaries of the relationship.

> #5 (gay male therapist, gay male client):
> I often sit with clients very close. But with him I never did that and maybe because I sensed some of that going on so I sat on a chair that was some distance from him. I was never afraid of him; I didn't feel like I couldn't handle the situation. He was not a big man, he was sort of timid anyway so I felt comfortable with knowing he wouldn't scare me.

Many clinicians responded saying they normalized the sexual and loving feelings, realizing that intimacy between therapist and client may be associated with sexual/ and or loving feelings. As participant #8 noted, "By default, you are in an intimate relationship when you are in the therapeutic arena." The majority of participants stated that exploring the erotic transference invoked shame in their client initially but that overtime, some were able to allow those feelings to exist with the other feelings happening in the room. This seemed to be the general pattern for its unfolding and helped determine a positive outcome on the relationship. Moreover, these outcomes seem to result when there exists a certain level of comfort with the countertransference feelings, which permits the therapist to derive the correct interpretation to reduce the client's sexual desire and resistance.

> #1 (lesbian therapist, lesbian client):
> Because there was so much shame around it, I spent a lot of time normalizing it and holding that saying, "It's okay to tell me no matter how hard it is to say. At some point I said to her, "It's safe to talk about this in here because nothing can happen. The boundaries are there—this will remain that kind of relationship between therapist and client. And so it's safe to say any feelings because we won't act on them." So I'll say that just to reassure people because even for people who haven't had those boundaries violated, they want to know like I can count on you, right?

#6 (lesbian therapist, lesbian client):
It was so interesting to talk about this more fully and it actually came up in my session with her after I met with you [finished our interview over the phone the following day]. And we periodically talk about this. And she said…and it was really was validating of what I had said to you, the way that I had treated it so nonjudgmentally that it had a positive effect on her. She said, while those feelings still remain and feel real, she so appreciated the way that I treated that so gently. And she could not at that time have imagined not feeling ashamed and that it is incredible to her that she doesn't feel ashamed, even now when she says: "I still have those feelings but I don't feel ashamed about them." And I think that that has been such an important part of our work all together, and her process, and her growth.

One out of the two participants who spoke about erotic countertransference feelings seemed ashamed and judged him self harshly for having such feelings in the therapeutic arena.

#4 (straight male therapist, straight female client):
If there's an attractive woman sitting across from me, it's hard for me not to notice she's attractive. Umm…I wouldn't even know if it's in the back of my mind all the time, but I'm able to focus on the session and everything. It's like talking about it now, verbalizing it…it's just seems kind of skummy.

Interestingly, the therapist who transgressed his professional role by meeting his client for coffee and entertained the idea of future romantic involvement did not seem uncomfortable with his behavior. In the end, it did not go further (to the therapist's stated relief), yet one could argue a seemingly benign meeting over coffee constituted a sexual boundary crossing that could have slid into a sexual violation.

#9 (straight male therapist, straight female client):
It was very clear at this point that therapy was ending. I'm not remembering exactly why but I think she was saying she's was having a lot of financial problems and she was also saying that yeah, that she wanted to be my girlfriend or at least to date me. I told her…I was learning all about, every state has different rules and different questions about this; is there ever a time that you terminate with a patient and down the road could you date them? So I was thinking about these things and ultimately we decided we needed to terminate therapy because of this issue and I said, "Well, you can call me if you want to.

This was an area that some clinicians brought up voluntarily, as if opening up the

discussion around clinicians' erotic countertransference lifted a veil of secrecy and

revealed a human need for empathy and validation. Some expressed a desire to open the

dialogue with other clinicians around sexual dynamics happening in the therapeutic arena

so there was a place to go when these situations arise.

> #9 (straight male therapist, straight female client):
> I think this [topic: erotic transference] is important and it would be useful to
> address it in schools. And this is my countertransference, but I don't think in
> places of employment or schools is it safe because those people have the power to
> give you a diploma, or not, to give you a paycheck, or not, to hire you, or not.
> But somewhere in the field of therapy, there needs to be a safe place where we
> can say, "hey, let's address this and let's figure out how we can make it better for
> everybody- for patient, therapist, and everybody."

Out of sight, out of mind

One participant did not feel safe verbalizing feelings of attraction one may have

towards a client, as if speaking about it made the situation more real and unsettling,

heightening discomfort levels. This discomfort seemed to elicit a defense to censor

oneself and keep the feelings underground.

> #4 (straight male therapist, straight female client):
> It's normal you know, that kind of stuff happens in the process, but just kind of
> talking about it, verbalizing it…it's just…not right.

Clinical tools to manage the erotic transference:
Creating a safe holding environment

Some talked about creating a container to hold the feelings, which allowed for the

full unfolding of the feelings to surface over the course of treatment.

> #1 (lesbian therapist, lesbian client):
> Client commented, "I can say any feelings to you and count on you to keep it with
> all the feelings I have in here."

One participant shared an incident where there was physical touch during a session; specifically they shared a long embrace while her client sobbed on her shoulder. This hug represented a 'holding' where she physically contained her client in an embrace that made room for feelings to surface and release between them.

> #3 (lesbian therapist, straight client):
> To be willing to let go rather than holding back in fear of, "Oh no, all these feelings are going to come up and I won't know what to do." And I think I'm able to keep my center with him, even with the hug, I was holding this man for longer than I've ever held someone. That feeling of worry came up and then when I was able to come back to my center and get really clear in what was what, "no, this is okay."

Making space for exploration

> #12 (straight female therapist, straight male client):
> Is it Winnicot who calls it potential space? You want there to be a space to develop the fantasy and develop the understanding from the fantasy. And I think it would foreclose it if you said, "that's not going to happen here." At some point you might have to say it depending on how it continues but certainly not like right when it emerges.

Development of the erotic transference across time:
Ebb and Flow of erotic feelings

While a few therapists reported it came up only once, most felt it surfaced at different times for different reasons. This allowed for therapist to revisit the feelings and explore the significance of why they were coming up. Some linked the coming-and-going nature of the erotic transference as intense, perhaps because the feelings lingered, sometimes surfaced, then went underground.

> #1 (lesbian therapist, lesbian client):
> It changed but it never went away; there were always intense feelings.

> #6 (lesbian therapist, lesbian client):
> I'm trying to think of the first time we talked about it because we talked about it various times over the years, and times when I was like, "oh, she's over it now."

And it would come up again and we would sort of spend some time on that and it would maybe cycle back down out of the main energy between us.

Sometimes the intense feeling was left unresolved and might contributed to the demise of therapy.

> #7 (gay male therapist, gay client):
> He just actually dropped out of therapy entirely, all of a sudden, saying it had become too intense for him.

> #13 (lesbian therapist, lesbian client):
> She left me a message saying she found somebody and felt she's had enough closure and thanked me and said good-bye, basically all by telephone.

Some felt the erotic transference took over and consumed the therapy, which left the clinician feeling frustrated because the other clinical work got pushed aside. It became the focus of treatment in some cases and overpowered other areas.

> #11 (gay male therapist, gay male client):
> He was always frustrating for me because he never did a lot of work. I mean we were making progress but he never did as much work in the therapy that I would have liked him to. He never really followed recommendations.

> #7 (gay male therapist, gay male client):
> It was just interesting because there was a lot of sexual tension in the room but it was all one-sided, it was not coming from me, it was coming from him. And that was kind of bizarre, I never really got down to where that was coming from because it wasn't the kind of transference like I was talking about earlier [therapist used two case examples], it was almost like there was this over-sexual tension in the room that seemed to transcend the therapy itself if that makes sense.

> #4 (straight male therapist, gay male client):
> Now every time I bring him in from the waiting room, he looks at me differently now. He would look me up and down and looking at what I was wearing and he's never been like that. So it was very provocative I guess the way he was looking at me. And that's how it is now. I guess it's distracting in a way.

> #1 (lesbian therapist, lesbian client):
> Not that I said that to her but I realized that was a different boundary personally. I did tell her, "No, I'm not going to answer that question and she was like, "this is horrible that you won't answer that." And she spent the next few sessions talking

about that and finally said me, "If you can't tell me basic things like that to me then I can't work with you."

Clinicians' countertransference reactions

Although participants' countertransference reactions varied, all reported a heightened affect of some kind. The most common responses included surprise, disgust, and offense.

Surprise

#6 (lesbian therapist, lesbian client):
The first time it [disclosure of erotic transference] came up I was surprised, maybe mostly because she's one of the people who really comes prepared to therapy, not much that comes up surprises her, she doesn't like to be surprised. And so she's got some good containing defenses; so she was obviously brewing with that [erotic feelings] for some time before she figured out how to bring it to me. She wasn't very spontaneous there wasn't a lot that was going to come out by accident, so I didn't have a lot of hints that that [erotic transference] was coming up for her.

#10 (straight female therapist, straight male client):
I was a little surprised that he disclosed the part about the fantasies [masturbating while thinking of his therapist] and he was able to talk about that because it seemed so hard for him to say.

#11 (gay male therapist, straight female client):
It was different because I was the one kind of shocked in the interview; I was the one taken by surprise.

#13 (lesbian therapist, lesbian client):
I was surprised.

Disgust

#2 (straight female therapist, straight male client):
This guy was slimy; he had issues with depression. I believe he had some trauma history, but he was provocative from day one. And his talk in the therapy felt exhibitionistic to me.

#12 (straight female therapist, straight male client):
After a while, I thought, "Well, this is kind of exciting but it's also disgusting." I didn't like my role [in the fantasy], I didn't like the role he put me in…and I didn't really want to be in it.

#5 (gay male therapist, gay male client):
If there was any kind of emotional part of mine it had more to do with, I guess to be fair, to be perfectly honest, there was both sympathy and to be fair, there may have been just a little bit of…I thought he was pathetic in some ways, a disgust.

Offense

Some expressed feeling offended by explicit, overt forms of erotic transference.

However, they did not want to hinder its full expression in the therapeutic encounter and

so they allowed it to unfold uninhibited.

> #2 (straight female therapist, straight male client):
> I sort of resent people judging my use of words. And I think there was a hesitancy to judge him on his use of words [client often used sexually graphic language] because if that was how he was expressing his sexuality…in other words, until he made the comment directly to me [client asked participant if she ever 'went to bed' with clients], it was looser argument; was he doing that to offend me or is that really how the guy talks and I think it is…maybe that's how he talks. So there was a part of me that didn't want to hinder his ability to communicate in the way that was natural for him anymore than I had a psychiatrist who told me that I shouldn't use the word "fuck" because it was feeding my anger and my attitude was "fuck you". I mean this is my words and yeah, it does express anger and I'm fine with that. It felt like a class attack— so there's that going on for me…that somebody's words I'm not as likely to say, "No dude, you can't say it that way." Even though it sounded offensive.

> #7 (gay male therapist, gay male client):
> I try very hard not to tell patients I'm offended by what they say because I think that just kills the relationship with the patient. So even if I'm offended by it, I don't really let people know about that.

Working with the transference in Managed Care Settings

While most participants addressed the transference, some felt constrained and

limited when working in managed care settings. Due to the constraints of the system,

treatment providers in this environment are limited by the amount of sessions they can

offer as well as the attention given to presenting concerns. This environment is not

designed to offer patients exploratory, insight-oriented psychotherapy; however this does

not preclude fundamental dynamics, such as erotic transference, from surfacing within

the clinical dyad. The structure of managed care and services offered to patients acts as a

barrier to providing adequate care and in effect, closes down the exploration process

prematurely. As participant #4 noted,

> There's so many patients who have issues that I would love to pull out if I were in
> private practice, but if I bring them up then I have to tell them, "Oh, we can't talk
> about this." It's not something I want to bring up [in a managed care setting] and
> then four weeks later talk about again.

Thus, clinicians who work in these settings generally treat presenting concerns

that meet medical necessity only, meaning does the level of pathology meet DSM-IV

standards. This treatment arrangement may provide a disservice to patients who struggle

with interpersonal and/or relationship issues; thus clinicians may fall short of adequately

addressing patients' clinical needs. Eight of the thirteen participants worked in this

setting; five in this group referenced clients treated in this setting. Generally they

expressed a common sentiment that it would not be helpful, nor benefit the client, to

explore the erotic transference in-depth when meeting on a semi-frequent basis. Five of

the eight participants struggled in this arena because they were not given the space and

time to fully unpack, understand, and make meaning of complex erotic entanglements;

thus, these participants were caught in a pickle so to speak, having to privilege certain

clinical needs above others.

> #2 (straight female therapist, straight male client):
> I would have handled it differently if I was working with him in intensive therapy.
> I would have tried to work with what it meant for him to say that…for me to say,
> "No, this is a professional relationship," to explore where it was coming from. In
> terms of within [a managed care environment], with him saying it at the end of
> session and not seeing him for another 4-6 weeks…I wouldn't have handled it any
> differently. I think it needed to be addressed, not just left hanging—literally and
> figuratively. And I did run it past one of my friends and she said, "You couldn't

do anything else, this is [a managed care environment]." And I really couldn't. So the nature of the relationship and the consistency of the relationship is a real big factor in how you work with it. It hasn't come up in my personal practice.

#4 (straight male therapist, gay male client):
No, I'm kind of afraid to go there with the boundaries I've set for him. Right now I'm just trying to formulate how to mention it would be good to do weekly therapy outside of here. And I think if I open up the whole casual thing, it might make things a little messier…just in terms of my caseload, I think it will be better for him because I won't be able to see him for another 5 weeks… I don't know if I want to be stripped of the medical model, he just doesn't meet medical necessity, so I really stretch it with him in terms of anxiety or depression.

#7 (gay male therapist, straight female client):
Seeing her once every three months for a 30 minute session is going to be tough to process that [erotic transference] and would leave her with more questions than answers. So I don't ever even open that box up with her.

#9 (straight male therapist, straight female client):
One of the problems that I have at [a managed care environment] is because we see so many patients here (and we see them so infrequently) the depth you can actually go into is not that much. So I find myself on a conveyor belt, that I don't even have time to go that deep. And it's not always possible to go that deep and may not even be useful in this setting because you're not going to see each other enough to process it. It's not so much about the relationship, it has to be for it [therapy] to be successful, but we're really constrained in this environment.

What does it all mean?
Clinicians' formulations and symbolic meanings

While clinical settings, theoretical orientations, and personal styles varied, all of

the participants made a concerted effort to understand the symbolic meanings of erotic

transference rather than respond to it literally.

#12 (straight female therapist, straight male client):
He has a number of very violent urges that are mixed…for instance, we have a drive toward life or a drive toward death. And he includes your sexuality in your drive towards life. But I think some people strive to get all things together. And I think for him, the idea of coming together sexually, it was all mixed in with violence. Everybody's sexual life has a certain kind of aggression in it but this went all the way through the end of violent aggression. So the fact again that he would have a fantasy where we both come together to unite and also destroy something was very useful for him to see that he mixes these things together in a

very potent way for him. Because this is how he sees connection in the world, that when people come together there's both the opportunity for procreation, for coming together, and for destroying.

#9 (straight male therapist, straight female client):
Well it told me that she sexualizes relationships; she used that as a way to get what she wanted in the world, or could. And part of that was because she frankly could and she did but also that came from a low self-esteem saying maybe, "this is the only way I can get what I wanted in life." And it's also very disempowering in the sense that it's really not her, it gives her power to another person because it's to what extent can I get this person to do something for me.

#7 (gay male therapist, straight female client):
These transference issues came up throughout the whole course of psychotherapy and actually got much worse at the end for different reasons. But I would say we kind of put the sexual transference piece behind us in the therapy and I really did see that just more as a sign of her increasing trust and intimacy, which were two of the major issues that she faced.

Two participants felt the erotic tranference might have been a test for the therapist.

#1 (lesbian therapist, lesbian client):
I really struggled with knowing if I'm colluding with a distraction or is that the work…that the work will take place through that. Or was she testing the waters with how much she could trust me, and wanting me to be trustworthy for her, because she's had so many people betray her trust in her experience. It was like I was going to betray her trust…that was the inevitable story that would always happen. So…it was always a struggle what was the therapeutic way of handling it?

#6 (lesbian therapist, lesbian client):
My guess is it was another step in the process of the building of trust and strengthening and deepening our relationship. Her trusting she could be vulnerable with me and not shamed; I'm sure it was a huge step in all of our work. It was a big test, if you believe in tests.

Participants' response to the thesis topic

While most participants found the interview process helpful and appreciated the time reflecting about a client, one participant was still cautious and uncertain about how this information would be used.

#9 (straight male therapist):
So I don't think it's [erotic transference] fully addressed in classes, at least none that I've taken, or schools, or clinics. And I think it could be and this is a great thesis you're doing. I don't even have conversations about this subject, this is why I wasn't sure if I even wanted to do this because it's uncomfortable. People are afraid of losing their license, having people say you have poor judgment, or something like that…maybe that's just me… I am very aware and even today, I don't want to lose my license, I don't want to lose my job. I don't want to put anything at risk so that's why I was guarded. You didn't understand when I said I have nothing to gain and a lot to lose because it's very real. I've worked in a lot of different agencies in my career. A lot of work places are not that safe so I've been guarded because of that. I'm not sure I am that happy that I did this. I feel like I hope that you will be very respectful and write nothing in this thesis that would lead anybody to think it could be me. So I felt uncomfortable about that…it has felt interesting because I hadn't thought about this patient.

Others responded positively to the project and stated it was a useful experience.

Participant #3 stated, "It's good, I've enjoyed talking about this; I hope it was helpful."

Participant #6 noted: "This has been a great experience for me, so I appreciate that, and I hope your research goes well." And participant #7 stated, "I think this is a great project."

In all, these results illustrate how clinicians' reactions to clients' expressions of erotic transference impact the therapeutic relationship. Alternatively, it shows cases where clinicians reciprocated feelings of sexual and/or loving desire towards their client and elected to nondisclose feelings of mutual desire. These situations highlight factors that contribute to therapists' formulations of and interventions used to manage the erotic transference/countertransference matrix.

CHAPTER V

DISCUSSION

The clinicians' responses to the erotic transference in the therapeutic arena yielded a variety of outcomes in the treatment relationship. These outcomes were both influenced and determined by a number of factors that proved significant to effectively manage the erotic transference. Factors that influenced clinicians' subjective reactions to the erotic transference and helped determine the therapeutic outcome on the relationship included boundary issues, personal or professional stress, comfort level, lack of extensive knowledge about the technical handling of erotic transference, and presence of sexualized countertransference.

As encounters with loving and/or sexual feelings have been shown to exist on a continuum, they represent a variety of scenarios. To be sure, the degree of intensity of the erotic transference affected clinicians' responses and determined how it was handled. When erotic transference was more extreme and explicit, coined by Blum in 1973 as "eroticized transference", these cases generally evoked a negative response in clinicians. When the nature of the disclosure of attraction was more benign and loving, originally referred to as "transference-love" by Freud, clinicians' reactions were more accepting, more tolerant, and more willingness was shown on the part of the therapist to explore the erotic transference. This response seems commonsensical, the less urgent the demand or

wish for sexual contact, the more room there was available in the treatment relationship to work with these dynamics.

In cases of eroticized transference, the majority of clinicians confronted with such extreme manifestations of erotic material responded saying they felt disgusted, threatened, intruded upon, abused, and/or violated. The patients in this category often exhibited axis II psychopathology, meeting criteria for Cluster A and B disorders, mostly borderline personality disorder. These findings corroborate Rossberg's et al (2007) study that measured countertransference reactions toward patients with personality disorders. Given that patients in this category were characterized by their treatment provider as having more primitive pathology, they substantiate Sandler's et al (1992) claim that such patients exhibiting "a severe disturbance of the sense of reality" tend to develop the extreme end of erotic transference, namely eroticized transference (as cited in Koo, 2001, p. 29).

To examine the findings of the current study more fully, it is helpful to refer to the standardized tool that Rossberg et al (2007) used to measure countertransference reactions. This instrument, known as the Feeling Word Checklist-58 (FWC-58), categorizes responses into 7 clinically meaningful dimensions. In the current study, just under half of the clinicians described the erotic transference as more "loving", specifically participants #1, #3, #6, #7, and #10. These countertransference reactions fell into either one or both of the two positive subscales named *important* (empathic, caring, and enthusiastic), and *confident* (relaxed, objective, and calm). Thus, when the erotic transference elicited a positive countertransference reaction it helped facilitate exploration and meaning underlying the erotic transference. Conversely, those who

described the erotic transference as more extreme, or eroticized, fell into one of the five negative subscales named *rejected* (disliked, disparaged, and stupid), *on guard* (anxious, cautious, and threatened), *bored* (aloof, indifferent, and empty), *overwhelmed* (surprised, confused, and invaded), and *inadequate* (sad, distressed, and helpless). In this category, the clinicians who reported negative countertransference reactions tended to ignore or avoid exploring the erotic material as some responded they felt threatened by the material and thus avoided it all together. While I understand that some of the participants' countertransference reactions did not fit conveniently into either positive or negative evaluative categories, based on their descriptions, they tended to fall into one of the two groups. In terms of future research done in this area, the Feeling Word Checklist-58 (FWC-58) is an instrument that can help standardize responses and may be useful to help quantify data more accurately.

Alternatively, the clinicians' non-responses to the erotic transference also proved to impact treatment dynamics in significant ways. Of those clinicians who made the clinical choice not to acknowledge the erotic transference, the result invariably led to a therapeutic impasse of some kind, either a temporary rupture that later recovered or a derailment of the therapy all together.

In cases where the patient's disclosure of erotic transference was ignored or avoided initially (often because the clinician was caught off guard), these situations were reparable often after the clinician sought consultation and then revisited the issue in subsequent sessions. Utilizing outside supports allowed for the clinician to access blind spots in his or her consciousness, which Rappaport (1956) recommended to help prevent harmful reenactments. Thus, consultation proved an invaluable source that most

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clinicians utilized to gain self-knowledge as well as guidance and support around the technical handling of erotic manifestations. As participant #12 stated, "It [consultation] made me feel stronger and more prepared."

Conversely, those who did not seek consultation seemed mired in shame or felt the need to hold their erotic feelings secret. Thus, mutually reciprocal erotic feelings in the clinical encounter created ambivalence and uncertainty around what to do and where to go with them. This reaction contributed to a sense of isolation, deepened confusion, and fueled a sense of shame in the clinician. Simon (1989) warns of the negative consequences that can impinge upon the clinical dyad when clinicians withdraw in silence: "Professional isolation and secrecy distort transference and countertransference feelings and dilemmas creating more difficulties for the therapeutic process" (as cited in Bridges, 1994, p. 425).

Another recommendation that may have prevented therapeutic ruptures from closing down the treatment process requires the therapist to reside in the therapeutic middle ground (Fitzpatrick, 1999; Gabbard 1994), neither avoiding nor seducing the patient in the development of the erotic transference. Given the great variety of erotic manifestations described by clinicians, it is crucial the therapist maintain a dual focus of attention on action and reaction in the clinical space, thus gaining access to inner and outer realms of phenomena. Furthermore, clinicians do well to maintain an open mind with a flexible frame to allow for the full unfolding of the erotic transference.

To help formulate the symbolic meaning embedded in the erotic transference, expanding the conceptual frame to include past and present object relations provides a window into how the intrapsychic world impacts interpersonal relating. Crucial to this

process, Gabbard (1995) states understanding the role that the clinician is scripted to play in the sexual enactment can help unravel repetitive patterns that cause the patient great suffering (as cited in Gabbard, 1999). This was shown in the case of participant #12, who disliked the particular role she was given in her patient's sexual fantasy, yet working through her adverse reaction privately in consultation allowed her to tolerate the discomfort. Thus it's the clinician's task to keep the focus of treatment on the patient, however unsettling the process becomes: "You're the clinician and it's your job…to manage whatever response you have to the fantasy and make as much space as possible for the fantasy to be presented and understood" (Participant #12). This echoes Gabbard's (1994) position that suggests the optimal technical approach to managing erotic encounters depends on the therapist's ability to recover his or her bearings in order to do the critical work.

In particular, the constraints on the delivery of mental health services in managed care settings made it difficult for these clinicians to devote adequate attention to fully understand the various layers of meaning embedded in the erotic manifestations. These constraints involved working within a time-limited model that generally favors a Cognitive Behavioral Therapy methodology with an emphasis on symptom reduction. Notably, the clinicians in this setting expressed a resistance to exploring the erotic transference, evident by therapists' negative countertransference responses to erotic material they deemed offensive (as seen in participant #2, #4, and #7). As a result, clinicians' feelings of distance and avoidance toward the patient inhibited the development of the erotic transference and perpetuated therapists' non-response in the clinical encounter. This response inevitably led to treatment ruptures, often prematurely

ending treatment. This result substantiates the position of Edelwich and Brodsky (1989) who state, "Therapists' inability to deal with their own and their patient's sexualized aggression often leads to countertransference withdrawal and treatment failures" (as cited in Bridges, 1994, p. 432).

Interestingly, how one defines the erotic transference intellectually affects the clinical assessment and ultimate handling of the erotic transference. In some cases, clinicians were aware of erotic dynamics in the room (examples reported: adjusting male genitalia repetitively in session, exposing oneself outside the therapist's door, or sexually graphic language used frequently in session) before the patient made a direct disclosure of attraction; however erotic dynamics were not acknowledged until overtly verbalized by the patient. Consequently, the result on the treatment relationship was often negative, perhaps because the clinician did not address the early signs of erotic transference until it became unbearable. Other early signs that signaled the development of erotic transference spanned the non-verbal realm including body language that was sensual or sexual in nature, provocative dress, and/or sexually charged energy in the room. Gabbard (1999) speaks of noting the non-verbal correlates, such as tensing of the muscles, changes in breathing, or shifts in body posture as they may indicate early signs of erotic transference. These situations substantiate a broadened view of erotic transference as an evolutionary phenomenon rather than limited to separate, concrete disclosures of attraction, as I originally believed was the case. It is a phenomenon that exists on a continuum ranging from subtle to extreme manifestations of desire. Disclosure of erotic feelings do not exist in isolation, they are attempts by the patient or therapist to bridge the gap between fantasy and reality, merging of self with object, past with present, hence a

complex understanding of erotic material gives the therapist freedom to enter the patient's world.

Given its ever-changing and slippery nature, it challenges the therapist to find steadiness amid fluctuating erotically charged interactions. It reminds me of the saying, "Love is like a bird resting in the palm of an outstretched hand." It is a phenomenon that needs space and time for it to grow and develop without constraint. By inhabiting the therapeutic middle ground, the therapist does not slip to the extremes of grasping for a particular ideal nor aversion to working with erotic manifestations. Hence, the slippery slope is an appropriate metaphor to capture the complexity and difficulty inherent in managing erotic feeling.

In most cases, the strength of the alliance was a factor that seemed to underscore how erotic dynamics were addressed and handled by clinicians. When the alliance was strong, it allowed for more openness, thereby making adequate room for the erotic transference to fully surface and explore its manifestations safely. In addition, a strong alliance helped integrate feelings of shame or embarrassment that were associated with the disclosure.

In addition, the absence of erotic countertransference allowed clinicians to address erotically charged material with greater ease, less discomfort, and less anxiety in general. As participant #7 stated, "When she brought them in, initially I probably saw them as an opportunity and I wasn't particularly threatened by this because I'm homosexual and she's heterosexual, there clearly was no sexual tension from my part." Hence in cases where erotic feelings were not mutually shared by therapist and patient, the comfort and ease allowed for exploration in a neutral, constructive manner. This

clinical stance reinforces Gabbard's (1994) claim that the optimal technical approach depends on the therapist's ability to recover his or her bearings in order to do the critical work.

Alternatively, when erotic countertransference was present for the clinician, these situations often became muddled in confusion and doubt; this effect both compromised the clinician's sense of competence and professionalism and proved to interfere with one's ability to explore issues in a compassionate, accepting manner. In general, those who reciprocated feelings of attraction to their patient viewed this response negatively as participant #4 comments on the deep shame associated with sexual feelings: "Most patients come in and they're vulnerable you know; for them to have those [erotic] feelings is one thing but then for you to have that countertransference…just for me, it's unethical…it's not even that it's unethical, it's just not right, it's immoral." Such a response reveals the continued taboo associated with sexual transferences and countertransferences. This draws attention to the disparity that exists between the stigma associated with erotic material and the prevalence of attraction for therapists: "Most therapists across mental health disciplines, roughly between 70% and 90% of clinicians, have been attracted to at least one client" (Fisher, 2004, p. 106). Thus, creating more of a dialogue, engagement, and open acknowledgement of such natural human responses seems crucial to implement in training programs as well as in working environments.

On a more personal note, while conducting the interviews, I was surprised by my own countertransference responses. When hearing the two heterosexual, male therapists speak about their erotic countertransference reactions to female patients, it evoked my own self-consciousness and guardedness because it felt threatening and objectifying of

women. I wondered about the female patients whom they were referencing; in particular, what was their level of trust and sense of safety in the therapeutic relationship? While noting this response, I recalled the advice that two female participants had shared: "remember to breathe" (participant #3) and alternately, "do not be afraid of these feelings" (participant #6). It was a useful strategy and helped me to stay centered and engaged; thus my initial internal response of dread softened and became more accepting and compassionate.

In general, the interview process stimulated a dual awareness that tracked my own internal reactions to the actions being exchanged in real time. I was aware of my biases as a heterosexual, white woman who thinks relationally and acknowledges that two psychologies co-create an intersubjective space that helps to level the therapeutic playing field. This conceptual frame influenced my interpretations as well as guided my approach to doing this research.

Lastly, I was aware of the therapeutic value in opening up the dialogue around erotic dynamics: it seemed reparative for participants to reflect on the experience working with the erotic transference and explore the various symbolic meanings. My role as interviewer served to help facilitate as well as contain the heightened affect that accompanied this process. Three of the participants reported this was their first time talking about these dynamics. In the end, all expressed it was a positive experience and they appreciated having the opportunity to participate in the research.

In situations where erotic countertransference was an issue, it was shared with a sense of urgency and exhilaration. All of the participants who acknowledged erotic countertransference also revealed they were having personal difficulties in their own

relationships (or single relationship status). This affirms the need for individual therapy

or supervision to sort these feelings out without using the therapeutic relationship to fill

an emotional void. Bridges (1999) cites many authors (Blackshaw and Patterson, 1992;

Gabbard, 1989; Gabbard, 1994; Pope and Bouhoutsos, 1986; Schoener, Milgrom,

Gonsiorek et al., 1989; Strasburger, Jorgenson and Sutherland, 1992) who confirm the

need for therapists to acknowledge the potential harm that can occur from therapists'

unexamined personal or professional stress: "The danger of destructive behavioral

enactments is real. Therapists most at risk are those under great personal or professional

stress or those who use patients in a narcissitic, self-serving manner" (Bridges, 1999, p.

139).

Interestingly, my own countertransference to hearing such accounts of erotic

countertransference evoked a sense of both detachment and involvement by validating

the need for these individuals to find support networks that would help reduce feelings of

isolation and desperation. To be fair, the withdrawal spoke to some of what I sensed they

were feeling but also revealed my own discomfort knowing that some therapists sexualize

dynamics in therapy; they are not immune to the erotic spell.

To help mediate such ethical dilemmas, Geller (2003) uses a model that

incorporates a dual focus on the interaction between intentional self-disclosures and the

expressive styles from which they surface and in which they are embedded. This

approach emphasizes having an awareness of contextual factors that influence one's

choices about "when, what, and how to say something personal about myself to a

patient." This approach serves as a reminder to contextualize each treatment relationship

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to help shed light on how particular idiosyncrasies within the dyad influence reactions and actions taken by therapist and patient in the clinical encounter.

Surely, clinicians have the potential of experiencing a range of erotic wishes and desires. Thus we have an ethical duty to work through these issues privately rather than risk empathic failures and destructively act-out such feelings in the therapeutic arena. While most would agree with this ethical obligation, sometimes a therapist's feelings of shame or fear can cause one to withdraw in silence. Bridges (1994) states this is a dangerous for both practitioner and patient. Thus, when such feelings of desperation go un-checked, there is a greater risk of harmful reenactments, paving the way for the therapist to slide down Gabbard's metaphor of the slippery slope, where sexual boundary crossings may escalate into boundary violations. "Under these conditions, the potential for acting upon these feelings increases" (Bridges, 1994, p. 425).

Given only one participant (#9) admitted to disclosing to his patient reciprocal feelings of attraction, as well as meeting after the therapy had ended to explore the possibility of a future romantic relationship, this sexual transgression was not the norm. To be sure, he had tremendous courage to talk about this instance and it seemed important for him to come forward and admit he needed guidance. Indeed, caught within the web of desire without added support can be a lonely place. From a strengths-based perspective, I was encouraged by the healing power underway, evident by his changing affect in the room, through the simple act of sharing in dialogue about such ordinary human emotions. In the end, I appreciated his emotional honesty, his ease in speaking about his misstep, and his unselfconsciousness, all of which are attributes I feel necessary to competently doing clinical work. I left feeling reassured that he would seek clinical

support by means of individual therapy and/or consultation if faced with such an ethical dilemma in the future.

The implications of this research are clear: clinicians need specific training in graduate counseling programs as well as support networks in work environments where erotic issues can safely be explored and technical guidance is made available. The level of sophistication and maturity required of the therapist to navigate effectively the erotic transference/ countertransference matrix requires that graduate training programs model and support the need for open dialogue to lesson the continued taboo around erotic dynamics. As Person (1985) states, these transferences "remain both goldmine and minefield" (as cited in Bridges, 1994, p. 425). Interest in this topic is manifest as indicated by popular culture as well as the proliferation of writers on this subject. However, secrets still abound as some clinicians fear exposure of wrongdoing and thus remain silent. Thus, the lack of training coupled with feelings of shame around sexual feelings creates a double bind that inhibits patients' growth and development and undermines clinicians' competent handling of erotic issues.

The results obtained in this study did reveal a positive relationship between treatment course and psychodynamic and/or relational theoretical orientations. However, I did not compare to what extent the therapists experience, level of training, and theoretical orientation influenced the reported countertransference reactions to erotic transference. Obviously statistical analysis was not used, as this was a qualitative study, however future studies on this subject would benefit using a quantitative or mixed-methods research design. Specifically, recommendations for future research include conducting a quantitative study of countertransference reactions to erotic transference and

also qualitative research with a larger, more diverse sample to understand the variance in reactions to erotic transference from multiple perspectives.

In sum, the literature supports using a broadened theoretical framework to identify erotic manifestations happening in real time. Adopting an expansive understanding of the erotic dynamics will allow the therapist's scope of awareness to include a wide range of affective experiences, developmental difficulties, and interpersonal conflicts or needs that factor into the ultimate expression of erotic transference. Incorporating a more nuanced understanding of this phenomenon will lead to earlier identification and assist the therapist in feeling informed, rather than residing in the fray, to stay with the process and allow its full unfolding. In this way, how one defines the erotic transference intellectually affects the clinical assessment and ultimate handling of the erotic transference. By proceeding with care rather than fear, clinicians can transform the stigmatized narrative around sexual dynamics into a healthy exchange that has a potential for healing problematic relationship patterns and furthering growth.

References

American Psychological Association Ethics Committee. (2002). Ethical priniciples of psychologists and code of conduct. *American Psychologist, 57*, 1060-1073.

Anastas, J.W. (1999). *Research design for social work and human services*. (2nd ed.). New York: Columbia University Press.

Anderson, S. and Mandall, D. (1989). The use of self-disclosure by professional social workers. *Social Casework, 70*(5), 259-267.

Blum, H. (1973). The concept of the eroticized transference. *Journal American Psychoanalytic Association, 21*, 61-76.

Bouhoutsos, J., Holroyd, J. Lerman, H. Forer, B. & Greenberg, M. (1983). Sexual intimacy between psychotherapists and patients. *Professional Psychology: Research and Practice, 14*(2), 185-196.

Book, H. (1995). The "erotic transference": Some technical and countertransferential difficulties. *American Journal of Psychotherapy, 49*(4), 504-513.

Bridges, N. (1994) Meaning and management of attraction: Neglected aspects of psychotherapy training and practice. *Journal of Psychotherapy,* 31, 423-433.

Bridges, N and Wohlberg, J. (1999). Sexual Excitement in Therapeutic Relationships: Clinical and Supervisory Management. *The Clinical Supervisor, 18*(2), 123-141.

Burkard, A., Knox, S., Groen, M., and Perez, M. (2006). European american therapist self-disclosure in cross-cultural counseling. *Journal of Counseling Psychology, 53*(1), 15-25.

Coughlin, D. (1998). *What's love got to do with it? Therapists' reactions to erotic transference.* Unpublished Masters Thesis, Smith College School for Social Work, Northampton, MA.

Cornell, W. (2007). The intricate intimacies of psychotherapy and questions of self-Disclosure. *European Journal of Psychotherapy and Counselling, 9*(1), 51-61.

Davies, J.M. (1994). Love in the afternoon: A relational reconsideration of desire and dread in the countertransference. *Psychoanalytic Dialogues, 4*(2), 153-170.

Farber, B. and Hall, D. (2002). Disclosure to therapists: What is and is not discussed in

psychotherapy. *Journal of Clinical Psychology, 58*(4), 359-370.

Fisher, C. (2004). Ethical issues in therapy: Therapist self-disclosure of sexual feelings. *Ethics and Behavior, 14*(2), 105-121.

Flax, M. & White, G. (1998). The erotic spell: Women analysts working with male patients. *Gender and Psychoanalysis, 3*, 5-31.

Gabbard, G. (1994). Sexual excitement and countertransference love in the analyst. *Journal of the American Psychoanalytic Association, 42*, 1083-1105.

Gabbard, G. (1999). Countertransference issues in psychiatric treatment. *Review of Psychiatry, 18*(1), 1-25.

Geller, J. (2003, May). Self-disclosure in psychoanalytic-existential therapy. *Journal Clinical Psychology/In Session, 59*(5), 541-554. Retrieved from, http://www.interscience.wiley.com.

Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients*. Counseling and Psychotherapy Research, 5*(2), 96-104.

Litjmaer, R. (2004). The place of erotic transference and countertransference in clinical practice. *Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry, 32*(3), 483-498.

Mann, David. (1997). *Psychotherapy, An Erotic Relationship: Transference and Countertransference Passions*. New York: Brunner-Routledge.

Rachman, A., and Kennedy, R., and Yard, M. (2005). The role of childhood sexual seduction in the development of an erotic transference: Perversion in the psychoanalytic situation. *International Forum of Psychoanalysis, 14*, 183-187.

Rossberg, J., Karterud, S., Pedersen, G., and Friis, S. (2007). An empirical study of countertransference reactions toward patients with personality disorders. *Comprehensive Psychiatry, 48*, 225-230.

Rouholamin, C. (2007). The 'frame' as a container for the erotic transference—A case study. *Psychodynamic Practice, 13*(2), 181-196.

Schaverien, J. (1999). The death of an analysand: Transference, countertransference and desire. *Journal of Analytical Psychology, 44*, 3-28..

Flyer

Ever felt or have a client express sexual and/or loving feelings toward you in therapy?

If so, you may want to participate in my research study on erotic transference and contribute to the lack of knowledge on managing and formulating this important dynamic in the therapeutic relationship.

To be eligible you must be a clinician over the age of 21, fluent in English, with at least one year of post-graduate experience, and have worked with a non-thought-disordered client who formed an erotic transference toward you.

Please contact me, Stacey Spilly, for additional information at: sspilly@email.smith.edu
Thanks and hope to hear from you!

Appendix B

Informed Consent Form

Dear Potential Research Participant,

      My name is Stacey Spilly, I am a graduate student at Smith College School for Social Work. I am conducting research with a semi-structured interview to explore the subjective experience of clinicians who have experienced a client expressing loving feelings or erotic desire about them, and how these issues were managed within the therapeutic process. Data collected for this study will be used in my master's thesis.

      Your participation is requested because I will be interviewing therapists with post-graduate experience (at least one year), doing therapy with diverse populations in public or private settings. If you choose to participate, I will conduct a one-hour long interview and tape-record our interview. The focus of the questions will center on your internal reactions to the client's expression of loving and/or sexual feelings and how these issues affected the therapeutic process.

      The risk of participating in this study may be revealing case examples where self-disclosure was problematic or harmful to the working alliance in some way. It is hoped you will share experiences, whether regarded as helpful or unhelpful for the client, to enrich and broaden this study of clinicians' subjective reactions to disclosure of erotic transference.

      Participation in this study is entirely voluntary and you will receive no financial benefits for your participation. Though you will be adding to the limited knowledge regarding clinicians' countertransference reactions and management of complicated transference issues. This information will provide both experienced and neophyte clinicians the possibility to strengthen their therapeutic skills and gain more knowledge about ways to respond to these expressions of love and/ or fantasies. The interview will be conducted either in person or by phone and will last approximately one hour. If meeting face-to-face, the interview will happen in one's office.

      Your participation in this study will be confidential, except for the fact that I will know your name and demographics. I will label audio-tapes and interview notes with a numeric code instead of your real name. I will secure all thesis related material in a locked file for three years; if no longer needed after this time, it will be destroyed. In my written thesis, I will not use demographic information to describe each individual; rather I'll combine the demographic data to reflect the subject pool in the aggregate. I will also disguise specifics of cases presented to prevent detection of identifying information. In this way, participants and clients will not be identifiable in the written work. If I use a transcriber, they will sign a confidentiality agreement.

      As stated above, participation in this study is completely voluntary and will include no financial compensation. You may refuse to answer any of my interview question(s), and you may withdraw from the study at any time without penalty by indicating in writing that you are no longer interested in participating. Should you

choose to withdraw, all materials pertaining to you will be destroyed. You have until April 1st, 2008 to withdraw from the study; after this date, I will begin writing the Results and Discussion section of my thesis. If you have any questions and/or concerns, please do not hesitate to contact me at sspilly@email.smith.edu. You may also contact the Smith School for Social Work HSR Committee at (413) 585-7974 for any reason. Please retain a copy of the Consent for your own records.

Your signature indicates that you have read and understand the above information and that you have had the opportunity to ask questions about the study, your participation, and your rights and that you agree to participate in the study.

_____   _____

Signature of Participant   Date

_____   _____

Signature of Researcher   Date

Appendix C

Interview Guide

Demographic Questions:

How do you identify racially and/or ethnically?

What is your sexual orientation?

What is your professional degree?

How long have you been in clinical practice?

What is your client population and theoretical orientation (if any)?

Formal Questions on erotic transference and countertransference reactions:

1) When did your client disclose their sexual and/or loving feelings (or fantasies) about you?

2) What was your initial reaction?

3) What were your thoughts and feelings before the disclosure?

4) What were your thoughts and feelings during the disclosure?

5) What were your thoughts and feelings after the disclosure?

6) Did your countertransference indicate there was erotic transference? (Meaning, did you know that was in the room prior to the disclosure?)

7) How did you respond?

8) What did you say, if anything?

9) What was the context of the disclosure? (Was it said as a dream, etc.)

10) What factors influenced your response? (i.e. training, previous experience, theory, client's history, therapist's history, etc.)

11) Did the transference affect future sessions?

12) Did you discuss it again? How did it come up?

13) Did you turn to anyone for guidance (i.e. colleagues, supervisor, case conference, etc.)? If so, whom? How was that experience? If no, why not?

14) How did you make meaning of the erotic transference?

15) Did it affect your formulation of the client?

16) Did it illustrate underlying issues?

17) What did it tell you about your client?

18) Did the erotic transference affect the therapeutic process? (e.g. Did it lead to an impasse, breakthrough, derailment, or no impact?) If so, how?

19) What was the outcome on the relationship?

20) Would you have handled it differently if given the chance to address it again?

21) What else would you like to share?

Appendix D

Human Subjects Review Letter

January 13, 2008

Stacey Spilly

Dear Stacey,

Your revised materials have been reviewed and all is now in order. We are, therefore, happy to give final approval to your project. One thing, before you duplicate your Informed Consents, please add a line for your signature as well.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your recruitment and with your study.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Pearl Soloff, Research Advisor