
An Exploration of Erotic Transference in the Therapeutic Encounter

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Abstract

Erotic transference occurs frequently in psychotherapy and psychoanalysis yet very little has been published on the topic to date. This research study seeks to explore the phenomenon of erotic transference and erotised transference as it emerges in the therapeutic encounter, the therapist's countertransference and the importance of the therapeutic relationship in managing outcomes. This paper also seeks to explore the significance of gender differences on the transference process with particular emphasis on the female therapist- male client dyad and the female therapist-female therapist dyad. The methodology used was semi-structured face to face interviews with a small select group of participants and subject responses to a detailed qualitative analysis; Interpretative Phenomenological Analysis (IPA). The sample for the research study included three experienced female, humanistic and integrative Irish psychotherapists. The purpose of this criterion was to facilitate the researcher in collecting data from more experienced psychotherapists and also with the intention of collecting research data from a humanistic and integrative perspective. Three themes emerged from the interviews: the role of the therapist in the emergence of the erotic transference, resistances to the erotic transferences and the issue of boundaries in the erotic transference. The research would suggest that erotic transference is the most challenging phenomenon in psychotherapy and psychoanalysis and the therapist may possibly be the most important influence in the transference as it emerges in the here and now.

Chapter One - Introduction

Erotic transference occurs frequently in psychotherapy and psychoanalysis yet very little has been published on the topic to date. According to Mann (1997) erotic transference is rarely absent from the therapeutic relationship and the therapist and client often experience erotic feelings and fantasies towards each other. Existing literature has focused primarily on the phenomenon of erotic transference experienced from a psychoanalytic viewpoint and although, this literature has made a significant contribution to understanding the phenomenon of erotic and erotised transference very little information is available on managing such transferences from a contemporary psychotherapeutic perspective. Many of the existing authors such as: Koo, 2001, Stirzaker, (2000), Covington, (1996) Wrye & Wells (2013) believe that there is a dearth of literature on the topic of erotic transference and that this is particularly evident in relation to the female therapist-male client dyad.

According to Wrye & Welles (2013) our capacity to love develops from our first love affair the relationship between mother and baby which begins from birth. The baby feels the mother's love and desire from within the womb but these feelings cannot be reciprocated until the baby develops capabilities far beyond reflexive and impulsive reactions. The baby must recognise her separateness from the mother, identify that mother satisfies her needs and then recognise her desire to be cared for and to be held by her mother. In order to be able to love another person the baby must be in touch with her inner world and her mother's world: to internalise, symbolise, comprehend and communicate meaningfully; and to engage in the intersubjectivity created unconsciously by both parties. It is only then that love is possible in all its richness. Love and desire are replayed in the therapeutic alliance. Wrye & Welles (2013) state that with clients who are seriously damaged the capacity to love does not materialise until treatment is coming to an end.

In order to fully understand the phenomenon of erotic transference, it is necessary to return to the theories of psychoanalysis and the work of Sigmund Freud. The term "talking cure" was the term devised by Josef Breuer as a consequence of his talk therapy with Anna O. (Person, 1985). It is well recognised that Freud's psychoanalysis emerged from the talking cure as indeed did the concept of transference. Anna O. was a pseudonym given to a patient of Breuer's, a young woman who came to Breuer for treatment suffering from a myriad of ailments. She was diagnosed with hysteria. The case study of Anna O. was first published in 1895 in Breuer's book entitled *Studies on Hysteria* which was a collaboration of work by Breuer and Sigmund Freud.

The concepts of transference and countertransference first came to light in Josef Breuer's treatment of Anna O. and it was the interruptions in the therapy that gave an insight into the phenomenon of erotic transference. It is well documented that Breuer became obsessed with Anna O. and prematurely terminated her treatment in an effort to appease his jealous wife (Person, 1985). According to Davies (1998) the question still remains did Breuer terminate the treatment in an effort to run from Anna O. or from himself, from her sexual feelings or his own? Szasz (1963) suggested that because Freud acted in the role of observer in Breuer's treatment of Anna O. he understood the transference and countertransference experienced by Breuer and Anna O. as belonging to them and therefore he was in a position to give a theoretical explanation of the phenomenon rather than someone who was directly involved with the patient (Person, 1985).

In the early stages of their work with female "hysterics" both Freud and Jung realised the power of the erotic transference and the risk of their own erotic transference (Covington, 1996). Many prominent figures in psychoanalysis became sexually involved with their patients including Carl Jung, Otto Rank, August Aichorn and Frieda Fromm-Reichmann

(Koo, 2001). In his paper entitled "Observations on Transference-Love" Sigmund Freud first used the term transference-love however, this term is now referred to as erotised transference. While erotic transference is seen as a positive transference of the patient's sexual fantasies onto the therapist which the patient knowingly believes to be unrealistic, erotised transference is viewed as being an extreme form of erotic transference and it is viewed as being pathological (Koo, 2001).

Because of its sexual nature, erotic transference has often been referred to as a taboo subject or something that is not talked about in therapy (Pope et al., 2006). Rachman et al (2009) refer to erotic transference and countertransference as concepts that have long been difficult and mysterious while Stirzaker (2000) refers to it as the "taboo which silences". Davies (1998) believes that within the profession, analysts have misled themselves and their patients in an effort to minimise, pathologise or deny their sexual feelings as they emerge in the therapeutic process between the analytic couple. Davies purports that just as Breuer ran away from the sexual feelings of Anna O. and his own sexual feelings we as a profession have been running away from our countertransference ever since. In order to provide a "safe place" within which to explore these sexual feelings Davies believes that the therapist must have the capacity to support and endure their own positive and negative countertransferential responses (Davies, 1998). In an Irish study, Colom-Timlin (2014) states that amongst therapists there is a propensity to view erotic transference and erotic countertransference as sexual attraction only; in fact they mean so much more. To truly understand the meaning of erotic transference and countertransference it is important to note that the word "erotic" which is derived from the Greek term "Eros" (love) also includes feelings of affection and unconditional love significant factors in building the therapeutic alliance. Understanding this broader view of "erotic" goes some way to normalising it, bringing it beyond just sexual attraction to something natural something that is ever present in the therapeutic relationship

(Colom-Timlin, 2014). Mann (1997) views love and erotic transference and erotic countertransference as one and the same. Yalom (1980) also recognised that Eros can make therapists "squirm" (p. 407).

In psychoanalytic psychotherapy, it is thought that the narrative of desire is conveyed through the phenomena of transference and countertransference. The more primitive aspect of the client's narrative desire which is preverbal emerges through bodily feelings and sensations which can be picked up by an attuned and receptive therapist. In the therapeutic encounter, the use of language and the feelings that emerge between the client and the therapist create an associative link to that early maternal care. The therapist's ability to tolerate and accept the client's pre-oedipal fantasies creates a secure environment in which the client's sense of self is strengthened and for the development towards an oedipal transference. Transference is viewed traditionally as being oedipal. Wrye & Welles (2013) maintain that by focusing on the preoedipal origins of erotic transference from an object relations perspective it will explain how these transferences serve as a "gold mine" (Person, 1985) in transforming therapeutic work rather than being seen as an obstacle to be avoided. Mann (1997) proposes that in his experience, many people seek therapy because they are experiencing difficulties in their loving relationships. This difficulty arises he maintains because the person unconsciously chooses a partner who bears too much of a similarity to one or both parents or because it is possible to project such similarities onto the partner. What the therapist has to offer is sufficiently dissimilar from the parental objects. The good enough therapist offers the possibility of an encounter that is different from what has previously been experienced or known by the client a new transformational object (Mann, 1997).

Research Aim:

The aim of this paper is to explore the phenomenon of erotic transference and erotised transference as it emerges in the therapeutic encounter, the therapist's countertransference and the importance of the therapeutic relationship in managing outcomes. This paper also aims to explore the significance of gender differences and the influences of the sexes on the transference process with particular emphasis on the female therapist-male client dyad.

Research objectives:

1. To explore the manifestation of erotic transference, in a sample of experienced female, humanistic and integrative Irish psychotherapists.
2. To conduct a detailed literature review in relation to previous literature and research in relation to the topic.
3. To carry out interviews with a small select group of participants and subject responses to a detailed qualitative analysis.

Chapter Two - Literature Review

2.1 Introduction

The focus of this literature review is to explore the existing literature which has been published on the subject of erotic transference and to examine the role of the therapist in determining therapeutic outcomes. The literature review will also explore the origins of erotic transference and examine how gender differences can influence the erotic transference while focusing in particular on the female therapist-male client dyad and the female therapist - female client dyad. Finally, the literature review will explore ways in which the erotic transference can be managed effectively in contemporary psychotherapy practice.

2.2 The Influence of Gender

Person makes reference to Lester (1982) who states that erotic transference occurs more frequently in the female client and male therapist dyad. According to Person (1985), female patients are more likely to use erotic transference as a resistance to analysis, whereas resistance to the awareness of the erotic transference occurs more frequently with male patients. Person (1985) maintains that as the erotic transference is not experienced or expressed to the same degree in every analysis there are variable factors involved such as the client's unconscious conflicts and personality, the sex of the client and the sex of the analyst and how both sexes interact with one other. According to Isolan (2005) the therapist's and the client's sexual identities create specific transference and countertransference difficulties and resistance.

Person (1985) is of the view that although transference is one of the best interventions available in psychoanalytic treatment, erotic transference has been tarnished by objectionable

associations and continues to be thought of as somewhat shameful. Schafer (1993) described the erotic transference material of the patient as being a form of communication or an attempt to produce something new. Person points out that erotic transference whether heterosexual or homosexual, can be difficult to manage and can result in interruptions to the treatment. A patient may be frightened and this may prompt them to cease the treatment entirely or at best the sessions may become unfavourable or hostile (Person, 1985). Person (1985) further maintains that erotic transferences occur to a greater extent in cross-sex dyads specifically in relation to heterosexual patients. Karme (1979) was of the view that in reality the female analyst's gender was a significant factor in the emerging transference of the patient at the oedipal level. According to Person, women patients are more likely to exhibit open and persistent erotic transference towards the analyst regardless of their sex but such transferences focus on love rather than on sex. Person (1985) believes that the intensity of the erotic transference can conceal more significant conflicts and dynamics and that while there is huge therapeutic potential in the erotic transference, it can also be viewed as a form of resistance to the work by masking the underlying causes of the conflicts. A patient's profound expressions of love may be interpreted for example as a defence against remembering more painful experiences (Lijtmaer, 2004).

Rosiello (2000) states that more cases of erotic transference have been reported by female analysts involving the female analysts and male patient dyads. But according to Slochower (1999) the bulk of the literature on the topic has focused on the male analyst female patient dyad. There is agreement however that fewer papers have been written regarding erotic feelings in same sex dyads (Sherman 2002). Erotic feelings which develop within same sex dyads or female analyst male patient dyads are wishes and feelings of expression both pre-oedipal and oedipal maternal longings (Lester, 1982). Blum (1973) along with many other theorists (Searles 1959; Saul 1962; Hirsch and Kessel 1988; Mann 1994) believe erotic

transference to be an essential part of therapy which occurs to varying degrees in the therapeutic process; he viewed it as being a re-enactment of an early close relationship like many relationships but particularly one of an oedipal nature. Wrye and Welles (1994) refer to pre-oedipal maternal erotic transference-countertransference whereby the analyst and the patient at the same moment experience fear of, yet longing for integration with the other. Welles (1989, 1994; Wrye 1999) maintain that maternal erotic transference and countertransference provide an opportunity to explore with the patient in the therapeutic space, the emergence of early longings and fear of the mother experienced in the preverbal stage of development.

Freud (1915/1959) referred to certain patients whom he believed were untreatable because of their need to actualise the transference and he maintained that there are certain factors which are common in patients who exhibit eroticised transference such as: early sexual seduction during the oedipal phase; innate over-stimulation together with inadequate parental support and protection; strong masturbatory struggles and acceptance within the family of homosexual or incestuous behaviour. Contrary to Freud, Blum (1973) believed that even the most perverse forms of eroticised transference can be worked with if the patient has the ability to test reality (Lijtmaer, 2004).

With regard to the female patient-female analyst, Person (1985) states that the erotic transferences tend to be affectionate and tender in nature and not overly sexual. According to Person, these erotic transferences may be in the form of idealisation which may be a response to a competitive transference or they may be a reaction to a patient's sexual experiences with men and can be regressive in nature. However, Person (1985) cautions that if they are of an intensely sexual nature these homosexual transferences may be eroticised elements of the pre-oedipal phase or expressions of a negative oedipal complex. According to Lester (1982) in

the female therapist-female client dyad there is potential for a strong erotic transference to the phallic mother because of the nature of female development. The lengthy preoedipal attachment of the girl to the mother may lead to regression in therapy which can trigger infantile omnipotence in the female client which does not threaten gender identity (Lester, 1982). According to Person, females attain their self-identity as females because of certain significant interpersonal relationships whereas males attain their self-identity as males through their accomplishments and independence (Person, 1985).

In her article entitled "Erotized Transference in the Male Patient-Female Therapist Dyad" Koo (2001) reiterates that there is a lack of published material on the subject of erotised transference and in particular she refers to the male patient-female therapist dyad. Koo like Lotterman (2013) presents a case study detailing eroticised transference in a male patient-female therapist dyad and examines how the phenomenon is viewed in contemporary psychotherapy, its significance to the therapeutic relationship and current approaches to treatment. Koo (2001) believes that the paucity of case reports on male erotised transference significantly contributed to the difficulties she and her fellow clinicians experienced in handling erotic transferences during their training. Koo (2001) states that while an erotic transference is both normal and manageable, often patients refuse to work through it and will not accept that their present experiences relate to past experiences and they decline the opportunity to explore or understand the root cause of their presenting problems. Such patients use the therapy sessions to seek fulfilment by proclaiming their love for the therapist and although their demands are not sexual, they seek affection from their revered therapist. Narcissistic needs are also apparent. Koo (2001) also makes the distinction between erotic transference and erotised transference she refers to Sandler et al. (1992) who state that erotised transference equates to a serious distortion of reality which is indicative of patients who present with a serious condition such as borderline personality disorder or schizophrenia.

In the male patient-female therapist dyad Koo (2001) asks the question 'is eroticized transference truly rare in males?' she believes that although very little has been published on the subject it is not such a rare occurrence. According to Koo (2001), female therapists may feel that their role as a competent professional could be compromised if they reported being looked upon as a sexual object and society would not look upon them favourably. Koo (2001) also refers to the theoretical explanation given by Person (1985) to justify the lack of eroticised transferences in male patients in that the male patient feels a sense of weakness and lack of control if he permits himself to express erotic feelings towards the female therapist which would suggest his dependency on her. Therefore, Person (1985) states that the male patient desexualises the analyst in an effort to redress the power imbalance which he feels exists in the therapeutic relationship and permits himself to feel some affectionate feelings. Lester (1985) suggested that male patients may experience fear of the pre-oedipal mother in the transference which may pose a threat to his self-identity.

According, to both Person (1985) and Fuerstein (1992), sociocultural beliefs regarding gender roles restrict the emergence of erotic transference in men and the female analyst must adhere to the nurturing role that society expects her to assume rather than the stronger more penetrating role required to manage and work through an erotic transference. Blum (1973) believes that seduction, trauma and genetic factors contribute to erotised transference. Menninger and Hulzman (1973) warn the analyst to be mindful of the aggressive element present in the eroticised transference; the intense love which protects the therapist from more hostile feelings and the transference resistance which relates to concealed impulses of hatred.

2.3 Countertransference

Koo (2001) suggests that traditional psychoanalytic literature does not take into consideration the contribution of the analyst in the emergence of eroticised transference and attributes the transference, to a certain type of patient whose pathology is considered to be the main source. Lijtmaer (2004) states that traditionally when therapists wrote about their sexual feelings towards patients the advice they were given was to control their feelings and to return to analysis, however if their feelings were still out of control and they were in danger of acting out in the therapy, they should terminate the treatment. Erotic countertransference can have negative ethical implications if acting on but that does not mean that the feelings are not legitimate. So even though the therapist wishes to remain impartial the therapist's feelings are also part of the relationship. The transference relationship is multifaceted and complex and it is further complicated due to the impact of countertransferential responses (Ladson & Welton, 2007). According to Mann (1994), there are two dangers which emerge when therapists experience erotic feelings towards their patients; firstly denial, repression, split off feelings leading to a projection or displacement onto the client and secondly, if the therapist becomes overwhelmed by these feelings it could lead to the therapist acting out.

Lijtmaer (2004) states that countertransference reactions at times unconscious, give clues to what cannot be said verbally. This enables the therapist to focus in on the unconscious processes and to become more aware of his/her own physiological sensations which may be attributable to erotic feelings (Solomon, 1997, p. 74). Davies (1994) likens the therapist to a magnet that draws out the re-enactment of the unconscious internalised structure of self and object and provides a transitional arena where past experiences can be replayed in a more harmonious way. According to Koo (2001), by permitting countertransference feelings to emerge in the therapeutic space and by acknowledging and understanding these feelings it

may unearth underlying issues. This leads us to the issue of self-disclosure by the therapist of his/her erotic feelings for the client. Gorkin (1985), Maroda (1992) and Gabbard (1994) in Messler Davies (1998) are wary of pathologising the analyst's countertransference but see it as valuable information to be processed and understood but never to be openly discussed or explored by the analyst and patient. Mann (1994) believes that just as a parent would not expect their child to cope with their incestuous feelings, likewise the therapist's erotic feelings should not be revealed to the client. Other analysts however argue that tactful and perceptive disclosure of the analyst's erotic countertransference can uncover unresolved infantile conflicts which can result in a deepening of the analytic work (Messler Davies, 1998, P. 748).

Contemporary analytic literature implies the analyst's interpretations alter the erotic transference and countertransference feelings into a more workable therapeutic alliance (Sherman, 2002) or that treatment may be terminated by either the therapist or the patient (Rosiello, 2000). However, Koo (2001) states that the more contemporary psychoanalytic theorists now believe that the analyst's personality significantly influences the transference which can emerge in the here and now. The analyst may possibly be the most important element in the transference and the topic requires further discussion both in terms of the literature and in terms of training therapists. According to Lijtmaer (2004) a lack of awareness in the therapist or an inability to tolerate erotic transference may result in the therapist acting out through mothering responses or failing to bring feelings into awareness thereby interfering with the therapeutic process.

2.4 Management of the Erotic Transference

Lijtmaer (2004) states that the patient's demand for love from the therapist and the therapist's own erotic countertransference may create an unsuitable alliance or may lead to difficulties in the therapy. Patients who express love for the therapist may exhibit symptoms of pathology while others may not; likewise therapists may not experience erotic countertransference in response to the patient's expressions of love. The patient whose expressions of sexual feelings towards the therapist dominate the therapy may experience a sense of satisfaction; however those feelings may be tinged with a sense of shame, humiliation and feelings of rage for the therapist. The desire for sexual contact could be interpreted as a re-enactment of past trauma and in the interest of re-establishing boundaries and in an effort to redress ego deficits the therapist may be required to interrupt the illusion in the transference thus preventing the fantasy (Stern, 1991).

In relation to the transference, Freud suggested that "what we do, above all, is to stress to the patient the unmistakable element of resistance". The analyst "must take care not to steer away from the transference-love, or to repulse it, or to make it distasteful to the patient; but he must just as resolutely withhold any response to it" (Freud, 1915, p. 166-167). As Koo (2001) points out, the erotic transference must remain in fantasy and words regardless of the patient's urgent desire for actual physical contact. At the initial interview Koo (2001) suggests that the therapist should closely observe how the patient presents paying close attention for any warning signs such as a preoccupation with material of a sexual nature, subsequent material, marriage difficulties or a young man who declares that dating is boring. The patient may not always be able to differentiate between fantasy and reality, the therapist may materialise in the patient's first dream. Koo (2001) advises that the therapist should use

appropriate language and behaviour and meet with the patient at a place and at a time that does not imply any sexual connotations.

Kumin (1985) like Freud believes that the analyst must accept the patient's sexual desire without avoiding it or without being seduced by it and Gabbard (1994) states that it is incumbent upon the analyst to strike a balance between sympathetic identification with the patient and remaining objective to do the work. The analyst must have the ability to sustain and manage their own countertransference feelings in order to make appropriate interpretations and to help the patient moderate their sexual desire and resistance (Koo, 2001). Bridges & Wohlberg (2005) stress the importance of having a strong, shame free, and safe supervisory relationship to facilitate open dialogue and to explore these erotic issues. According to Lijtmaer (2004) many patients exhibit a strong desire for actual bodily contact, a desire to be consumed by maternal love yet terrified of being lost or swallowed up within the maternal orifices. The patient desires bodily contact without any boundaries between him and the therapist. There is a yearning to be one yet horror at oneness though the analyst cannot return these sexual feelings (Solomon, 1997; Wrye & Welles, 1994).

Lijtmaer (2004) describes experiencing intense erotic transference from a female patient; she did not have any erotic feelings for the patient but she had a feeling of being engulfed and her reaction was to run away. Khan (1979) states that a common reaction in children who have experienced maternal deficiency is to libidinise the body and to exhibit premature sexual behaviour in an effort to serve non-sexual needs and to conceal the person's unfulfilled primitive needs. This libidisation can be seen as an attempt to unify with the omnipotent, wholesome breast-mother. Stein (2000) states such sexual excitement is used to disguise overwhelming pain. Sexuality has the ability to obscure one's level of human experience so that all things take on sexual connotations (p.169).

If these transferences are recognised, accepted, understood and worked through they may introduce a severely damaged client to the kind of real intimacy they never experienced before (Wrye & Welles, 2013). Benjamin (2015) warns of the *ötoo muchnessö* in the intersubjective space and both the therapist and the client may not be able to work through the enactment until both experience the danger. Mann (1997) proposes that erotic transference offers the therapist and the client a transformational opportunity firstly because it deals with the deepest layers of the psyche and secondly because it destabilises the therapist's and the client's equilibrium thus providing both with an opportunity for major growth within the therapeutic relationship through erotic and love experiences.

2.5 The Use of Relational Psychotherapy in Treatment of Erotic Transference

In her article entitled *öErotic Feelings Toward The Therapist: A Relational Perspectiveö* Jenny Lotterman (2013) focuses on relational psychotherapy as a form of treatment in the case of a male client who presented with sexual and erotic feelings towards the therapist. The author believed that the client's sexual/erotic transference feelings which were directed toward her in the therapy originated from previous relationships. Lotterman (2013) used relational psychotherapy as a way to collaborate with her client to demonstrate how the therapeutic relationship can be used as a tool in which to channel the client's sexual feelings in order to strengthen his sense of self sexually as a man and also romantically as a partner. According to Lotterman (2013), the therapeutic relationship is becoming increasingly important across various therapeutic modalities as a means of enabling therapeutic change (Norcross & Lambert, 2011).

Relational psychotherapy developed from psychoanalysis focuses on unconscious thoughts, feelings and struggles from which experienced emotions and behaviours emerge; the

therapeutic relationship is used as a means to enable growth in the client by improved self-reflection and increased understanding of how the client relates to others. According to Lotterman (2013) relational psychotherapy is dependent upon the client's improved understanding of their relational patterns and this is crucial to self-awareness. Lotterman (2013) explains that traditionally in psychoanalysis the aim of the therapist is to uncover unconscious drives, wishes and fantasies, in person-centred therapy great emphasis is placed on the therapeutic alliance however; relational psychotherapy regards the therapeutic relationship as being a representation of the client's behavioural patterns and feelings in previous relationships. According to Lotterman (2013) relational psychotherapy is a two-person process whereby the therapist focuses and acknowledges how they are influencing the therapist-client dyad and the therapist is aware of how their own personality, history and the way they interact with the client can influence outcomes.

By openly discussing with her client his feelings and desire provided Lotterman (2013) with the opportunity to explore his childhood, past and present relationships, cyclical relational patterns and his sense of self. Dealing with a client who is experiencing sexual or erotic feelings towards the therapist is extremely challenging and may be prone to many ruptures. The patient may become distressed or fearful and the therapist may feel uncomfortable or overwhelmed but according to Lotterman (2013) relational psychotherapy is designed to withstand these ruptures (Safran et al., 1990, 2000, 2001, 2005, 2011) by allowing the therapist and client to explore what is occurring in the erotic transference in an honest and open way without judgement or reproach. According to Lotterman (2013), relational psychotherapy provides an effective framework within which a client can acknowledge and discuss sexual feelings thereby gaining an understanding of their behaviour and their emotions (Lotterman, 2013).

2.6 The Taboo Which Silences

Alex Stirzaker (2000) published a paper entitled "The Taboo Which Silences" in which he explores why therapists encounter difficulties openly discussing the topic of erotic transference. While discussing the topic of erotic transference with his colleagues the group was split between those who were aware of erotic issues occurring frequently in therapy and those who were unaware of such issues. From this information two questions arose for Stirzaker (2000); firstly to what degree did erotic transference occur in therapy? Secondly was it acknowledged by therapists and clients? It became obvious to Stirzaker (2000) that even though it occurred frequently in therapy, most therapists were reluctant to discuss it. He then carried out research to ascertain therapists' and clients' thoughts and experiences of erotic transference to differentiate between inappropriate physical contact between therapists and clients and therapists' experiences of the use of the erotic transference in therapy in the context of the reworking of the oedipal relationship.

From a sample of 107 therapists (clinical psychologists, psychotherapists and counsellors working within the health service and private practice) who were contacted, only 4 questionnaires were returned. Stirzaker (2000) received some comments from therapists who refused to participate in the study who quite clearly stated that the study was "abusive", "unethical" and would "affect the therapeutic process". The paper did not specify how many clients were contacted and it is assumed that none of the questionnaires were returned by the clients. The poor response surprised Stirzaker (2000) as he felt participants would be able to talk about the topic through an external medium and he consequently designed a new questionnaire in which he asking therapists to make general comments about the difficulties they experienced around erotic issues in therapy and supervision. This time 79 questionnaires were sent out to the same group of therapists excluding the 4 who had already

replied and 13 questionnaires were returned. Stirzaker (2000) does not specify the sex of the therapists (or the clients) in his survey findings (see Appendix 3 and 4). Colom-Timlin's (2014) article entitled "Desire in the Therapeutic Relationship" published in "Eisteach" refers to a more recent survey carried out by the Irish Association of Counsellors and Psychotherapists (IACP) in 2014 on the topic of erotic transference. 150 questionnaires were sent out to randomly chosen accredited counsellors/psychotherapists (75 male and 75 female) and 63 were returned, the identities of participants remained anonymous (25 male and 38 female). The results differed significantly from those of Stirzaker in that more women than men (36% to 28% of men) stated they did not have a problem discussing feelings of attraction with supervisors and peers (see Appendix 5 and 6). The IACP (2014) survey doesn't take into consideration the therapist's working environment or the type of clients.

2.7 Conclusion

In view of the paucity of literature published on the subject of erotic and erotised transference further discussion and research on the topic is required to highlight what has up until now been minimised or avoided. As erotic transference is rarely absent from the therapeutic relationship, particular focus is required in relation to the importance of a strong therapeutic alliance, as the therapeutic relationship is becoming more and more significant as a means of enabling therapeutic change across various therapeutic modalities. The research suggests that erotic transference is the most challenging phenomenon in psychotherapy and psychoanalysis and the therapist may possibly be the most important influence in the transference as it emerges in the here and now. Further research is also required on the significance of gender differences and the influence of the sexes on the transference process particularly in relation to the female therapist-male client dyad and the female therapist-female client dyad, to

support the female therapist and patient in view of the potential risks involved in the transference and countertransference processes. Research is also required to compare and contrast differences and similarities across various research studies and in the management of erotic transference in a contemporary psychotherapy practice.

Chapter Three - Methodology

3.1 Introduction

The main aim of this chapter is to expand on and to give clarification to the researcher's motivation in using the qualitative method of interpretative phenomenological analysis (IPA) as the most suitable and effective methodology for this research study. Qualitative research is predominantly exploratory research and the rationale for using this research method for the purposes of this study is to gain an understanding of the participants' feelings, experiences, perspectives and belief systems. Qualitative research develops the principal philosophical assumptions which form the basis of IPA and gives the reader real insight into the impact of the interview process on each of the participants, the researcher's own personal experience of the interview process and it also examines the process from the perspective of intersubjectivity. This chapter also aims to delineate the techniques that were adopted in order to compile and analyse the data and in conclusion the ethical considerations of the research study are outlined

3.2 Interpretative Phenomenological Analysis

Qualitative research techniques provide researchers with an opportunity to understand complicated and subtle information that materialises within the therapeutic relationship and within the research inquiry (McLeod, 2001). In order to understand fully the subtle meanings, responses and differences associated with the complexities of the erotic transference a qualitative approach was undertaken. Interpretative phenomenological analysis is a qualitative methodology framework the principal aim of which is to investigate how individuals derive meaning from their life experiences. It involves a comprehensive

analysis of individuals' interpretations of their experiences which are subsequently presented and discussed to identify common themes that are then combined with the researcher's own interpretation this is known as double hermeneutics. According to Taylor (1985), people are 'self-interpreting beings' so they interpret people in their lives, events and objects. IPA has its origins in the disciplines of phenomenology, hermeneutics and idiography and it draws upon these disciplines to examine the process of self-interpretation (Pietkiewicz, I. & Smith, J., 2012). Phenomenology developed by Edmund Husserl is concerned with the study of conscious experience and how experience is perceived by individuals. The aim of phenomenology is to recognise the essential components of phenomena or experiences which are unique to each individual and eidetic reduction is used to identify what essential components make any given experience unique. The study of phenomenology specifically focuses on how people perceive and speak about objects and events rather than using a predefined scientific criteria or classification system. This affectively means 'bracketing' one's preconceived ideas or prejudices and permitting phenomena to speak for themselves. Martin Heidegger (1962) further developed Husserl's thought into existential philosophy and hermeneutics. Hermeneutics is the methodology of interpretation it is concerned with understanding the mind-set of a person and the narrative used to depict how one experiences the world and the way in which one communicates his or her message (Freeman, 2008).

IPA was used to analyse the data as it allows the researcher to step into the shoes of the subject and it is the most appropriate way of interpreting the data effectively from the participant's perspective. It is a dynamic process, in which the researcher plays an active role in accessing the participant's experiences and interpreting those experiences in an attempt to make sense of the individual's inner world. IPA is often described as a dual interpretation process, a double hermeneutic firstly because the participants make sense of their world then the researcher attempts to decode their meaning and make sense of the participants' sense of

meaning (Smith & Osborn, 2008). Simultaneously, the researcher tries to devise questions which expand on the material: Is there something being said here that the participant is not consciously aware of? What is it that is not being said? What is being communicated in their body that is not being communicated verbally? Double hermeneutics enrich the existing data. The third and last theoretical orientation that IPA draws on is idiography, which is concerned with case by case in-depth analysis and examines each individual's perspectives in relation to their own unique context. The idiography approach is based on the principle of studying each case individually prior to making any general statements. Rather than being universal, IPA relies on idiography in that researchers focus on the particular (Smith, Harre, & Van Langenhove, 1995). As the analysis concentrates on a comprehensive case exploration specific statements can be made in relation to individual study participants. In order to make sense of each individual's experiences the researcher needs to remain impartial and to be aware of his or her own feelings, experiences, perspectives and belief systems.

3.3 The Sample

Due to the paucity of research which have been carried out on the topic of erotic transference, and because existing literature has focused primarily on the phenomenon of erotic transference from a psychoanalytic perspective, this research study focuses on the topic from a contemporary psychotherapeutic perspective. The research sample included participants selected from the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP) and the Irish Association for Counselling and Psychotherapy (IACP) registers of psychotherapists who are humanistic in orientation (Smith et al., 2007). As the study concentrated on the female therapist-male patient dyad and the female therapist-female patient dyad the participants selected included female psychotherapists. The research therefore excluded all male therapists and female therapists whose orientation was not humanistic. For the purposes

of this particular study, there was also a requirement that participants should have at least five years experience working in the field of humanistic integrative psychotherapy. The purpose for this criterion was to facilitate the researcher in collecting data from more experienced psychotherapists and also with the intention of collecting research data from a humanistic and integrative perspective. IPA studies favour a homogenous and small sample size of between three and six participants in order to obtain a detailed interpretative account of each participant's experience (Smith et al. 2007). To this end it was intended that interviews would be carried out with three closely selected psychotherapists. The sample consisted of three female psychotherapists who ranged in age from 45 to 50 years of age. Information relating to pseudonyms and demographics of the participants are listed in *Table 1* below.

Table 1: Demographic Information (see Appendix D)

Pseudonym	Gender	Age	Approach	No. of years practicing	Work Place	Qualifications
Jane	Female	50	Humanistic & Integrative	6	Organisation & Private Clients	BA Psychology & Dip. In Counselling & Psychotherapy
Donna	Female	40	Humanistic & Integrative	12	Organisation & Private Practice (Supervisor)	Dip. Counselling & Psychotherapy
Anne	Female	40	Humanistic &	12	Organisaton & Private Practice	Dip. Counselling &

			Integrative			Psychotherapy Cert. in Child Psychotherapy
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3.4 Recruitment

The strategy employed to recruit participants was explicitly targeted at female psychotherapists from the (IAHIP) and the (IACP) lists of accredited practitioners with a minimum of five years experience whose orientation is humanistic. A random sample of potential female participants was subsequently shortlisted from each of the membership lists and participants were initially recruited via phone calls. From the outset, the researcher experienced difficulty in recruiting volunteers for this research study. The very mention of the topic seemed to evoke a certain amount of giddiness in people which was undoubtedly masking some form of embarrassment or anxiety and there was a real reluctance on the part of would be participants to engage with the topic. These reactions evoked a sense of hopelessness in the researcher and doubt as to whether or not volunteers could be recruited who would be willing to participate. After several failed attempts eventually through word of mouth the first interviewee was recruited via a phone call. The second interviewee was also recruited via a phone call and the third interviewee was recruited through snowball sampling (Patton, 2002).

It is not surprising that the eventual participants all had one factor in common; they all had experience working with male clients in organisations; the first interviewee Jane (pseudonym) previously worked with young adult males in a care setting and she is now in private practice while the other two interviewees Donna (pseudonym) and Anne (pseudonym) work predominantly with male clients who have been sexually abused and consequently they

have extensive experience and have received specialised training in the area of sexuality and related issues.

3.5 Method of Data Collection

The interviews were semi-structured in nature to allow in-depth engagement with each participant and to enable the researcher to thoroughly compare and contrast the data and examine in detail the differences and similarities in each individual case. Also by undertaking semi-structured interviews it allowed the researcher the scope to revise or rework the questions depending on the responses received from the participants. Twelve broad and open-ended questions (see Appendix A) were devised which were informed by the literature review and by the researcher's own interest in the topic (Lofland & Lofland, 1995). The questions were revised and reworked by the researcher following recommendations by colleagues and supervisors to ensure the best possible outcome.

The interviewees evoked a mixture of different emotions in the researcher which added to the richness of the data collected and this contributed to the overall analysis. All of the participants were interested to know why the researcher had chosen the topic and in the interest of solidarity with the participants the researcher gave a brief account of her own experience of erotic transference as a psychotherapist in training and her genuine desire to know more about the topic. All participants were furnished with an Information Sheet (see Appendix B) explaining the purpose of the research and this information was reiterated to the participants prior to the interviews. The Information Sheet and the Consent Form (see Appendix C) were handed to the participants for their perusal and signature before the interviews commenced. With the knowledge and consent of the participants and in an effort to ensure accuracy in the collection of the data all of the interviews were recorded and

transcribed. Notes were also made by the researcher at the end of each interview in order to capture the essence of the interview process.

In an effort to fully understand the participant's interpretations of their experiences and their unique context, the researcher dealt with each of the case studies individually (Smith et al, 1999). By listening to the recordings and by reading the transcripts the researcher endeavoured to gain a better understand of the participant's feelings, perspectives and belief systems. Key words and phrases were noted and colour coded by the researcher and placed under a series of headings in order to select relevant themes (Smith et al., 2009). Having selected the themes the researcher realised that the literature review had in fact influenced the theme selection and with renewed effort the researcher repeated the selection process again. By listening to the recordings again and by rereading the transcripts the researcher was able to become immersed in the data this helped the researcher to depersonalise, remain objective and impartial and identify three dominant themes which captured the essence of the interview data (Willig, 2008). Having analysed the data on a case by case basis the researcher then examined the material collectively and by comparing and contrasting the data differences and similarities began to emerge.

3.6 Ethical Considerations

Before the research was undertaken, approval was received by the ethics board of DBS. Potential participants were contacted and furnished with information regarding the topic, the objectives of the research, the methodology to be used and they were provided with a copy of the code of ethics of DBS. To safeguard confidentiality and insure the anonymity of the participants' pseudonyms are used throughout the study and the researcher refrained from using information that could potentially identify the participants. Participants were given

assurances that results from the research together with any correspondence received will be stored onto a computer that will be password protected and which can only be accessed by the researcher. All information furnished by participants in the course of the interviews will be appropriately destroyed on completion of the study. Participants were informed of their rights as voluntary participants and their right to withdraw at any time and the benefits of the study to them.

3.7 Conclusion

In order to fully understand the phenomenon of erotic transference, IPA was selected as the qualitative research technique for this study as it incorporates key ideas from phenomenology, hermeneutics and idiography. It is descriptive in that it is concerned with how things appear and letting things speak for themselves, it is interpretative in the sense that it recognises that all phenomena is interpreted and it is concerned with case by case in-depth analysis which examines each individual's perspectives in relation to their own unique context. In this regard three semi-structured interviews were conducted with three female psychotherapists in order to collect the data. Each of the interviews were then subjected to IPA to ensure the best possible outcome.

Chapter Four - Results

4.1 Introduction

The literature illustrates the many facets and complexities of the erotic transference and the diverse ways in which an erotic transference can emerge within the therapeutic alliance. The literature also refers to the variable factors involved in the erotic transference such as the clients' and the therapists' unconscious conflicts, the sex of the client and the therapist and how both sexes interact with one other. The aim of this chapter is to analyse the rich data acquired by the researcher having undertaken in depth interviews with three psychotherapists on their experiences of erotic transference and to convey to the reader the individual experiences of each of the three interviewees and how their experiences shaped client outcomes. At this stage of the analysis it should be noted by the reader that crucial differences were identified by the researcher that undoubtedly contributed to the richness of the data collected namely; the personalities of each of the participants, the participants' understanding of the topic, the participants' ways of working, the level of awareness of each of the participants of the erotic transference, the participants' working environments and their level of training and experience.

4.2 Theme 1: The Role of the Therapist in the Emergence of the Erotic Transference

The bulk of the literature does not take into consideration the contribution of the therapist in the emergence of the eroticised transference. The interview process highlighted the complexity of the transference relationship and the significance of the impact of countertransference reactions. This theme endeavours to illustrate to the reader the role of the therapist in the developing transference.

In order for the researcher to be able to interpret the participants' understanding of their experiences of erotic transference, it was important from the outset to establish each of the individuals' understanding of erotic transference in relation to the work. Jane explained it as the client transferring erotic feelings onto the therapist that belong to a previous relationship perhaps the primary caregiver. Because of the nature of her work in the organisation this type of transference occurred quite frequently.

I suppose people transferring erotic feelings onto the therapist that probably belong to I suppose significant relationships in their life [pause] primarily I suppose [pause] their primary caregiver.

and

When I worked for the organisation there would have been kids coming from very very damaged upbringings so you are more likely to get that kind of transference going on.

It would appear that Jane perceives that she is taking on the role of primary caregiver or mother in the transference and this type of transference is more likely in view of the type of client in the organisation. Erotic feelings which develop in the female analyst-male patient dyads can be interpreted as wishes and feelings of expression of both pre-oedipal and oedipal maternal longings. Donna perceives erotic transference as feelings of love being transferred onto the therapist by the client which are misplaced due to the intimacy of the therapeutic relationship. This she explains can also occur in a countertransference way with the therapist.

I suppose the obvious thing is the connection that you have with somebody and that someone may develop feelings that are [pause] of love towards you as a client and generally in the work that I do it's generally felt that it's misplaced you know somebody feels that towards you because you've given them your undivided attention your capacity to love them so to me it's blurry [pause] and also I work with people who are talking about sexual issues so that can get confused in the room sometimes but my understanding is it can happen very much in the therapeutic relationship it can

happen in a countertransference way for the therapist as well that they may occasionally feel it towards a client and it's to be expected and not to be feared.

Donna seemed unfazed discussing the topic it seems like a natural phenomenon to her something not to be feared which demonstrates that in some way she is accepting the client's sexual desire without avoiding it or being seduced by it. Anne confessed to never having really thought about erotic transference before this and described it as being more sexualised.

I have this thing it's a sexualised something sexualised that's how I see it em would have erotic feelings about the client or they'd have about me probably more the client would have about me something like that I'd pick that up so that's kind of what I'm thinking as I've said I've never really given it a lot of thought do you know.

This could be interpreted here as a lack of awareness of the erotic transference by the therapist.

As is evidenced from the interviews erotic transference can emerge in the therapeutic relationship in many different ways. From the therapist's perspective it can be blatantly obvious or it can be more subtle in its presentation taking on the guise of many different and diverse emotions and behaviours which may be positive, negative or sexualised. Erotic transference is most commonly felt by the therapist as idealisation or as an expression of love. Jane explained that in her experience erotic transference is usually expressed as idealisation rather than as a direct expression of love.

I don't think they would verbalise it directly they might say you're the most important thing to me or you're the only one who really cares or [pause] more kind of I need you or you're the only person who cares.

Jane was visibly uncomfortable speaking about erotic transference in terms of love, she made light of it and seemed more comfortable speaking about it in terms of understanding, caring and needing. This reaction could be interpreted as embarrassment or shame as the topic of erotic transference has been tarnished by objectionable associations and continues to be

thought of as somewhat shameful. Conversely Donna openly described erotic transference in terms of an intense love for the therapist.

I feel a lot of the time it's around love it can be with women as well an intense love you're the only person that gets me or I feel here I'm really understood.

Donna evoked a real sense of emotion in the researcher when describing the intensity of the erotic transference here. She also conveyed a great sense of awareness of how she experienced the transference from both male and female clients. It would appear that female clients are more likely to exhibit open and persistent erotic transference towards the therapist regardless of their sex but such transferences focus on love rather than sex. It could be interpreted that Donna is very aware of the nature and intensity of the erotic transference as it emerges in same sex dyads. Anne described the erotic transference in relation to a particular client who sent her a gift of flowers.

He had finished I don't think we had a closing as such I wasn't here and when I came in this beautiful arrangement of flowers it wasn't just a bunch of flowers a bouquet it was a lovely arrangement.

It would appear that Anne was placing significance on the meaning of the gift rather than the gift itself, the flowers were not just symbolic of an appreciation of the work they had done together. The personal nature of the gift is indicative of erotic transference. Later Anne describes the real connection she had with this particular client. This could be interpreted as representing a need in the therapist; *"Well I would have felt it with him."* Anne may have been flattered by the client's obvious feelings for her however this could be seen as colluding with the client and Anne appeared to be unaware of her role in the emergence of the transference. The first interviewee Jane describes in detail how she experienced a considerable level of aggression, anger and threat in the erotic transference in her work with

young adult males coming out of a care setting. Her interpretation of this negative transference is as a consequence of the client's needs not being met;

If you're not meeting all their needs which clearly you can't you'll get a level of aggression and anger [pause] it's not kind of falling into where you're becoming everything to them I would have seen in the work where people you know as you say falling into the fantasy.

As suggested by Jane the aggressive and angry reactions she experienced in the transference could be interpreted as occurring as a result of the client's demands not being satisfied by the therapist. The fantasy she refers to could have a defensive function of abandonment or separation or could be interpreted as an attempt to re-establish a state of narcissistic fusion with the mother.

In some cases there would be a level of aggression and a sense of being rejected and in some instances kind of threats being made [pause] one in particular I think towards your children but that was all around their own kind of abandonment so in a way it was being kind of as much as kind of like an erotic transference it was than the thing around the mother thing and then the reason they were going for the children bit is that you infer that they've experienced or something close to you what it's like for me to have that abandonment. I think because it was all men I was working with before I became quite desensitised.

In this instance Jane felt that she took on the role of mother in the transference and the level of fear and threat she felt in the countertransference is palpable it would appear that because of the client's felt rejection by the therapist and the client's issues around abandonment that the client wanted to inflict some form of retribution on the therapist. This anger could also be interpreted as the client being frightened of the erotic transference or as unresolved oedipal issues as male clients may experience fear of the pre-oedipal mother in the transference which may pose a threat to their self-identity. Jane alludes here to the difficulties she experienced in doing this particular type of work and how she became desensitised over time. This could also be interpreted as resistance to the awareness of the erotic transference.

Where you see it is then the anger if they see you with another client or another client might be coming out and they might be coming in and there's a level of agitation that it's not just them it's not verbalised directly in that way you know kind of bearing gifts it's more kind of well it's not that subtle because you can pick it up.

The researcher questioned why these emotions were being evoked in the clients? It could be interpreted that in reality the therapist's gender is a significant factor in the emerging transference of the client at the oedipal level. Feelings of aggression and anger can also be interpreted as masking more serious underlying conflicts. The second interviewee Donna works predominantly with clients who have been sexually abused she describes her experiences of aggression in the erotic transference as occurring very rarely and as occurring with male clients who are very damaged sexually, their sexuality is used as a form of defence.

I suppose one that comes up for me is around a man who I had a very obvious dislike in the work and he would have come in and he always wore shorts and he sat in a very kind of physical way with his legs apart and for me the countertransference was very uncomfortable I felt a little bit unsafe and he talked a lot about sex and whether he was gay because in a way for me erotic transference is around that other stuff too the more subtle stuff bringing sex in.

and

I think particularly for men who have been damaged in a way sexually they can use their bodies or their sexuality in an aggressive way like a tool as a defence.

The transference relationship is multifaceted and complex and it is further complicated due to the impact of countertransference responses, therefore this could also be interpreted as the client picking up on the therapist's countertransference and obvious dislike for him. All of the interviewee's experiences of erotic transferences could be interpreted as having been evoked by their role in the therapeutic relationship and their particular personalities and their way of working. The erotic transference responses by the clients could also be interpreted as being evoked by the therapist's unconscious countertransference reactions to the erotic transference or the therapist's own unconscious conflicts.

4.3 Theme 2: Resistance to the erotic transferences

The therapist's and the client's sexual identities create specific transference and countertransference difficulties and resistance and the therapist must have the ability to sustain and manage their own countertransference feelings in order to make appropriate interpretations and to help the client moderate their sexual desire and resistance. The purpose of this theme is to highlight the complexities in managing the therapist and the client's unconscious conflicts and resistances in the transference. Jane for example talked about clients in the organisation where she previously worked who had finished therapy but wanted to come back to therapy specifically to work with her. She seemed reluctant to work with them again because of some kind of erotic transference;

You might have a GP who would be contacting you saying the person wanting to work specifically with you but if you know that there is kind of an erotic transference going on.

This could be interpreted as resistance by the therapist to engage with the client and work through the erotic transference. Jane also displayed resistance in managing the erotic transference with private clients and she explains how the client may be reluctant to admit their feelings for the therapist for fear of shame, abandonment or withdrawal by the therapist.

....it's that kind of thing it might be something that is completely shameless but if they have a huge sense of shame around it and struggle in terms of naming it and that....
and

And I suppose the reason why generally people hide it because it's this sense that people feel that they lose people who are important to them so you know when there isn't that reaction and there isn't that sense of withdrawal or anything like that I think that's where you can feel a slight kind of transference but no one I mean no one has ever come in and said directly as you were saying I think I love you but I think people are aware of [pause] I'm not saying [pause] I'm sure some do but I think there's an awareness that you're not meant to.

Jane feels that one of the reasons why a client may not openly discuss their feelings for the therapist is because unconsciously they may be aware that they are not supposed to as it is a taboo subject and therefore it brings up feelings of shame. This could also be interpreted as the client feeling a sense of weakness or a lack of control if he allows himself to express his feelings for the therapist it would suggest his dependency on her. Also, the client may not be able to distinguish between fantasy and reality.

Because if they name it you know I think in the back of their head it's kind of improbable that you're going to say oh me too so you know it kind of blows their fantasy into smithereens doesn't it.

The therapist's behaviour could be interpreted as colluding with the client in the erotic transference or it could be interpreted as the therapist's sense of shame as Jane may feel that her role as a therapist is being compromised if she is looked upon as a sexual object. While there was a lot of discussion around the client's feelings for the therapist Jane was somewhat resistant when the discussion focused on the therapist's erotic transference towards the client.

I suppose if I was sexually attracted to them it would be a little different I think than them being sexually attracted to me....yeah....I don't think it would be conducive to the work if I was sexually attracted to them...then I would have to absolutely if it was me being sexually attracted to them.

Jane intimated that if she was sexually attracted to the client that she would absolutely cease working with the client or alternatively refer them on to somebody else. There was resistance again here in not wanting to work through the erotic transference. Jane was quite dismissive of her own countertransference in this situation and the researcher sensed her embarrassment and in order to alleviate her discomfort the researcher moved the interview along. Jane would appear to be running away here from her own countertransference responses. Anne

had stated early on in the interview that she wouldn't avoid the erotic transference she would name it and work through it.

Again I would name it you know because I think when you name it and name that nothing is going to happen it's part of the work I think that helps to dissipate it but by not naming it and avoiding it it gives it legs it creates something else so I think for me I would name it.

However, it would appear that Anne later contradicts herself by displaying huge resistance in naming and working through the erotic transference with the client who gave her the flowers.

I hadn't been in work but I thought oh that's nice and I would have [pause] thought of him in the sense [pause] because he was a lovely man could I not that could I have been in a relationship or not but how would I have been if I was in a relationship because he had used a lot of pills I would have said to myself how could you stay in a relationship with somebody who's acting out so bad and that thought would have come into my head I don't know what name you'd put on that.

It could be interpreted that in reality, Anne was resistant to an awareness of the erotic transference and her own countertransference responses. Her erotic feelings for the client remained in fantasy. By permitting countertransference feelings to emerge in the therapeutic space and by acknowledging and understanding these feelings, it may unearth underlying issues. Donna did not appear to show any resistance to working with and managing erotic transference in her work;

Bring it into their conscious awareness without it being confrontational because they've so much shame the clients that I work with around sexual abuse and in their bodies and it's trying to honour what I pick up in the room at a countertransference level and trying to work with that in a way that's measured and that a client can cope with without them you know giving up on therapy.

Donna is very aware of the sensitivity required in working with clients who have been sexually abused and issues around shame. By recognising, accepting, understanding and working through the transferences without judgement or reproach, a severely damaged client may be introduced to real intimacy for the first time.

4.4 Theme 3 - The Issue of Boundaries in the Erotic Transference

In terms of training and helping therapists to successfully manage erotic transference and countertransference it is importance to maintain appropriate boundaries within the therapeutic space as erotic transference can lead to serious disruptions in the therapeutic process. This theme gives the reader some insight into what is meant by appropriate/inappropriate boundaries. Anne gave an example of a situation she found herself in with a particular client.

What's actually coming to me is a client I had a long time ago a lovely lovely man but he actually invited me to his daughter's wedding. And he didn't know that it wouldn't be appropriate for me to attend his daughter's wedding it was a throw away remark as he was going out the door.

It would appear that Anne's relationship with this client lacked healthy boundaries and as a result the erotic transference was allowed to develop whereby the client may have felt his feelings would be reciprocated. When Anne informed her client that it would not be appropriate for her to go to the wedding with him this may have felt like a rejection and it may have prompted the client to leave therapy. Earlier Anne stressed that if she felt something she would name it and if required she would bring it to supervision to help her manage it.

You have to own it I think you have to own your own piece I think if I felt it with a client I'd have to bring it to supervision and try and manage it that way.

This statement would appear to contradict what happened in reality with the client who gave her flowers and the client who invited her to the wedding. It would appear that on these occasions, Anne was not aware of or was resistant to the erotic transference. It would also appear that Anne was not aware of her role in the emergence of the erotic transference and the impact of her countertransference responses and consequently the boundaries were compromised. Donna stated that she would explain the nature and the intensity of the relationship to the client in order to help the client to understand what was happening in the erotic transference. She also spoke about the necessity for healthy boundaries and how important it is for the therapist to act in a professional manner.

This is a very powerful and intense relationship but it's not real it's not equal because you don't know anything about me and I think it's just trying to explain that to people but keeping firm boundaries keep it to the hour keep it to whatever people will buy presents and things like that I've never not taken a present from somebody but I would say really I'd prefer if you didn't do it again thanks a million but I wouldn't not accept a present and have someone bring it out but I think you have to be very clear that the role is professional.

and

We're not friends you know so in a roundabout way you know.

Donna addresses how the relationship between therapist and client is not equal and how important it is to handle situations sensitively particularly when a client gives you a present.

According to Jane, she would refer a client on to somebody else if she felt the transference was strong and it was interfering with the work; *"I suppose it depends how strong it is isn't it if I felt it was interfering with the work then I'd probably refer them on to somebody else."* It would appear here that Jane would assess the situation and depending on how strong the transference was, if it was disrupting the therapeutic process for example, she would then make a judgement whether or not to refer the client on to somebody else. She also stated that

if she felt that the client was psychotic or unable to understand the therapeutic process she would refer them on;

If there is something like a psychosis or something like that or kind of slipping into that kind of thing where all you're doing is adding further confusion I think someone has to have an understanding and also you have to be careful with it as well.

By maintaining healthy boundaries the therapist is ensuring her safety remains a priority particularly in a situation where she may have felt overwhelmed or when a client may not have the ability to test reality or to engage in the therapeutic process or in an instance where the client may be medicated. Referring a client on may be the best option particularly where the client may need to be referred on to psychiatric services. In order to maintain healthy boundaries Donna explained how she would handle a situation if she felt intimidated by a client;

I would shut down the session I wouldn't be intimidated by somebody if I felt that somebody was in any way overly aggressive I would say I'm feeling intimidated here I'm sorry now but I'm closing the session or they would maybe work with a male therapist.

If you are working as a female therapist in an organisation and the erotic transference is excessively aggressive or sexualised there is an option to refer the client on to another therapist who may be more experienced or alternatively to refer the client on to a male therapist. This could be interpreted as the therapist being unable to contain the 'excess' or 'muchness' of the situation and this can be frightening for both the therapist and the client and the therapist may deem the situation unmanageable in the here and now. Above all the therapist has a duty of care with regard to clients and to herself. Jane also stated that as a therapist you have a responsibility to maintain boundaries and there are other ways of

working that are going to be more effective than directly naming the erotic transference particularly with clients whose egos are fragile as they may perceive the therapist as trying to rationalise something which may seem like further rejection to them.

I think they'd struggle I think they would reject it [pause] that you're rationalising something and I think that would be seen as further rejection and wouldn't be beneficial at all and your job as a therapist is to maintain the boundaries.

Chapter Five – Discussion and Conclusion

5.1 Introduction

The aim of this dissertation has been to explore the phenomenon of erotic transference and erotised transference as it emerges in the therapeutic encounter, the therapist's countertransference and the importance of the therapeutic relationship in managing outcomes. The purpose of this chapter is to review the existing research which has been published on the subject of erotic transference and to compare it to the findings of this research study. With regard to the influence of gender on the erotic transference, as the researcher is female this study focused in particular on the female therapist-male client dyad and the female therapist-female client dyad. Finally, the research study explores ways in which the erotic transference can be managed effectively in contemporary psychotherapy practice.

5.2 Awareness of the Erotic Transference

The data collected from this research would appear to suggest that the majority of the participants had some knowledge or understanding of the phenomenon of erotic transference in the therapeutic relationship. The last participant Anne, was the only participant who by her own admission 'had never really given it a lot of thought' and she interpreted it as being 'something sexualised'. This would concur with Colom-Timlin's (2014) article in which she purports that there is a tendency amongst therapists to view erotic transference and countertransference in terms of just 'sexual attraction'. Lotterman (2013) believed that the client's sexual/erotic transference feelings which were directed towards her in therapy originated from previous relationships. Jane and Donna described erotic transference in similar terms; erotic feelings or feelings of love that were transferred onto the therapist which were misplaced or that belonged to a significant other, invariably the primary caregiver.

Although the literature would suggest that erotic transference is rarely absent from the therapeutic encounter, Jane's experiences of erotic transference would appear to be more isolated and confined to specific incidents, mainly in relation to her work in an organisation with young males who came from damaged backgrounds. Jane admitted to becoming desensitised when working in the organisation due to the difficulties and challenges she encountered in her therapeutic work with these troubled young men. This could be viewed as a resistance to the erotic transference. Jane also interpreted the anger and threat she experienced in the transference as the client's fear of abandonment rather than erotic transference however Menninger and Hulsman (1973) warn the therapist of the aggressive element present in the eroticised transference and the intense love that protects the therapist from more hostile feelings. Anne's experiences were quite specific even though she struggled to recognise the phenomenon of erotic transference in her work (Mann, 1997). For example, she mentioned that at times she found herself fantasising about a particular client but did not recognise this as erotic transference 'I don't know what you'd call that'. This could also be interpreted as a lack of awareness or understanding of the erotic transference or it could be viewed as a resistance to the awareness of the erotic transference.

Only one of the interviewees Donna, stated that it occurred frequently in the therapeutic encounter; 'my understanding is it can happen very much in the therapeutic relationship'. It would appear that the majority of the participants were very aware of what could generally be described as 'normal' transference within the therapeutic relationship but did not necessarily see these transferences as being erotic (Stirzaker, 2000). When discussing the topic of erotic transference with his supervision group, Stirzaker (2000) became aware that the group was split between those who were aware of erotic issues occurring in therapy and those who were unaware of such phenomenon. The data collected from this research study would appear to mimic Stirzaker's (2000) findings in that some therapists have a better awareness of erotic

issues than others. Erotic transference offers the therapist and the client a transformational opportunity because it deals with the deepest layers of the psyche and it destabilises the therapist's and the client's equilibrium thus providing both with an opportunity for major growth within the therapeutic relationship through erotic and love experiences (Mann, 1997). However, if the therapist is unaware of the erotic transference or is unable to tolerate it, this may result in the therapist acting out or not bringing feelings into awareness thereby interfering with the therapeutic process which could result in the client becoming hostile or at worst ceasing therapy altogether.

5.3 The Role of the Therapist in the Emergence of the Erotic Transference

Ladson & Welton (2007) state that in contemporary psychotherapy, the therapist is less of a blank screen and plays more of an interactive role in the therapy therefore it is inevitable that the therapist is part of the emerging transference. While all of the participants had experienced erotic transference in the therapeutic relationship, none of the participants alluded to their role in the emergence of the erotic transference. It could be interpreted therefore that the participants were unaware of their role in the emergence of the erotic transference. Anne and Donna did however infer that erotic transference could occur in a countertransference way whereby the therapist may occasionally have erotic feelings for the client. Person (1985) maintains that as the erotic transference is not experienced or expressed to the same degree in every analysis, there are variable factors involved such as the client's unconscious conflicts and personality, the sex of the client and the sex of the analyst and how both sexes interact with one another. The data from this research would suggest that Person's views are accurate in that all of the participants' experiences of erotic transferences were different in terms of; the type of the transference; the level and intensity of the transference

and the participant's acknowledgement of the transference. It could be interpreted therefore that the therapist may possibly be the most important element in the transference (Koo, 2001).

Koo (2001) suggests that the more contemporary psychoanalytic theorists now believe that the analyst's personality significantly influences the transference which can emerge in the here and now. Donna referred to her 'obvious dislike' for a male client whose transference towards her was very sexualised and aggressive and Donna felt unsafe in the session. Her countertransference reaction would appear to have had a significant impact on the transference in the here and now as suggested by Koo (2001). Jane's recollections of her experiences of erotic transference focused mainly on the more negative aspects of the erotic transference such as anger, aggression, hostility and even threatening behaviour from clients. Jane maintained that in these negative transferences she took on the role of 'mother' in the transference. This could be interpreted as the therapist's inability to tolerate erotic transference which could result in the therapist acting out through mothering responses or failing to bring feelings into awareness thereby interfering with the process as suggested by Lijtmaer (2004). Lijtmaer (2004) also suggested that many patients exhibit a strong desire for actual body contact, a desire to be consumed by maternal love yet terrified of being swallowed up within the maternal orifices and both Solomon, 1997 and; Wrye and Wells, 1994 also refer to the client's yearning to be one, yet horror at this oneness though the analyst cannot return these sexual feelings. Although all of the participant's clients shared similar characteristics and backgrounds, Donna and Anne's experiences of aggression in the transferences were rare. The research data would suggest therefore that the analyst's personality can significantly impact the transference as it emerges in the here and now (Koo, 2001). The findings of the study would also suggest that the transference relationship is multifaceted and complex and it is further complicated due to the impact of

countertransference responses. All of the participants referred to the connection they have with their clients. Donna stated that this was "because you've given them your undivided attention your capacity to love them"; this gives an indication of the intimacy and uniqueness of the therapeutic relationship and the centrality of the therapeutic relationship in managing outcomes. Anne felt a particular connection in the therapeutic relationship with the client who invited her to his daughter's wedding and the client who gave her flowers and her countertransference could be interpreted as a need in the therapist, colluding with the client or a resistance to the awareness of the erotic transference. It could also be interpreted as the therapist's own unresolved unconscious conflicts. Wrye and Welles (1994) refer to pre-oedipal maternal erotic transference-countertransference whereby the analyst and the patient at the same moment experience fear of, yet longing for integration with the other. The research would suggest that even though the therapist wishes to remain impartial the therapist's feelings are also part of the relationship (Lijtmaer, 2004). Therefore it can be interpreted that the therapeutic relationship is a two person process whereby the therapist is required to focus and acknowledge how they are influencing the therapist-client dyad and the therapist needs to be aware of how their own personality, history and the way they interact with the client can influence outcomes (Lotterman, 2013).

5.4 The Influence of Gender in the Erotic Transference

Karme (1979) was of the view that in reality the female analyst's gender was a significant factor in the emerging transference of the patient at the oedipal level. Jane maintained that on occasions she experienced a considerable level of aggression from male clients in the transference this she explained was as a consequence of the client feeling a sense of rejection by the therapist. She felt that in these instances she invariably took on the role of "mother" in the transference and this originated from the client's issues of abandonment rather than erotic

transference. This would correspond with Lester's (1982) view that erotic feelings that develop within female analyst male patient dyads are wishes and feelings of expression both pre-oedipal and oedipal maternal longings (Lester, 1982). It can be interpreted therefore that the therapist's and the client's sexual identities create specific transference and countertransference difficulties and resistance (Isolan, 2005).

Person (1985) maintains that erotic transferences occur to a greater extent in cross-sex dyads specifically in relation to heterosexual patients. The research data would appear to agree with Person's views as only one of the participants, Donna, referred to her experiences of erotic transference occurring in relation to female clients. The data collected would suggest that it is however very common in cross-sex dyads with the female therapist and male client. Donna described her experiences of erotic transference from female clients as being positive in nature – an intense love – idealisation of the therapist. This would concur with Person's view that women patients are more likely to exhibit open and persistent erotic transference towards the analyst regardless of their sex but such transferences focus on love rather than sex.

5.5 Resistance to the erotic transferences

Although Anne stated that she had never given any thought to the topic of erotic transference, she seemed certain however that she would name it even if she did not know what she was naming. She felt that she would pick it up, it might take her a while but she would come back to it and be able to say 'what's happening or this is what I'm feeling'. However in reality it would appear that Anne was unaware of or had a resistance to the awareness of the erotic transference with regard to two of her male clients. Both clients subsequently ceased therapy before Anne had the opportunity to work through these erotic issues with either of them. A

reasonable explanation for such an occurrence was offered by Person (1985) who indicates that erotic transference can be difficult to manage and may result in interruptions in the treatment as the client may be frightened and this could prompt the client to cease the treatment entirely. Although challenging the therapeutic relationship can provide an effective framework within which a client can acknowledge and discuss sexual feelings thereby gaining an understanding of their behaviour and emotions (Lotterman, 2013).

Jane stated that she had been contacted by a G.P. from the organisation where she worked previously asking her to take on clients who had finished therapy but who specifically wanted to see her. Jane alluded to the fact that she had experienced some kind of erotic transference with these clients and she was reluctant to see them again. This could be interpreted as the therapist's reluctance to engage with the client and a resistance to working through the erotic transference. Blum (1973) believed that even the most perverse forms of eroticised transference can be worked with if the patient has the ability to test reality (Lijtmaer, 2004). Jane also showed resistance in naming the erotic transference she experienced when working with male clients in private practice and she explained this by saying that clients may feel a sense of shame in admitting their feelings for the therapist. They may struggle in naming it for fear of abandonment or withdrawal by the therapist and the client may not want to openly discuss their feelings for the therapist because unconsciously they know they are not meant to. This data would seem to support Person's (1985) view that resistance to the awareness of the erotic transference occurs more frequently with male patients. It can be interpreted that females attain their self-identity as females because of certain interpersonal relationships whereas men attain their self-identity as males through their independence and accomplishments (Person, 1985).

Jane stated that the client's fantasy would be destroyed if the therapist was to name the erotic transference and the client would feel a sense of shame. However, this could also be interpreted as the therapist's sense of shame at being seen as a sexual object. According to Koo (2001), female therapists may feel that their role as a competent professional could be compromised if they reported being looked upon as a sexual object and society would not look upon them favourably. Koo also refers to the explanation given by Person (1985) to justify the lack of eroticised transferences in male patients that the male patient feels a sense of weakness and lack of control if he permits himself to express erotic feelings towards the female therapist which would suggest his dependency on her. Jane stated that if she was sexually attracted to one of her clients she did not feel that it would be conducive to the work and she would either cease working with the client or she would refer the client on to somebody else. Davies (1988) purports that just as Breuer ran away from the sexual feelings of Anna O. and his own sexual feelings, we as a profession have been running away from our countertransference ever since. Jane would appear to be running away from her own countertransference reactions and Davis (1998) believes that within the profession, analysts have misled themselves and their patients in an effort to minimise, pathologise or deny their sexual feelings as they emerge in the therapeutic process between the analytic couple. In view of the apparent resistance or resistance to the awareness of the erotic transference by the majority of the participants the data would appear to support this view. However, in order to manage the erotic transference the therapist must have the ability to sustain and manage their own countertransference feelings in order to make appropriate interpretations and to help the patient to moderate their sexual desire and resistance (Koo, 2001).

5.6 The Issue of Boundaries in the Erotic Transference

Kumin (1985) like Freud believes that the analyst must accept the patient's sexual desire without avoiding it or without being seduced by it and Gabbard (1994) states that it is incumbent upon the analyst to strike a balance between sympathetic identification with the patient and remaining objective to do the work. It would appear from the data research that due to a lack of boundaries, Anne may have been seduced by the sexual desires of the client who invited her to the wedding and by the client who gave her the flowers. Contrary to what Anne had previously stated; that she would pick up on the erotic transference, own it and in order to manage it she would bring it to supervision, the reality was quite different. It would appear that Anne was either unaware of the erotic transference or resistant to the awareness of the erotic transference. Unfortunately both clients ceased therapy before Anne had an opportunity to bring these issues to supervision in order to sustain these ruptures. Anne may have been unaware of the vast potential to harm the client if the erotic transference is not handled correctly however, Person (1985) points out that erotic transference can be difficult to manage and can result in interruptions in the treatment.

Freud (1915) advised the therapist to be careful not to steer away from the erotic transference, or to reject it, or to make it seem distasteful to the client but not to respond to it. Donna stressed the importance of maintaining firm boundaries in the work by; explaining to the client the nature and intensity of the therapeutic relationship, educating the client about what can happen in the work, and by bringing the client's feelings into conscious awareness without being punitive. In this way it is possible to work through any erotic issues. Schafer (1993) described erotic transference material of the patient as being a form of communication an attempt to produce something new and Donna would appear to be aware of the value of working through these transferences both for the therapist and for the client. Isolan (2005)

urges the therapist to show the reality to the patient. In relation to having erotic feelings for the client, Donna stressed that this is a natural phenomenon, there is nothing to be feared by it and in order to manage erotic transference effectively she emphasised the importance of bringing any issues/difficulties to supervision. This would concur with Colom-Timlin's (2014) view that using personal therapy, supervision and having a good understanding of the theory of attachment and psychodynamic theory together with a Rogerian perspective to therapy, would appear to be the way forward in managing erotic transference and erotic countertransference effectively (2014).

Jane inferred that depending on how strong the erotic transference was, would determine whether or not she would continue working with a client. In the interest of maintaining healthy boundaries she stated that if she felt the erotic/eroticised transference was interfering with the work and if the client was unable to engage in the therapeutic process, then she would definitely refer the client on to somebody else in the organisation or alternatively the client may require the assistance of psychiatric services.

Both Jane and Donna pointed out that if you are working as a female therapist in an organisation and the erotic transference is excessively aggressive or sexualised, there is an option to refer the client on to another therapist who may be more experienced or alternatively to refer the client on to a male therapist. This could be interpreted as the therapist being unable to contain the 'excess' or 'muchness' of the situation and this can be frightening for both the therapist and the client and the therapist may deem the situation unmanageable. Above all the therapist has a duty of care to herself and to her clients. Jane also stated that as a therapist you have a responsibility to maintain boundaries and there are other ways of working that are going to be more effective than directly naming the erotic transference particularly with clients whose egos are fragile and who may perceive the

therapist as trying to rationalise something which may seem like further rejection to them. Benjamin (2014) refers to 're-creating mutual regulation in the therapeutic space' (p. 20) in order to contain the excessive and this may be achieved by referring the client on. However, the only option that may be available to a therapist or a client if such an incident were to arise in private practice is to terminate the therapy. Contemporary analytic literature implies the analyst's interpretations alter the erotic transference and countertransference feelings into a more workable therapeutic alliance (Sherman, 2002) or that treatment may be terminated by either the therapist or the patient (Rosiello, 2000).

5.7 "Excess" or "Muchness"

Koo (2001) suggests that traditional psychoanalytic literature does not take into consideration the contribution of the analyst in the emergence of the eroticised transference and attributes the transference to a certain type of patient whose pathology is considered to be the main source. The data collected from this research study would concur with the traditional psychoanalytic literature Koo refers to in that two of the participants inferred that there is more likelihood of erotic transference occurring in the therapeutic encounter with clients who come from very damaged backgrounds or clients who have been sexually abused. Jane referred to clients she worked with in the organisation who were extremely damaged as a result of their upbringings and one client in particular who displayed symptoms of psychosis whose behaviour was very sexualised. Stein (2000) believes that sexual excitement is used to disguise overwhelming pain. Donna also described some of the clients she sees who have been sexually abused as being damaged in a way sexually, using their sexuality as a defence and because of the nature of her work clients talk a lot about sex in the sessions and this can get confused in the room. Stein (2000) suggests that sexuality has the ability to obscure one's

level of human experience so that all things take on sexual connotations (p.169) and Sandler et al. (1992) suggest that erotised transference equates to a serious distortion of reality which is indicative of patients who present with a serious condition such as borderline personality disorder or schizophrenia. The data collected would suggest that there are certain clients whose pathology is more likely to contribute to erotic/erotised transference. According to Stirzaker (2000), therapists have difficulty openly discussing erotic transference issues due to the confusion between people who have been sexually abused and those who he refers to as having experienced 'normal' transference issues in therapy. The research findings would suggest that the participants did not have difficulty in discussing erotic transference in relation to their experiences with clients who have been sexually abused or who came from damaged upbringings. This could have been interpreted by participants as a 'safe topic' whereas it would appear that the participants did have some difficulty discussing issues of erotic transference in relation to what Stirzaker (2000) terms 'normal' transferences as very little information was forthcoming with regard to their work outside the organisations they worked in and in relation to their private clients. Jill was the only participant who gave the researcher some insight into her experiences of erotic transference in her work with private clients.

5.8 Conclusion

The focus of this research study was to explore the subject of erotic transference, its emergence in the therapeutic encounter and to examine the role of the therapist in determining therapeutic outcomes. The study also focused on how gender differences can influence the erotic transference while focusing in particular on the female therapist-male client dyad and the female therapist-female client dyad. Finally, the research study explored

ways in which the erotic transference can be managed effectively in contemporary psychotherapy practice. To this end, face to face interviews were conducted with three experienced humanistic and integrative Irish psychotherapists and their responses were then subjected to a detailed qualitative analysis.

Not surprisingly the research data would appear to substantiate the view that erotic transference occurs frequently in the therapeutic encounter. However, the participants involved, all of whom were experienced psychotherapists and who had been specially trained in their field of work, demonstrated a surprising lack of awareness of erotic issues in their work. This could be interpreted as; resistance to the transference, resistance to the awareness of erotic transference or as suggested by Stirzaker (2000), due to a lack of confidence in handling erotic issues as they emerge in the therapeutic relationship. This research data would suggest that although participants received similar training, there were other variable factors at work besides the client's personality which influenced the emergence of the erotic transference. In view of the varying degrees of transferences experienced by therapists and the various types of transferences they experienced, it could be interpreted that the role of the therapist is the single most important factor in the emergence of the erotic transference in the here and now. It could also be interpreted that the therapist's and the client's sexual identities create specific transference and countertransference difficulties and resistance particularly in relation to unresolved oedipal conflicts. The data collected would suggest that there are certain clients whose pathology is more likely to contribute to erotic/eroticised transference.

Surprisingly participants did not demonstrate clear boundaries in managing erotic issues and only two of them considered the use of supervision as a resource in working through such transferences. The data would seem to suggest that the therapists did not consider personal therapy as a useful resource in working through erotic issues. One of the participants did

however display a significant degree of awareness in relation to the topic; this could be interpreted as the therapist's on-going engagement, in her own personal process in terms of the work. This therapist seemed comfortable discussing the topic of erotic transference and issues of sexuality; she was also aware of the impact of her own countertransference in the therapeutic process, the necessity for clear boundaries and she placed significant value on bringing erotic issues to supervision. It could also be said that this therapist had the confidence to trust in the therapeutic relationship as a resource in working through erotic issues. It could be interpreted therefore that regardless of therapists training and the lack of specific guidelines it is incumbent upon individual therapists to become more self-aware in terms of their own individual process, to engage in appropriate supervision and to build up an appropriate set of skills to effectively deal with erotic issues. Clear guidelines for therapists are required in terms of handling erotic issues in the therapeutic encounter and further research is required to explore this complex and multifaceted phenomenon.

Limitations

Several limitations came to the fore while carrying out this research. Firstly the fact that the researcher had real difficulty in recruiting potential participants for this research topic would appear to suggest that the topic of erotic transference still lives up to its name, of being a "taboo topic". Therefore it was difficult to recruit willing participants. Secondly, the participants who were willing to participate in this research study appeared to exhibit resistance to discussing the topic of erotic transference in relation to their private clients therefore the data collected relates to clients who were severely damaged or who were sexually abused. There is a paucity of information in the data which relates to "normal" erotic transferences. None of the data collected refers to homosexuality within the therapeutic

relationship with either homosexual therapists or homosexual clients. And lastly the data collected deals mainly with the female therapist-male client dyad and very little information is contained in the data which relates to same sex dyads.

Recommendations

Few studies have been carried out on the topic of erotic transference and countertransference particularly from a humanistic and integrative psychotherapeutic perspective, most of the research previously carried out is from a psychoanalytic perspective. In addition the research that has been carried out previously is predominantly theoretical in nature, or in the form of client case studies, or alternatively similar to the Irish research carried out by the IACP. None of the research has been done by conducting semi-structured face to face interviews therefore there is a requirement to carry out more face to face research in the format of this study in order to glean rich information on this 'taboo subject'.

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APPENDIX A

QUESTIONS

1. How many years have you been practicing as a counsellor/psychotherapist?
2. What do you understand to be the nature of erotic transference in relation to the work?
3. Could you envisage an occasion where you might avoid the topic of erotic transference and how would you manage this?
4. How would you envisage managing the therapy if you realised that your client or you were sexually attracted to one other?
5. How would you deal with the erotic transference and countertransference responses that may be evoked as a result of this?
6. Could you tell me a little bit about your experiences of a client who brought up the topic of erotic transference?
7. Could you envisage a time when you may be or have been uneasy when it has been brought up by a client?
8. How would you feel about broaching the subject of erotic transference with a client if they hadn't brought the topic up themselves but you felt it was relevant to their process?
9. Are there any circumstances in which you feel it would be inappropriate to bring up the topic and if so can you explain why this might be the case?
10. Have there ever been occasions when you reflected back and considered it may have been important to bring the topic up in therapy with a client?
11. Similarly, have you ever reflected back and considered it may not have been helpful to bring the topic up in therapy with a client?
12. Is there anything else that comes to mind for you in relation to the topic of erotic transference that I didn't ask you?

APPENDIX B

RESEARCH STUDY: AN EXPLORATION OF EROTIC TRANSFERENCE IN THE THERAPEUTIC RELATIONSHIP

INFORMATION FORM

My name is Yvonne Barnewall and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which is an exploration of erotic transference in the therapeutic relationship. I will be exploring the views of psychotherapists like you who practice psychotherapy from a humanistic, integrative and psychodynamic perspective.

What is involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, being an experienced female psychotherapist. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) _____

Signature _____

Date / /

APPENDIX C

CONSENT FORM

Protocol Title:

An exploration of Erotic Transference in the Therapeutic Encounter

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

- Yes**
 No

I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason.

- Yes**
 No

I understand that my identity will remain confidential at all times.

- Yes**
 No

I am aware of the potential risks of this research study.

- Yes** **No**

I am aware that audio recordings will be made of sessions

- Yes** **No**

I have been given a copy of the Information Leaflet and this Consent form for my records.

- Yes**
 No

Participant _____
Signature and dated

Name in block capitals

To be completed by the Principal Investigator or his nominee.

I the undersigned have taken the time to fully explain to the above participant the nature and purpose of this study in a manner that she could understand. We have discussed the risks involved, and have invited him/here to ask questions on any aspect of the study that concerned them.

Signature

Name in Block Capitals

Date

APPENDIX D

DEMOGRAPHICS

1. Name: _____

2. Date of Birth: _____ / _____ / _____

3. Duration of practice as a therapist: _____ years

4. Psychotherapy accreditation:

IACP IAHIP Other please specify

5. Psychotherapy practice location: _____

6. Psychotherapy specialisations/focus of work:

7. Education/therapy background:

8. Contact details:

9. Email: _____ **Mobile:** _____