It’s always in the room

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Date: June 2019

Submitted in partial fulfilment of the requirement of the MA Psychotherapy at Dublin Business School, School of Arts, Dublin.

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Acknowledgements

The researcher would like to thank his thesis supervisor, Dr. Siobháin O' Donnell for keeping him focused with her patience, wisdom and wit. Thanks also to my module tutor Dr. Gráinne Donohue for her gentle encouragement over the past four years. To the participants in this research who generously shared their experience and insights, I am indebted to you. To my wife Aileen and my family, without whom this adventure could not have happened, thank you. To my classmates, thank you for being there and for being you. This thesis is dedicated to the memory of my late brother, Philip Casey RIP.

Abstract

This present study explored how female therapists experience erotic transference in the therapeutic encounter. Five experienced female therapists were interviewed. Data were analysed using thematic analysis. The findings revealed that, female therapists in the main, recognise erotic transference. The present study found that the therapist's personality and experience are invaluable resources when dealing with it. Erotic transference can have an emotional impact on the therapist for whom supervision is a stabilising process. A common thread running through this research was that erotic transference enters the room regardless of the gender or sexual orientation of either the client or the therapist. This present study may have implications for therapists, supervisors and trainers who bear a responsibility, to be fully aware of the possible impact of this phenomenon.

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Chapter 1: Introduction:

1.1Background and Context:

According to Murdin and Scott (2010) unconscious processes are used by the psyche to hide its desires, from itself and others. Transference, in this view is one of the devices that facilitates this deception (p. 46). Erotic transference and erotic countertransference are terms given to the loving, sexual or erotic feelings that a client may have for their therapist and vice versa. Sigmund Freud (1915) in his paper Observations on Transference Love, was the first to raise this subject. For reasons including, shame, disgust and guilt, there is a reluctance by therapists to talk about what is referred to as erotic transference (Colom-Timlin, 2014; Krause, 2016; Ridley, 2006; Strizaker, 2000). This thesis sets out to examine why according to Pope, Speiegel and Tabachnick, (1986) 24% of female therapists have not experienced erotic transference, on at least one occasion in their careers. Pope et al, (1986) surveyed 575 psychotherapists on this issue. Results revealed that 95% of male therapists and 76% of female therapists have been sexually attracted to their clients, on at least one occasion. A minority acted upon their feelings, roughly 9%. However, 63% felt confused and guilty even though they had not transgressed the boundaries. 90% of clients who had a sexual relationship with their therapist suffered harmful effects which in some cases resulted in hospitalisation, attempted suicide and suicide (Syme cited in Proctor, 2014, p. 189). Given that contemporary therapists of whom the majority are women, are aware of ethical guidelines regarding boundaries, it is difficult to conceive that thoughts of transgressions including those of an erotic nature are not more mindful. This fuels the question as to why notions of erotic dalliance have never crossed the minds of 24% of women therapists, according to existing research. Colom-Timlin (2014) explains that the word erotic, from the Greek Eros or love, means much more than sexuality and sensual pleasure. She contends that the fuller meaning of erotic transference contains affection which is necessary

for building a therapeutic relationship (p. 19). Celenza (2010) refers to all transference as the unconscious dance which is co-created between the therapist and their client. Stefana (2017) describes to 'erotic' as a bridge concept between pleasurable at one end of the continuum and sexual at the other, which can be superimposed onto the pre-oedipal to oedipal spectrum (p. 505). The focus of this present study is not a gender-based comparison, though gender is an important factor and is addressed here, nor is it a commentary on right or wrong ways of conducting therapy. It is an exploration of the way erotic transference is recognised and experienced in the therapeutic alliance by female therapists. This present study will embrace such issues as; socialisation, perceived power, attraction, resistance, denial, defences, boundary testing, raw emotions and loving feelings. The growing awareness and acceptance of the phenomenon of erotic transference, may pose challenges for some clinicians, regarding the approaches they adopt, when these elements arise in their therapy room. While first suggested by Winnicott (1949), many contemporary therapists urge acknowledgement of erotic transference, and if deemed suitable, often use the opportunity to explore both the client's and the therapist's inner subjective feelings (Calenza, 2010; Krausz, 2016; Lijtmaer ,2004). Freud (1915) contends that, it is the therapist's role to help the client 'overcome the pleasure principle, to give up a satisfaction which lies to hand but is socially not acceptable' (p.170). Celenza (2010) treats erotic transference as a lens through which therapists monitor and explore their client's dynamics (p.176). This present study seeks to sharpen the focus of that lens.

Celenza, (2010); Kelly, (2014) and Krausz, (2016) have gone behind statistics to enquire if female therapist, are underreporting erotic feelings due to socialisation, culture, training or embarrassment. The classical position of interpreting erotic transference as resistance, defends against the therapists staying with and analysing it, which may also be an explanation for this lack of admission and reporting. The 1980s is recognised as the starting point of an acceptance and an overt awareness of this phenomenon of erotic feeling by female therapists (Mann, 2015).

This remarkable surge in interest in erotic transference in the 1980s and 1990s, then tapered off without much integration Sonne and Jochai, (2013). Excepting a handful of studies carried out over the past decade, there is scant modern research on this topic. Of the remaining body of research, few studies concentrate directly on the issue of erotic transference, with many researchers not asking critical questions. This observation informs the researcher's decision to confine this thesis to a female population, as there is a paucity of research within this cohort. An examination of the literature relating to erotic transference, including issues of supervision, boundaries, training, ethics and gender influences, provides a background for this thesis. Responses are presented from five experienced therapists to a schedule of semi-structured questions regarding their encounters with erotic transference. Using thematic analysis, themes are identified at the latent level which reveal the underlying concepts, nuances, and ideologies that inform the semantic findings (Braun and Clark, 2006, p. 84). These results are presented and discussed in chapters 4 and 5.

1.2 Aims and objectives:

Aim:

To explore female therapists' experiences of erotic transference / countertransference in the therapeutic relationship.

Objectives:

- To review existing literature on erotic transferences and related areas.
- To examine the various elements influencing erotic transferences in the therapeutic relationship.
- To examine the culture of self-disclosure and reporting regarding erotic transference.

Chapter 2. Literature review:

2.1 Introduction and overview:

The books, studies and research presented in this literature review are a representative sample of the literature pertaining to the topic of erotic transference in therapy that are available and accessible. Their publication dates demonstrate a slight swell of interest in this area over the past three decades, which appears to have waned again in recent years. A brief background to the context of transference informs the reader of the topic. Gender and its possible impact in the therapeutic relationship is raised without any conclusions being arrived at. Important aspects of therapy such as training, supervision, boundaries, erotic transference, eroticised transference and hate in the countertransference are discussed. Legacy issues, remaining from a time when male practitioners were in the majority are evident throughout this literature review. To standardise language, terms such as analyst, analysis and patient, are replaced by therapist, therapy and client in many cases throughout this literature review. Recommendations and some concluding observations round off this chapter.

2.2 Erotic transference and countertransference:

Since Freud's (1915) coining of the term 'transference love' to describe an aspect of therapy which can stem from other transferences and empathy, the subject of erotic transference has been a controversial and sometimes taboo subject. The notion of do no harm, the Hippocratic Oath and even earlier codes, are unconsciously ever-present (Pope and Vasquez, 2016 p. 225). To place this present study in context it is necessary to refer to transferences in general. May (2005) hypothesises that the empathetic process and mental telepathy, are interconnected and that mental telepathy serves as a means of transferring ideas between persons in everyday interactions, without either being aware that this psychic transference is at work. May also draws on Freud's notion that this psychic ability can be seen in action between a parent and a

child and possibly harks back to an archaic communal mind such as is evident in the insect world (p. 68-69). There is evidence that avoidance and deflection away from the taboo subject of attraction or any hint of love in the therapy room is common. Mann (2015) refers to Breuer, Jung and Ferenczi, who as therapists have struggled to work with their clients and their own powerful erotic images. Freud struggled also but held to his conviction that the erotic transference was a regressive resistance to the treatment process. The reasons for this are complex but understandable. 'The temptation to deny this universal vulnerability is viewed as effectively replicating the kind of vertical splitting or compartmentalisation that makes one vulnerable to sexual misconduct in the first place' (Celenza and Gabbard, 2003, p. 617). However, there is an acceptance that change is happening, albeit slowly, regarding attitudes to the recognition, processing and vocalising of erotic feelings manifesting in therapy. Mann (2015) notes that female therapists have only since the 1980s begun to speak out and then with emphasis on the pre-oedipal nature of their clinical observations, whereas male therapists from the beginning have been more inclined to see the phallic as well as the aggressive issues in transference and countertransference. He also notes that while female therapists have been more reluctant to discuss erotic transference than their male colleagues, they have been more positive about it, seeing it as more progressive and transformational than the typical male view of it as defensive resistance. Oelsner (2009) remarks that around the 1950s there was a shift in attitude to the constant unconscious communication between the client's fantasies and the therapist countertransference. Freudian thinking was that these rich interactions highlight the shortcomings of the therapist and entering personal analysis by the therapist was the way to prevent them. Verhaeghe (2008), in reference to transference, notes that the importance assigned to the therapist comes from elsewhere and has an ethical tone attached to it, where client fears judgement and seeks advice, approval and love. The therapist is considered the all-knowing master figure, however when this is found to not be the case, anxiety fills the void

and the never-ending search for a master figure who can supply the answers continues (p. 120). Mann (2009) posits that enactments occur in most therapeutic settings and are as a result of the unconscious resistances of the client and the therapist. The client's transference resistance confronts the therapist's resistance resulting in an observable presentation of an enactment. Failure to recognise the contribution of the therapist in an enactment is a primary cause of therapy ending badly (p. 28). Erotic countertransference (when the therapist reciprocates) is a phenomenon that is familiar to therapists and is described by Celenza (2010) as a lens used to sharpen the exploration of the client's dynamics. She refers to all countertransference including erotic countertransference, as the 'unconscious dance'. The question that she recommends each therapist should raise with their clients is, 'why can't we be lovers'? (p. 177). This is not a request for a liaison but rather a cautionary check as to the reasons why the 'liaison' cannot happen. A client falling in love with the therapist can be mistaken for narcissistic appreciation. However, it is part of the dynamics of the intersubjective process of transference and countertransference, which is usually a repetition of the unresolved relationship to their early caregivers. The client tries to fulfil a transference fantasy and turn the therapist into an ideal object ignoring any faults (Stefana, 2017, P. 506). Current thinking in intersubjectivity and relational schools of therapy is that the clients will find a place for their issues in the therapist's 'blind spot'. This unconscious interaction happens in the transference and countertransference. The client's problems will be given a voice in line with what the therapist is experiencing in their own lives. The resulting interaction is unwitting participation, where the therapist and the client find expression in the others' difficulties. Enactment of trauma often occurs but difficulties arise when the client represents something significant in the therapist's countertransference (Mann, 2009, p. 8). The 1990s has become known as the 'decade of the brain' as more attention was paid to the influence, interactions development of the child's primary caregiver's right brain to the child's right brain in attachment is critical. Schore and

Schore (2008) who refer to the right brain as the 'neurobiological core of the human unconscious' concur with Bowlby's attachment template that is formed in childhood will determine life's outcomes. Advances in neurobiological research have validated this stance. They maintain that the therapist's ability to regulate the client's arousal in the transference / countertransference is crucial to the effectiveness of the work. By creating positive states of arousal to counter negative arousal the therapist reconnects the client with his/her attachment security (P. 12). However, Stirzaker (2000) posits that therapists are aware of erotic transference, but many choose to ignore it (p. 198).

2.3 Gender:

Celenza and Gabbard (2003) state that between them they have treated, supervised, evaluated, and consulted with over two hundred therapists who have engaged in sexual misconduct, (p. 618). Slightly less than twenty percent of these cases are females who equally fit along the continuum from lovesickness to masochistic surrender. They overidentify with the client's suffering which results in ill-judged treatment attempts but most of these females will only violate boundaries with one client. They noted that female therapists are as likely to transgress with a female as a male client. The rate of success in treatment for female transgressing therapists is good, since predatory psychopathy is rare among women (p. 630).

In a study of Irish therapists, Colom-Timlin (2014) found that there was no gender difference in disclosure to a peer or a supervisor regarding attraction for a client. However, when reporting such attractions was considered, the gender breakdown concurred with the original findings of Pope et al, (1986). Kelly (2014) disagrees by suggesting that women therapists are socialised to resist even the notion of discussing any instance of erotic signals from a client, even when this conversation is part of supervision. She noted that there is a different 'emotional charge' between her male supervisees and her female supervisees, regarding feelings of attraction in

the therapeutic relationship. She asked if female therapists' experience erotic feelings less towards their clients or are they underreporting them due to socialisation or embarrassment. She cites many instances of male supervisors seeking advice on how to broach the subject of erotic transference with female supervisees since previous attempts to discuss this topic were met with disgust and rebuttal (p. 136). Carlson (1981) warns female therapists not to contribute to the stereotyping of traditional sex roles. She contends that women have embraced these changes by broadening their networks, while males have become more resistant to seeking help or intimacy because of the fear of losing their 'strong superman identity' (p. 228). According to Gornick (1986) this stereotype is that of a male therapist / magician like persona with limitless powers to 'save and subdue mutable womanhood'. She explores the possible gender related issues, intimacy and erotic transference that occur when the woman has the authority in the female therapist male client dyad. Person (1985) suggests that some male clients equate sex with power and in order to castrate their therapist they desexualise her in their own minds thereby dehumanising her. Schaverien (2004) suggests that male clients who end therapy too soon do so because of a fear of intimacy, idealising or denigrating the therapist. This can be assisted by the female therapist's pre-occupation with maternal role play as a defence against erotic countertransference. Refusal to connect with oedipal desires compounds the client's feelings of being denigrated (p. 9). Celenza (2014) identifies intense, erotic feelings connected with early maternal fantasies, that emerge in therapy, as representing a struggle to be receptive to feelings associated to femininity. These wishes pose a challenge for both therapist and client, but they are not at the intense shaming level of oedipal desires. There is a fear of disappearing into the mother's body causing psychic annihilation or losing nominal gender identity. Males use aggressive thoughts to fuel their erotic feelings for a woman which carry with them vulnerability and fear of emasculation. Female core gender identity is not threatened by merger with the mother's body, as they rarely display the erotic terror seen in males (p. 44-48).

However, are we turning a blind eye? Mann (2015) reminds us that blindness as a protection is common in the psychoanalytic Greek myth of Oedipus. He blinds himself in order not to see his done deeds and Tiresias is blinded by the goddess Hera, as punishment for seeing two copulating snakes. In the Oedipus story Jocasta, his mother is the perpetrator. Mann (2015) suggests that psychoanalytic thinking on transference is now shifting its focus from erotic transference, to transference that is mothering. Two thirds of female therapists who violate boundaries, engage in sexual activity with female clients. Many of these therapists had not previously identified as gay. By way of understanding, we must look at the pre-oedipal mother who is the embodiment of wonder, love and bliss. However, in her negative side, the erotic pre-oedipal mother is terrifying and embodies loss of self-identity and being consumed. She evokes exciting fantasies, fear of the female predator, seductive and breaking the incest taboo (p. 139).

Lijtmaer (2004) in a case study cites the viewpoints of Karme (1979) and Koo (2001) that the female therapist's gender can be a determining factor in the transference at the oedipal level and stimulates the male's sexual longings. Her male client was at the midlife stage, during which it is not unusual to seek confirmation of attractiveness and sexual vitality. Having described himself as a 'nerd' in his adolescence, he needed a companion to now share his new-found interests. His notion was that his therapist was the person who fuelled the erotic transference. The unresolved Oedipus complex leaves a process of containing and enhancing, which helps with the enjoyment of one's sexual subjectivity, despite the obstacles in different situations (p. 494). Strizaker, (2000) discusses how the resolution of the psychosexual phase known as the oedipal drama effects the therapeutic situation. This taking of a sexual position, either that of the mother or the father, is decided by the three years old boy or girl which is later re-enacted in therapy by the adult client (p.197). Person (1985) using the four main dyadic therapy configurations to demonstrate gender influences on erotic transference in the

therapeutic relationship, found that female clients are more open and show more sustained erotic transference towards their therapist, regardless of the therapist's gender, than male clients. The snap shots given in this literature review, suggest that there are many informing factors in the explanation and understanding of erotic transferences.

2.4 Training, Supervision and Boundaries:

Literature discussing erotic transference and countertransference in recent times, has focused mostly on the risk of boundary violations by male therapists (Celenza and Gabbard, 2003). Krausz (2016) notes that female therapists, who are less reported to be susceptible to erotic enactments, have led the charge over the last fifteen years in producing publications on new ways of conceptualising erotic experiences in therapy (p. 25). Feminist, humanistic, and existential orientations view the tearing down of artificial and rigid boundaries as essential for therapeutic effectiveness and healing (Zur, 2004). Pope and Spiegel (2008) present typical ethical dilemmas to advise therapists that there is a difference between boundary crossing and boundary violation. Context, (society, culture, era) are an influencing factor in deciding if a boundary has been breached. What is frowned upon in one set of circumstances, is tolerated in another. Celenza and Gabbard (2003) refer to reciprocated acts of attraction by therapists as transgressions. They attribute cause to the situational context of the therapeutic alliance. Personality characteristics, vulnerabilities and defensive styles of the therapist, fuels the transference-countertransference interactions of the therapeutic dyad (p. 623). They urge regular consultation with colleagues early in the process to prevent attraction becoming a disaster.

Pope et al, (1986) suggest that therapists in training be provided with a safe space to declare, explore and talk about feelings of sexual attraction without the fear of rejection from their teachers. They contend that learning is unlikely to happen if these feelings are treated as if they

are an indicator of a defect in a therapist. Educators must display the same openness concerning attraction for their students and clients as they expect those students to emulate in their careers (p. 157). Ridely (2006) declares that, it is okay for a therapist not to know what is happening for the client and to allow themselves to explore the client's feelings as real for him/her without responding from the therapist's own perspective. Accepting and exploring what is happening internally can become a rich source of knowledge within which he/she can explore his/her own and the client's fears or vulnerabilities. Self-awareness and active listening skills are gained over a lifetime within the intersubjective experience (p. 325). Ridley (2006) states that it is essential that psychosexual therapy training explores trainees' feeling responses to clients. This subject can evoke feelings of shame and disgust or thoughts that it is naughty or forbidden, to discuss clients' intimate details. She raises the uncomfortable notion that sexual arousal in the therapist occurs during psychotherapy. These spontaneous sensual stirrings can be alarming in the context of the professional relationship. The danger for therapy is, that the client's needs will suffer because the therapist is side-tracked by her/his own inner subjective feelings. The client will pick up on these hesitations and uncertainties in the therapist and feel rejected and isolated (p. 327).

Krausz, (2016) contends that a therapist's failure to recognise that an erotic fantasy comes from the client and not from within himself/herself, will cause him/her to ignore it. This probably results from not having these feelings dealt with previously in his/her personal therapy. Krausz believes that a lighter approach to the analysis of erotic transference, especially in training, needs to be implemented (p. 35). Stirzaker (2000) concurs and adds that supervision is of equal importance adding that therapists often suppress their own feelings in the countertransference by choosing to ignore them. Sharing some of her own experience, she sometimes recognises erotic transference but decides not to bring it into the session unless she feels that the client is willing to deal with it. However, Stirzaker (2000) suggests that it is much easier to discuss

erotic feelings with a client when they are related to past events. By linking the client's desires for their therapist to early oedipal relationships, normalises these feelings but does not belittle them. This approach allows the client to be more open and reduces anxiety. She advises that without a proper combination of training and supervision, attempts at dealing with countertransference can be more damaging than ignoring them (p. 211). Celenza and Gabbard (2003) encourage supervisors to focus on the supervisee's blind spots regarding boundary issues. They contend that one of the main aims of supervision should be the monitoring of boundaries and misconduct. Attention must be paid to heightening the transgressor's ability to identify, tolerate, and manage countertransference hate and anger (p. 632). Krausz (2016) notes that while boundary violations are the main risk for male therapists, while the female therapist's pitfall is avoidance and dissociation of erotic experiences in the clinical setting with a male client. This sometimes is the cause of the therapy being ended by the client. Female therapists are now starting to address this issue openly (p. 25).

Training and supervision present opportunities to address some of the situational factors and the initiation contexts highlighted by Sonne and Jochai (2013). These permutations include, therapists and clients' experiences of sexual feelings for each other or, the impact of one member of the dyad introducing erotic feeling. Also, to be considered is the influence of personality types who fuel attraction and the reporting of these transgressions. The therapists' behavioural and emotional reactions in these situations and how therapists perceive that their actions will affect the therapeutic process. Uncomfortable reactions to the issue of love in the therapeutic alliance is delineated by Krausz (2016) who recalls her own early therapy and the opportunities to explore her feelings that were squandered by her male therapist. She felt shame and humiliation when she voiced her attraction towards her therapist who defensively asked her 'do you always sexualise everything?' (p. 27). Using the analogy of the oedipal son's desire to marry his mother, she contends that therapists must acknowledge the erotic transference.

Stern (as cited in Krause, 2003) believes that disrupting the illusion of erotic transference by inserting a parameter is done by the therapist to cover inability or unwillingness to deal with it. He refers to the boundary creation as a lifeboat in a sea of affective turbulence for the therapist. Something is missing here. Krausz (2003) recalls beg given advice by a senior therapist who contended that even listening to the client elaborating on her attraction to the therapist, constitutes a subjectively experienced enactment of the erotic countertransference. He felt that the only option in such a case would be to cease the therapy. Much of the literature on erotic countertransference has suggested that erotic feelings have been equated with erotic actions and needed thus to be banished from the treatment (p. 28). Rodolfa et al, (as cited in Giovazolias and Davis, 2001) found that forty eight percent of the 386 respondents to a study concerning the management of therapists' sexual feelings towards clients, agreed that sexual attraction had helped the psychotherapy process in some instances. However, according to Pope, Sonne, and Holroyd (cited in Goodyear and Shumate, 1993) sexual feelings in therapy were met with a mix of emotions such as surprise, shock, guilt, anxiety, fear of losing control, fear of being criticised and confusion about boundaries. They suggest that this distress may result from a lack of acceptance of these feelings or skills in the management of them (p. 282).

2.5 Eroticised Transference:

Another phenomenon that manifests in therapy and can be confusing for therapists, is termed eroticised transference. Blum (1973) defines eroticised transference as 'an intense, vivid, irrational erotic preoccupation with the therapist, characterised by overt, seemingly ego-syntonic demands for love and sexual fulfilment from the therapist' (p. 63). Koo (2001) believes that regarding eroticised transference female therapists feel undervalued and

undermined, by being treated as sex objects. Whereas male therapists, due to social and gender issues, feel more at ease reporting and discussing eroticised transference. Person (1985) makes the distinction between erotic and eroticised transference. She believes that cases of eroticised transference in the male client/female therapist dyad occurs more frequently than has been reported. She explored how masculinity and femininity are constructed in the context of cultural factors, object relations and the asymmetric structures of the oedipal complex. Person (1985) observes that erotic transferences in male clients occur more frequently in those with strong bisexual identities or homosexual conflicts, and that the transference may serve as a defence against a threatening homosexual longing. This may be the client communicating some difficult piece to the therapist who bears some resemblance to a childhood object and can be seen by the client as a 'sex symbol'. The client is willing to exchange symptoms for an eroticised transference cure which evades the analytic work and discomfort in resolving infantile conflicts. Blum (1973) contends that, as falling in love is not necessary for success in therapy, neither is eroticised transference a sign of failure. Eroticised transference should be evaluated in the context of the client's total personality, including autonomous strengths and potential resources. Blum (1973) suggests that eroticised transference defends against many unconscious conflicts and is derived from many sources. These can include sexual seduction in childhood, instinctual overstimulation with deprivation of parental phase appropriate protection and support, intense masturbatory conflict, family tolerance of incestuous or homosexual behaviour and revival and repetition of precocious and sexual activity in adolescence.

2.6 Hate in the countertransference:

Celenza (1995) posits that hatred and anger towards clients is seen as a normal aspect of therapy. She contends that there is a language around countertransference hate in the literature but none for countertransference love, as any suggestion of love is treated with suspicion. She

also points to possible confusion between countertransference love and the warm positive feelings associated with the therapeutic alliance. Empathy and the therapist's need to have their competence validated can also cause confusion. Epstein (cited in Celenza, 1995) notes how a therapist's loving or neutral responses to a client's hostility can be experienced as confusing or seductive for those with mistrust issues or fragile egos. It compounds a sense of helplessness, in that not only do these clients fail to make others love them, they also fail in making others hate them. This reaction by the therapist is inauthentic and hypocritical as nature and congruence demand that the therapist is impacted by hurtful comments. It is easy to experience confusion between transference manifestations and the appreciation of the comforting and nurturant holding that comprises the therapeutic context. (P.304). Winnicott (1949) observes that however much the therapist loves their clients, hating and fearing them cannot be avoided also. The more this is understood the less fear and hate will motivate the approach they take with their clients (p. 350). Murdin and Scott (2010) regarding hate, make the analogy to a wound that will not heal unless it is exposed. Clients will project hate towards their therapist, so they do not have to revisit experiences from their past. Lacan's neologism l'hainamoration is a combination of hatred, love and admiration, to reflect the narcissistic aspects of being in love. Like 'mirror, mirror on the wall' we love and hate ourselves in the reflection of the other. The most powerful aphrodisiac is when someone declares their love for us. Could this be the irresistible bait that therapists find too difficult to resist? In Seminar XVIII Lacan coined a phrase which sums up the notion of desire. He declares, "I desire you" means, "I implicate you in my fundamental fantasy" as object (a), my unattainable object of desire, le petit autre. Verhaeghe (1999) declares that the definition of love can be found in the relationship between a mother and a child. (p. 36). However, Lacan's famous quotation from Seminar VIII "Love is giving something you don't have' describes the overbearing attempts by people to satisfy their

lover and re-enacts the oedipal need to be everything for their love object, mother or father (Bailly, 2013).

2.7 Observations and Recommendations:

Celenza and Gabbard (2003) recommend that the transgressing therapist returns to personal therapy and explores the myriad of complex factors that go into sexual misconduct and boundary violation. But they noted that fear of sanction by governing bodies is a barrier to self-reporting and can compromise treatment. Winnicott (1949) posits that only by dealing with their most primitive feelings by being in their own therapy can a clinician treat another person. In the case of psychotic patients, it is necessary for therapists to have reached down to the very primitive things in themselves, as the answer to many problems of psychoanalytic practice lies in the continued analysis of the analyst (p. 350).

Krausz (2016), embracing the ideas of Elise (2002) and Kulish (2011), suggest, that the countertransference could become a useful tool in the therapeutic endeavour rather than the hindrance as Freud categorised it. This can be achieved by extending the two-person model to a three-person model conceptualising erotic transference and erotic countertransference as a triangulation, whereby a third notional person is introduced. This technique facilitates the theoretical validation with which therapists can tolerate enactments which are expressed through fantasy and feelings. By using an intersubjective clinical approach, the therapist may explore both their own and the client's erotic feelings. There is an acceptance that this common and therapeutic interaction evokes something in both their developmental pasts (p. 28).

Pope (2001) refers to research that shows the brain and hormone differences which exist between males and females. Averagely, female brains are smaller than those of males, which was interpreted as an indicator of lower intelligence in the past. For example, the corpus collosum, the band of neural fibres that connects the hemispheres of the brain, is thicker in

women, which contributes to an enhanced lateral organisation in their representation of cognitive function. When animal studies revealed that reducing oestrogen levels caused a lowering of function in cognitive ability, it was suggested that this hormone gave an advantage to women in completing many tasks. Even though there are differences between the sexes in many areas, Pope (2001) points out that more similarities than differences exist, but research tends to ignore this fact (p. 974). Kaplan (cited in Ridley, 2009, p. 105) brings attention to what she terms the 'wider psychic matrix, of which sexuality is an integral and beautiful part'. Celenza and Gabbard (2003) posed a related query as to how different transgressors are, from the average therapist. They reflect that a typical reaction when a hearing that a colleague has falling from grace, is to declare that they can't imagine how that could ever happen to them. However, they add the caveat that we all bear some characteristics in common with those who have fallen from grace (633).

2.8. Summary:

The current literature relevant to the subject of erotic transference, raises issues of training, supervision, self-report, and the preparedness of therapists to hold the client's transferences. There is a consensus that unless therapists address their own erotic feelings, they will not be able to help their clients deal with theirs. It is hoped that the present study will inform the available literature in the field of erotic transference.

Chapter 3. Methodology:

3.1 Introduction and Methodological approach:

This present study seeks to examine how female therapists experience erotic transference in the therapeutic alliance. The main aim of this chapter is to describe the methodology used in the carrying out of this research project. The research design, sample of participants, method of recruitment and the mode of enquiry are outlined. The collection and analysis of the data are examined, and ethical issues are discussed.

3.2 Rationale for Qualitative Approach:

A Qualitative research design was chosen for this present study because of the sensitive nature of this topic. In-depth investigation of personal and intimate experience is such an integral aspect of this type of enquiry, that other research designs are not appropriate. Curry, Nembhard and Bradley (2009) contend that qualitative research explores complex social processes and captures the essence of a phenomenon from the perspective of the respondent. In this process, values, beliefs and motivations that underlie the individual's behaviours are uncovered. This is achieved by researchers with the ability to establish rapport with participants, use flexible guidelines and follow-up probing questions that draw out responses (pp. 1442/1445). Curry et al, (2009) declare that qualitative research occurs in natural settings, using open-ended discussions and observations, to produce text-based data. To justify choosing the qualitative over the quantitative method of research, they borrow physicist Albert Einstein's quip that, 'not everything that can be counted counts and not everything that counts, can be counted'. Qualitative thematic analysis was chosen as the method to analyse this data.

3.3 Thematic Analysis:

Braun and Clarke (2006) define thematic analysis as a useful and flexible method for identifying, analysing and reporting patterns or themes within data, in qualitative research. Researcher bias and giving voice to the participants, must be guarded against, to allow the participants' contributions to emerge. Giving voice is an approach where the participants are guided by the researcher to provide unacknowledged pieces of narrative evidence. This inductive or bottom up analysis tries to gain an understanding of the phenomenon in question by understanding the participants' experiences of reality. The data is coded without trying to fit it into the researcher's pre-conceived analytical notions. However, Braun and Clarke (2006) add the caveat that, while researchers make every attempt to be neutral, they cannot live in a theoretical and epistemological vacuum. McLeod (2014) refers to this subjectivity, personal interest and flavouring of the data by the researcher as, reflexivity. Clarke, Braun and Hayfield (2015) contend that analysis is always shaped by the researcher's theoretical assumptions, prior experience and personal standpoints. It is the aim of thematic analysis to stay as close as possible to the meanings in the data (p. 225).

3.4 Sample:

Due to the relatively small amount of research available regarding erotic transference in the therapeutic encounter, and even fewer studies focusing on female therapists, it was decided to confine the present study to a female therapist cohort. A purposive sample of five female participants who are humanistic, integrative psychotherapists in orientation were sought for interview. The research therefore excluded male therapists and female therapists that were not humanistic, integrative in orientation. The inclusion criteria required that they had completed a minimum of three years in this field post qualification, which equates to at least five years actively working as psychotherapists. The reason for this criterion was that experienced

participants would ensure the present study's validity. A classified advertisement was place on the Irish Association of Humanistic Integrative Psychotherapists (IAHIP) members' website, requesting volunteers who fitted the criteria to partake in the research interviews. This method of recruitment failed to provide enough volunteers who satisfied the criteria. The researcher extended the invitation to therapy centres to secure the remaining suitable participant (Appendix 4.). No dyadic configuration criteria were set, as it was the experience of the transference and not its source that was being explored. The five participants were allocated pseudonyms and were additionally coded in the original transcripts to ensure anonymity.

3.5 Overview of Participants:

Participants are anonymised by pseudonyms in Table 1. below.

Table 1. Participant's Details

Pseudonym	Gender Age Range	Years of Experience	Accreditation Body	Orientation
Orla	Female 60-69	34	IAHIP[1] IAPTP[2]	Humanistic Integrative
Izzy	Female 50-59	31	IAHIP ICP[3]	Humanistic Integrative
Thelma	Female 50-59	25	IAHIP IACP[4]	Humanistic Integrative
Vickey	Female 40-49	20	IAHIP IACP	Humanistic Integrative
May	Female 60-69	25	IAHIP ICP	Humanistic Integrative

[1] Irish Association of Humanistic Integrative Psychotherapists
[2] Irish Association of Play Therapy and Psychotherapy
[3] Irish Council for Psychotherapy
[4] Irish Association for Counselling and Psychotherapy

3.6 Data Collection: Semi-Structured Interviewing:

The participants in this present study were made aware that the face to face interviews that they had agreed to take part in, would be audio recorded. A list of eleven guide questions with additional probing and follow on questions was prepared in advance (Appendix 3.). To achieve the best coverage of the topic, the researcher invited colleagues to review and suggest modifications to the questions if required. A pilot interview with an experienced colleague was carried out, which allowed for the refinement of some areas of enquiry and interviewing procedure. In addition to the above steps, the advice of class tutor and thesis supervisor informed the final selection of open-ended questions. It was decided to leave the demographic questions, concerning age, gender and experience until the main interview was completed. The pilot interviewee on the researcher's invitation, put herself in the place of other participants, to second guess alternative answers or to allow her scope to answer some questions truthfully (McLeod, 2014, p. 150). It became evident that the sequence of questions could not be adhered to, as the participant's answers would lead organically into a question that was not next in line. Since the content of some of the answers was so rich and revealed unexpected areas of the research, it was sometimes deemed unnecessary to ask all the questions listed (Smith and Osborne, 2015, P. 36). McLeod (2014) advises that in addition to observing time boundaries and monitoring distress levels in relation to sensitive topics, it is useful to invite the participant to add anything that they feel would enhance the study. Immediately following the interview, field notes were jotted down, which captured the nonverbal and nuanced reactions of both the participant and the researcher to certain content within the interview.

3.7 Data Analysis:

McLeod (2003) advises that the researcher, at the planning stages of the study, needs to decide on the method of analysis before the collection of data begins. If in a qualitative study, the

sample size is big, this may present time and practical difficulties in transcribing and analysing each case in depth. In qualitative studies, the researcher will often analyse the data as it is gathered. This strategy allows for tweaking the questions for future interviews, in line with the responses of earlier participants. McLeod (2003) recommends close examination of previous published studies on the same topic as the present study, to learn how the data issues were dealt with (p. 36). The analogy of peeling back the layers of an onion and then re-assembling them again, is used by Cresswell and Cresswell (2018) to explain the process of making sense of the text data analysis in qualitative research. Using a Microsoft Word document, the audio recorded interviews were transcribed verbatim by the researcher. The next stage was to identify the essence of this body of narrative from which repetitive descriptions were emerging. These patterns were categorised, leading to the identification of sub-themes and main themes (Appendix 5.). The three main themes which emerged were:

Theme A. The impact of erotic transference, and circumstances around its surfacing in the therapeutic relationship.

Theme B. Therapists' hankerings after past clients, where naming erotic transference tested boundaries.

Theme C. Does supervision fill the void left by the lack of training around erotic transference?

3.8 Ethical Issues:

Prior to the commencement of this present study, approval was granted by the ethics board of Dublin Business School, in August 2018. Participants have been furnished with a consent form (Appendix 1.) and an information sheet (Appendix 2.) to allow them to give informed consent. Copies of these documents, which were signed by both the participants and the researcher, were retained by the participants. They contain an overview of the research topic and advise participants of their right to withdraw from the present study at any point. Talking about erotic

transference can evoke sensitive feelings and emotions, accordingly participants' attention was drawn to this prospect. The researcher gave a verbal explanation of the present study's requirements and assured participants of the safety and anonymity of their contributions and personal details. Pseudonyms where used to de-identify participants. As a data controller, the personal details of the participants in this present study are held, in line with the mandatory practice laid out the General Data Protection Rights (GDPR) Act 2018. Participants were also made aware that face to face interviews were being audio recorded and that these recordings along with transcribed notes were coded and were securely kept in adherence with Dublin Business School's ethical procedures. Participants have signed a consent form which outlines that they have been informed of the subject matter, research design, rights as participants and potential risks to them by partaking in the present study. Participants were invited to contact the researcher or the module tutor, should any queries arise later.

3.9 Summary:

The essence of this subject suits a qualitative research design. Eisner (cited in Smith, 2018) states that qualitative research 'relies on the capacity to evoke imaginative experience and reveal new meaning' (p.260). The data collection is done in a manner where the researcher uses his/her skills in a way that reflects a psychotherapy session, drilling down to the meaning in the responses, both spoken and felt. The inclusion criteria for the selection of participants insured that participants were experienced in this aspect of therapy. The connection between the participant and the interviewer works best when the rapport is good. In some way, there is mirroring happening within the research interview, similar to the way that erotic feelings in the therapeutic encounter can be transferred between the members of the dyad. Thematic analysis was selected as a mode of analysis for the data in this present study. This allows the nuances and tones of feeling to be coded, themed and distilled to arrive at findings which can be presented in a scientific report that carries validity and credibility.

Chapter 4. Findings:

4.1. Introduction:

This thesis sets out to examine psychotherapeutically female therapists' experiences of erotic transference'. In this chapter the findings of the semi-structured interviews on which this present study is based, are presented. The participants in this present study have an average of twenty six years of experience in the field of psychotherapy. They are all accredited by The Irish Association of Humanistic Integrative Psychotherapists (IAHIP) and at least one other governing body as detailed in Table 1. above. All five participants are qualified supervisors and are currently employed as tutors in various teaching institutions. Their main orientation is humanistic integrative. Excerpts of interviews presented in the following vignettes, are verbatim.

4.2. Main themes identified using thematic analysis:

Several themes emerged from the data collected. The main themes concerned therapists' awareness of erotic transference, holding a special place for these clients and issues around training and supervision. Theme A looked at the impact and the shock/surprise that the occurrence of erotic transference can inflict on an unsuspecting therapist. Theme B dealt with the human, caring side to psychotherapy where a fondness for past, sometimes troublesome clients still exists. Theme C discussed how supervision and training are integral to each other and inherent in this debate is the question is training ever enough. The three main themes which form the basis of the research findings, are set out in Table 2. below.

4.3 Table 2. Superordinate Themes:

Superordinate Themes		
Theme A	**Theme B**	**Theme C**
The impact of erotic transference and circumstances around its surfacing in the therapeutic relationship.	Therapists' hankerings for past clients, where naming erotic transference tested boundaries.	Does supervision fill the void left by the lack of training around erotic transference?
Subordinate Themes		
Boundary Testing Uneasy Shame Thrown by erotic transference Scaring Uneasy Exploring may involve naming it It is always in the room?	Real connection Regard for client Uneasy feelings remain after therapy has ended. Preference for males Fondness mixed with regret The child comes into the room.	Need for supervision Poor training Don't bring it to supervision Trained myself Trust the process Don't be looking for trouble. Anxiety

4.4. Theme A:

The impact of erotic transference and circumstances around its surfacing in the therapeutic relationship.

A common theme across all five participants was uncertainty around identifying and managing erotic feelings, when they arise in the therapy room, for either the client or the therapist. Four participants were clear that for them training in this area was virtually non-existent, the remaining participant while she did have some training, was caught off guard when she experienced this aspect of the therapeutic relationship for the first time. All the participants were aware of the taboo surrounding this topic during their training, their practice as therapists and still to this day. The researcher enquired of all participants about their early experiences of becoming aware of erotic transference. The cohort of participants in this present study, were trained mainly in the 1980s and 1990s, when an awareness of this phenomenon and a need for research in this field was beginning to emerge. The following five vignettes recount the initial recollections of erotic transference of each participant. They referred to body sensations or feelings that are sensed, but it was seldom verbalised.

> ***Orla:*** *'It was a kind of disrespectable to be talking about these things when I was training. Not just erotic transference, but any, body sensations you got, sadness or anything. It was a woman, that sex had come into the room somehow because, I was picking up the body sensations. She was very distressed, a great deal of sexual distress. I remember ringing four supervisors. There was rape and all kinds of things in the mess. I think she had worked as a prostitute. She told me that night that she could switch attraction on for a woman, man, it didn't matter.'*

Orla declared that she had a long process with this woman *'after I calmed down'* and she became therapist to many working girls, when word went around.

> ***Izzy****: 'Look it, sexuality is always in the room, but my ego was telling me it would never affect me you know, but it did, and I did feel that it interfered with the work while it was live. It's shaming, I found it. It's like a teenage blush came on me, out of the blue. I liken it now to menopause when a hot flush comes over you. It's like oh my God, can he see it'?*

Izzy described males and females that exhibited erotic transference towards her but focused on a male client for whom she had a countertransference. She became red in the face as she recalled the following memory.

> ***Izzy:*** *'A beautiful looking man in his mid-40s, we had a very good working alliance and I was seeing him for about two years. During that time what I caught in myself, that there were moments when I lost contact with the client and I was managing like an internal blushing. I had no erotic fantasy thoughts or anything like that, but I had a physiological response'.*

> ***Thelma:*** *'I would have went running to my supervisor (laughter) in panic stations and would have been maybe a bit thrown by it, way back twenty five years ago. I can still remember one or two clients that I kind of thought oh, I'm not sure if I can continue working with this person, purely because of my em… discomfort with picking up on the erotic transference. Thankfully now that isn't an issue'.*

Thelma added.

> ***Thelma:*** *'I rarely find that it needs to be named or that it needs to be verbalised. Actually… it's more about my comfort with holding it, (laughter) not withholding, containing it. It's like a process, it just works it's way, it sort of has a natural beginning middle and an end and it's me. Yes, all I need to do is just hold it. I found out it's a bit like a cycle, that just needs to happen'.*

Four of the participants alluded to the observation that men expressed erotic transference more explicitly than women, Vickey raised this issue by saying.

> ***Vickey****: 'Em… I would have sensed it with certain women and females and yet it wasn't explicit, and it wasn't something that I could ever put my finger on. It was all just a feeling I got with them… It felt much more obvious to me when it was a male client. The client would never explicitly say, I'm in love with you or I have fantasies about you or that I am sexually attracted to you, they'd never say that and yet I could feel it, It's in the room'.*

Vickey continued.

> ***Vickey:*** *'I'm not surprised that it comes in with male and female regardless of what sex the therapist is because, this is an unresolved piece for a client. So, they'll make us whoever they need to make us to be in the transference. So, it can be a straight client, gay, transgender male or female, it actually doesn't matter'.*

May agreed saying.

> ***May:*** *'A client has never declared it to me. It has not overtly been in the room. I think this psychic guy, a supervisee, was a bit flirty. He had this extra power and he knew I was interested'.*

May continued.

> ***May:*** *'I'd have little flashes of 'Jesus… he's very nice isn't he or something, you know. And ah, because of the trust and the intimacy there is little flashes of another boundary that comes into the room. So, that's the one where I do notice it. 'God, he's a bit of alright, isn't he? particularly if he has been on the boat all weekend and he's all rugged and muscly. I haven't told anybody else before'.*

The researcher is intrigued by some of May's comments. Displaying a broadminded approach to life in general, she doesn't appear to have noticed erotic transference in the same way as the other participants have. It seems that she takes flirting and flattery in her stride, treating it as a currency to smooth out relationships, regardless of whether she is giving or taking it. May asks, *'could it be that the therapist's perceptions, influence the phenomenon of erotic transference'?*

Thelma also puts forward this hypothesis.

> ***Thelma:*** *'I mean some of the things that will happen with the clients…would that have happened with another therapist, is it my openness'? I would worry about experienced therapists who have never experienced erotic transference or countertransference. That might suggest that they are blocked to sexuality in general'.*

Orla concurs.

Orla: *'Unless, the therapist is able to accept the feelings, the client's sympathetic will get panicked and shut down, they won't bring it'.*

May's view is.

> ***May:*** *'You never bring it into full awareness. I have…what it would be like to be sexually attracted to them or to be in bed with them? These are the little musing you have when you're sitting there'. The best therapists love their clients I think it's all about that, then with love comes the necessity for boundaries'.*

4.5. Theme B:

Therapists' hankerings for past clients, where naming erotic transference tested boundaries.

The participants in this present study, recall clients who have been the source of stress for them. However, the therapists do not hold grudges or ill feelings towards these past clients, whose unreasonable behaviour included stalking, threats and amorous unwanted advances. Some of these cases go back many years and are clearly and fondly remembered by the therapists, though some are recalled with tinges of sadness and guilt. A common theme in these examples is the abrupt ending of the therapy by the client when the erotic transference is named.

Orla recounted many examples which demonstrated the respect that she has for past clients who just '*needed someone to mind them'*.

> ***Orla:*** *'There was a male client who wanted a relationship with me. He had stopped working on his own stuff. I felt guilty having sent that man to someone else. It had just become this battle between us, he wanted to hug me, sit beside me, kiss me and he wanted to use the bean bags. I refused his flowers and chocolates'.*

The researcher sensed Orla's regret that she had not tried harder to work through this situation with him. However, she reported that she was scared and had to disguise her route home, in case he found out where she lived.

Thelma had experienced eroticised transference, from both males and females. She recalled that she sometimes had concerns for her safety, where she was threatened or followed. Despite these difficulties, she displayed regard for the following clients.

> ***Thelma:*** *'There was one female client who ended it, because she couldn't handle staying with the feelings, she had for me. Em… that was one of the more difficult ones because, in different sort of social settings, where we bumped into each other, she would follow me into the bathroom'.*

Thelma continued.

> ***Thelma:*** *'There were male clients, where they were disclosing in the sessions more their fantasies around, raping me and again that was very tough work with my supervisor. One man…we continued to work together for years afterwards. It was very*

> *positive but…he had a lot of misogyny. He felt safe to verbalise it without fear of rejection. It was probably his first positive relationship with a woman. I used to feel you know…somewhat violated'.*

Vickey, has gained experience of erotic and eroticised encounters, from her eighteen years as a therapist. She fondly recalls a male client whose wife lost a baby and he had feelings of guilt because he had not wanted her to get pregnant.

> ***Vickey:*** *'this was an erotic piece, it was his way of pulling me in, he was struggling in his marriage, so I became almost the idealised woman. I named it and I felt we had worked through it with him and then he suddenly stopped coming. I'm never quite sure if I hadn't managed it well'.*

On the issue of naming or not naming erotic transference, Vickey said.

> *'I do think we need to be very careful how we name it. If it's not being named, it's not being worked through so, there's an unresolved piece for the client. We need to use a language that the client understands, I think that's a big part of it. Jargon, throws clients, it unsettles them absolutely, it can shame them too'.*

Orla's approach is to say to the client.

> ***Orla: '****There's something very human that is here in the room but I'm wondering do you want to name it, or do you want it left unnamed? it is your choice. Because if I say oh, I think you are very sexually attracted to me, well that client is gone and will never go back to therapy again'.*

Izzy recalled.

> ***Izzy:*** *'I was minding myself rather than thinking, where am I with the client? and where's the growing edge and in hindsight, I'm wondering would I have challenged him differently. He finished not long after that. I have often wondered how he did, would he have come back'.*

During the interviews it emerged, that transference may have occurred, that there was residue of unrequited love for him in her mind, since Izzy had referred to the same male client repeatedly. This was expressed through a distant gaze as the researcher became aware that he was sitting in the same client chair as him.

It emerged that not all attraction is shown in an overt manner.

May explained:

> ***May:*** *'I have real cloudy memories about feeling a bit disarmed. A real healthy client just in from the gym or something… I'd be… he's a bit of alright. It can be disarming sometimes if you have too strong an attraction to them. You can lose your ground a bit, can't you? Not end the therapy but if there's that sort of muddy waters it doesn't sort of work'.* (laughter).

4.6. Theme C:

Does supervision fill the void left by the lack of training around erotic transference?

The participants in this present study expressed concern with the level of training they had received from their various institutions, regarding erotic transference. One participant recalled *'we got about five minutes, mostly we heard about Fritz Perls and others sleeping with their clients'*. However, there was a consensus that through reading, clinical practice and supervision, they had addressed this need. There was also a thread running through the interviews that theory and training can't prepare a therapist for the inevitability of erotic transference entering the therapy room. There seems to be a chicken and egg situation where unless therapists have experienced it, they can't understand it and bringing it to supervision hasn't always been easy due to the perceptions of shame and fear of being judged, associated with the delicate nature of this phenomenon. Izzy said, '*There still would be that little voice in my head saying, God almighty are you not able to manage your emotions and feelings'.* Supervisors themselves were/are trying to get to grips with what is increasingly being presented. All the participants in this research are qualified supervisors. The relationship with supervision has changed from Orla's early days when *'we got supervision wherever we could get it'* to the present structure where bi-monthly supervision is mandatory.

> ***Orla****: 'When I brought that 'sexual energy' woman to my first supervisor, she told me just do what you're doing and breath. I developed a softly, softly way of dealing with it, which I had learned from a peer group that I joined after a few more boundary testing encounters. You know all that stuff was landing there in the room it took me awhile'.*

There seems to be a reluctance to bring erotic transference to supervision, which was the case for Izzy when she experienced 'teenage blushes' for a middle-aged male client.

> ***Izzy:*** *'I'd say it was at least a month before I dared bring it and I had a really good relationship with my supervisor. Em… so I didn't even know because I hadn't it named for myself as erotic transference and it being you know a normality. The ironic thing is that once I brought it out of the closet and spoke about it and spent time in supervision talking about it, it's stopped happening'.*

Izzy further explained

> ***Izzy****: 'it was a real learning for me that and I would have been very clear because my training was gestalt and we would have been told sex is always in the room, you know, and if you have your sexuality underground, it's something you're not going to look at, by default your client is not going to bring it out either'*

Thelma: *'In my early training, I don't recall much of anything on erotic transference or countertransference. A lot of my learning was actually via experience and then my supervision. I think, from the get-go, I was always okay with the erotic transference, but when it was erotic countertransference, that ungrounded me a bit. That's where I needed support from my supervisor a lot in it. Now it doesn't… I recognise it's just a cycle'.*

There's a possible connection between Vickey's youthfulness and her ease of using supervision as a sounding board when difficult issues arise.

> ***Vickey:*** *'If I'm holding back in supervision, what am I doing to myself and to my work with my clients? Ultimately supervision serves the client. I just put it all out there. I just spit it out and obviously when I'm talking about myself also talking about the relationship'.*

May questioned why there is concern about what is, a normal part of everyday life. She doesn't believe that there should be targeted training for erotic transference and would rarely feel the need to bring it to supervision.

> ***May:*** *'yes, it does exist, so what? What's the big deal? I'm a great believer in trust and people been trained properly and don't be looking for trouble. I wonder would we be a healthier profession if all this was acknowledged and brought out into the open a little bit more'.*

Vickey matter-of-factly attributes erotic transference to the clients' history and experience.

4.7. Summary:

The above interview excerpts show an aspect of psychotherapy which is gradually coming into awareness and is emerging as a serious topic. All participants have encountered erotic transference and have demonstrated varying attitudes towards it. Three of the participants revealed that they had an attraction for a client, while all participants had a special place in their heart for past clients where erotic transference had been an aspect of the therapy. There were some references to the impact of gender, but it was mainly from the view that males and females reveal their attraction in a different form. However, there was agreement that regardless of the gender make-up of the dyad, sex is always in the room.

Chapter 5. Discussion:

5. 1. Introduction:

The aim of this thesis was to explore female therapists' experiences of erotic transference in the therapeutic alliance. This chapter will focus on the three main themes which were presented in the results chapter. The impact of erotic transference especially on the first occasion, hankering after past clients whose erotic feelings, having been named, may have ended the therapy and the concept of dumping it all on the supervisor, in lieu of proper training. Findings from the results chapter in conjunction with theory and literature, reviewed in chapter 2 forms the main body of this discussion, which concludes with recommendations for training and practice, limitations of the present research and suggestions for further study.

5.2. Theme A:

The impact of erotic transference, and circumstances surrounding its surfacing, in the therapeutic relationship.

Ridely (2006) declared that, it is okay for a therapist not to know what is happening for the client and to allow themselves to explore the client's feelings as real for him/her without responding from the therapist's own perspective. Working with what is happening internally can be a rich resource with which he/she can explore their own and the client's fears and vulnerabilities. Self-awareness and active listening skills are gained over a lifetime within the intersubjective experience (p. 325). This was the stance adopted by the participants in this present study who learned by experience. All the participants in the present study vividly recalled their first encounter with erotic transference and painted a clear picture of the context. The phrase that was common across all participants was, 'it's always in the room'. This consensus removed the need to question its validity as a phenomenon, however, it prompted another consideration, if erotic transference is omnipresent, why do not all therapists declare

it? Perhaps some therapists are not open to it, while others may simply display a reluctance to speak about it due to many factors including, shame, fear of boundary violation and anxiety around the sexual exploitation of clients which does happen, however, abuse is sometimes confused with erotic transference, which is a fundamental part of therapy (Stirzaker, 2000). These reasons may account for the finding that 24% of female therapists have never experienced erotic transference (Pope et al, 1986). In the present study, one participant stated that a client had never declared it to her, adding that it had never been overtly in the room. The researcher recognised that this response roughly mirrored the accepted statistic of one fifth of female therapists never experiencing erotic transference. Perhaps instead it points to a need to reformulate this type of research as there may have been a level of misunderstanding of the question, because, as the interview progressed, she referred to several instances of picking up erotic transferences. Her quick answering of that question validates the use of qualitative methods of enquiry in this type of research. A quantitative method would not have recognised her unconsidered response. This respondent also spoke of her policy to not report instances of erotic transference in supervision, which is in line with Kelly's (2014) contention that, the socialisation of women therapists is responsible for the blocking out even the idea of verbalising any perceived erotic signals which have been given in the therapy room.

Referring to her first awareness of any kind of body sensations, one participant said that it was disrespectable to be talking about these things, back then. Therapists are still discouraged from discussing erotic transference (Colom-Timlin, 2014; Krause, 2016). The language of shame and guilt is used liberally when describing attraction between client and therapist. Though erotic transference doesn't usually result in sexual intimacy, this association is often made and reinforced by referencing some of the aforementioned trail blazing therapists, who openly declared their indiscretions.

The participants in the present study who are themselves supervisors and tutors, concur with Freud (1915) and Fink (1999) that the personality of the therapist influences and facilitates the occurrence and the intensity of erotic transference. This theory was expressed directly by two of the participants and was intimated by others in an undercurrent of belief that, the therapist is the boundary minder and therefore the gatekeeper of transgressions including the mishandling of erotic feelings. Koo (2001) contends that modern theorists consider transference as a 'here and now' construction that is influenced and guided by the therapist's personality and not just a re-enactment of past events in the present. The therapist's skill in moderating this often eroticised, in your face, behaviour from clients was highlighted by participants who dealt with fantasies which included a desire to rape the therapist. The participants in this present study reported that they were caught off balance early in their careers, by feelings of 'sex is in the room'. They claimed that they were ill prepared for this inevitable occurrence and urged training institutions to direct greater resources towards addressing this phenomenon. House (cited in Clarkson, 2003, p. 27) posits that therapists are like any other member of society who can experience a pervasive hunger for intimacy. Clarkson (2003) likens therapists', dealings with the flames of burning love to that of working in a forge and not expecting to get burned. This effective analogy for dealing with Eros in the consulting room, is defended as she says therapists are prohibited from receiving any personal satisfaction, despite being constantly in the most potent cauldron of intimacy. This situation of the wounded healer tending to others' scars which are similar to their own scars, contributes to the high rate of burnout, loneliness, and breakdown in the therapy profession.

The five participants in this present study have delineated erotic interactions with clients that challenged them. There were areas of commonality among these episodes that are captured in a vignette by Kelly (2014) who describes her encounter with a male client who was a serial 'womaniser' and had been married and divorced twice. Though she was a seasoned therapist

and was aware of his history, when he paid her a compliment regarding her necklace, the look towards her neck that accompanied that remark blindsided her. She became defensive, blushing, unthinking, touching her necklace, she blurted that her husband had given it to her. She realised that her acting out was facilitated by her resistance to his charms and her sympathetic nervous system was activated, bringing her protective male/husband into the room. In supervision she was able to recognise that she had ignored her discomfort, fear and anger, in her need to remain in the role of therapist. She continued working with this client with renewed vigour, armed with the realisation of her own vulnerabilities and need to embrace rather than resist her own feelings in the service of the client. The participants in this present study, with little help from supervision in some cases, stumbled on the idea of the centrality of the therapist's erotic or sexual feelings in the service of the client's maturation (Kelly, 2014, p.162).

5.3. Theme B:

Therapists' hankering after past clients, where naming erotic transference tested boundaries.

Calenza's (2010) phrase 'why can't we be lovers' came to mind when hearing from the participants about the unfinished business with those clients that didn't remain in therapy after their bubble was burst by naming erotic transference. Some participants expressed a cautious delight to be partaking in the present study but were visibly impacted by the feelings and memories it awoke in them. This anticipated reaction, justified alerting the participants to the potential risks of this present study in the consent form, (Appendix 2.). The pre-oedipal mother described by Mann (2015) as full of wonder, evoking fantasy and excitement, resurfaces in the transference, in the person of the therapist. The female therapist's gender facilitates this oedipal level of sexual longing in male clients, Lijtmare (2004). Being re-enacted in therapy, is the

taking of a sexual position by the three year old boy or girl who has come into the therapy room (Stirzaker, 2000). Participants in the present study reported that, the intersubjectivity of the therapeutic alliance allowed for the them to fall into the mother role. Phrases such as 'someone to mind them' and 'I often wondered how he did' betrayed a thinly disguised feeling of loss when these past clients were brought to consciousness. An unspecified guilt was awoken in some participants regarding denying their clients that longed for incestuous relationship with their primary caretaker (Schaverien, 2004, p. 9). Stefana (2017) contends that a client's erotic desires for a therapist are part of the intersubjective process that informs transference and countertransference as a reflection of earlier unresolved attachment to their caregivers. The participants in this present study were aware of their mother role as they used phrases such as 'I reminded him of his mother' or 'they will make us whoever they need us to be, to be in the transference' the clients fantasy is to see as the ideal mother ignoring any faults (Stefana, 2017, p. 506). Schaverien (2004) posits that some male clients leave therapy before or when the erotic transference begins, for fear of intimacy or to avoid dealing with aggressive, sexual impulses which may denigrate or idealise the female therapist. Some female therapists find it more comfortable to remain in the maternal role rather than confront erotic transference. She advises that unless female therapists own their sexual impulses in therapy, it will become split off and be considered merely a male aberration and will inhibit working with all the material that emerges in psychotherapy (p. 5).

All five participants gave descriptions of clients' affections going too far. This sometimes, eroticised transference, took the form of stalking, overt displays of affection or subtle acts like, arriving to therapy directly from the gym, which the therapist found to be disarming, a muddying of the waters and ungrounding. Blum (1973) contends that this behaviour points to underlying issues in childhood which the client is defending against, including inappropriate role modelling by parents regarding sexual matters. The participant who was showered with

gifts by her male client, reported that if given the same situation again, she would handle it differently. Koo (2001) sees how the female therapist's competence can be undermined and devalued by being treated as a sexual object. One participant explained regrets around being self-absorbed when experiencing 'internal blushing' with a male client and minding herself instead of being there for him. She wondered how he fared and if he would come back. Ridley (2006) warns against this scenario, which will result in the client's needs not been met. The client also senses these uncertainties in the therapist and feels rejected and isolated, often resulting in the ending of the relationship. There were divergent views among the participants in this present study regarding the naming of erotic transference. Prompted by the interview question regarding the recognition of erotic transference, Vickey was clear that jargon is to be avoided as it can shame the client. Orla had developed a form of words that made it safe for the client to realise how normal his/her feelings are and to allow them to internalise a different mother to maintain object constancy (Covington, 1996, p. 343). Thelma mused over Koo's (2001) contention that current thinking on erotic transference, regards the 'here and now' as important as re-enactment of past events in the present. She questioned the idea that it could be her personality that orchestrated the client's behaviour in therapy, asking if another therapist would have achieved a different outcome. These examples of the high regard that therapist hold for clients is evident from vignettes above. Experienced practitioners are aware of clients' ability to dump their issues in the therapists' blind spot (Calenza and Gabbard, 2003; Mann, 2009). The mothering aspect of therapy which has been alluded to by Schore and Schore (2008) and Mann (2015) as another form of erotic transference was articulated by the participants in this present study by expressing their wish to be 'good enough' therapists. All participants in this present study stated their belief that if it is not sensitively handled, the naming erotic transference can scare clients away from therapy permanently.

5.4. Theme C:

Does supervision fill the void left by the lack of training around erotic transference?

Subjectivity, being that unique, exquisitely vulnerable, private world of feelings and thoughts is defined as,

> *'Within the secret depths of our personal experience are packed a seemingly infinite range of hopes, fears and fantasies, desires we hardly dare to recognise and shames that are anguish to contemplate'.* Smail (cited in Ridley, 2006, p. 321).

Trainee therapists need to embrace the subjective and intersubjective nature of sexuality, if the needs of the client are to be met in therapy. Failure to recognise and work with these individual feelings, is likely to result in harm to both therapist and client (Ridely, 2006). In the present study, an element of attraction in therapy, was seen as positive by all participants. (Celenza and Gabbard (2003) attribute the reasons for differing levels of attraction to intersubjective elements arising from the cocreated transference-countertransference interactions of the therapy dyad. They believe that regular use of consultation early in the process will help prevent this attraction becoming a transgression (p. 635). A legacy of suspicion towards supervision regarding feelings of attraction for a client, was alluded to by the more senior participants in the present study.

The contention that supervision serves the client, was the immediate response by the youngest participant who added that she brings everything to supervision. By contrast at the other end of this continuum another participant's response was, 'don't bother her with that stuff' and 'I don't bring it in, what's the big deal?'. There is a consensus among the research participants in this present study that, more attention in training and supervision needs to be paid to the issue of attraction in the therapy room between clients and therapists. In most teaching institutions, transference is covered in a general way but apart from passing comments or student's

questions, erotic transference is not seen as an issue that needs serious consideration. Despite training and sanction, erotic transference continues to happen (Kelly, 2014; Celenza, 2010; Strizaker, 2000). In support of this viewpoint, Izzy reported that a month elapsed before the case involving 'teenage blushes' was brought to supervision and this therapist has had training in this area. However, when it was brought into the open, talked about and named, it lost its power over her. In an analogy with the essence of 'talking therapy' Izzy declared that 'when it is underground, it has power'. The realisation dawned on this participant after her client had ended therapy, of the importance of the therapist being at ease with their own sexuality. Krausz, (2016) believes that avoidance and dissociation of erotic experiences in the clinical setting, is the biggest risk to the female therapists. Vickey was very clear that, in supervision we cannot talk about ourselves in isolation, we're in a relationship with the client. 'So, the client comes in, their history comes in, and I'll bring it all in as much as there is room for it on the day' A common theme running through the responses in the present study is that, if the therapist is hiding their sexuality, the client will not be able to reveal there's either. Failure of the therapist to recognise that a fantasy is coming from the client, but mistakenly attributes it to her own inner thoughts, will result in the client's needs been ignored (Krausz, 2016). This stance often results from the failure to deal with such feelings in her previous personal therapy. Stirzaker (2000) suggests that a therapist will supress their feelings by ignoring them in the countertransference. Mann (2015) refers to 'turning a blind eye' a concept he claims has pervaded psychotherapy since classical Greek times. Example, Orla's supervisor advised her to keep doing what she was doing and just 'breathe' could be considered unlikely to encourage self-disclosure of what Stirzaker (2000) refers to the taboo which silences. A combination of supervision and training, when the client is ready to embrace the countertransference is ideal (Pope et al, 1986; Goodyear and Shumate, 1996).

5.5. Limitations of the present study:

This present study explored how female therapist engage with erotic transference in the therapeutic alliance. The age profile of the participants in the present study is enriching, nevertheless it would be interesting to explore the responses that a sample of younger female therapists would make. This unknown would inform the aim of a future study. For reasons of homogeneity, the orientation of the participants in this present study is humanistic and integrative however, future research may expand this aspect of the inclusion criteria to avoid the accusation of a cohort effect.

5.6. Recommendations:

A re-working of the language surrounding erotic transference may help to make it more recognised as a phenomenon. Giovazolias and Davis (2001) report a trend among therapist to re-consider their attitudes regarding sexual issues and thereby lessening the taboo that surrounds them. As one participant explained, ‘we have to be careful how we name it’. Though there was a call from participants for more training in this area, the researcher was mindful of Krausz’s (2016) suggestion that a lighter attitude towards training is required. The ideal training for erotic transference, could be achieved through workshops and seminars, with a combination of experience and supervision. What has emerged from the present study is that, there are many situational, social, historical and gender-based factors at play in the prevalence of erotic transference. These same factors inform the therapeutic relationship’s ability and desire to confront it or hide from it. The counterintuitive learnings from this present study is that, a therapist must have encountered erotic transference, to be eligible to avail of and benefit from, this retrospective training, provided by supervision.

5.7. Implications for psychotherapy:

As supervisors become proficient in dealing with erotic or sexual issues, the more at ease the supervisees will become when self-disclosing. In fact, the word disclosing may be used less frequently as it somehow carries connotations of guilt or secrecy. A language needs to develop around erotic transference, but it cannot survive in a vacuum. Library resources such as PsycheInfo, Researchgate, Psyche articles, and Google Scholar are yielding marginally more search results recently which will help to keep the conversation going. It is hoped that colleges and psychotherapy training facilities will consider creating modules dedicated to erotic transference, resulting in phrases such as 'incest on the couch' being less used.

5.8. Conclusion:

This present study has found that there is a continued growing awareness of the existence, pitfalls and benefits of erotic transference in the therapeutic encounter. The present study explored female therapist's experiences of erotic transference in the therapeutic encounter. There were differences and commonalities among the five participants' responses to the eleven questions, which were asked in a semi-structured, audio recorded interview. The researcher felt privileged being allowed to enter the hearts and minds of participants who generously shared their reflections on the many aspects of erotic transference including, socialisation, power, attraction, resistance, denial, neuroscience and boundary testing. Reflecting on Calenza's description of erotic transference as a 'lens to explore their client's dynamics', the three main themes were identified in this present study to further that examination. They centred around the impact of erotic transference when it surfaces, the sometimes hankering after past clients whose romantic feelings became an issue and lastly the notion of dumping it all on the supervisor as a kind of therapeutic backstop. The researcher found it gratifying to recognise new learning and innovative approaches to this topic which indicates an attitude shift by female

therapists regarding the encountering and handling of erotic transference. A common thread running through the interviews is, it enters the room regardless of the gender or sexual orientation of either the client or the therapist. How we embrace it or not, is informed by multifarious social, historical, sexual and emotional factors. Regardless of how it is referred to, as a continuum, a bridge or a spectrum, the unconscious dance between transference and countertransference, is always in the room.

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Appendices

Appendix 1. Information Sheet:

My name is Peter Casey and I am currently undertaking an MA in Counselling and Psychotherapy at Dublin Business School. I am inviting you to take part in my research project, which is concerned with erotic transference, in the therapeutic encounter. I will be exploring the views of therapists like yourself who have worked in a humanistic, integrative manner for at least three years post qualification.

What is involved?

You are invited to take part in an audio recorded interview with myself in a setting of your convenience, which should take no longer than fifty minutes to complete. During this interview, 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.

Anonymity

All information obtained from you during the research will be kept anonymous. 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. 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 from the study without disadvantage. Should you need clarification on this study, you can contact me: petercasey114@gmail.com – 086-3335504.

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 please) _____

Signature:_____ Date :_____

Appendix 2. Consent Form:

Protocol Title:

An exploration of Therapists' experiences 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 anonymous, 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	**Date**	**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 he/she could understand. We have discussed the risks involved and have invited him/her to ask questions on any aspect of the study that concerned them.

_____	_____	_____
Signature	**Name in Block Capitals**	**Date**

If you have any questions regarding your rights as a participant in this research, please contact Dr. Grainne Donohue research co-ordinator, Dept. of psychotherapy, School of Arts, Dublin Business School. **grainne.donohue@dbs.ie**

Appendix 3. Interview Questions:

1. Can you tell me if over the years you have developed a preference for a category of Client? – For example, age, gender, nationality or profession

2. Can you recall experiences that challenged your boundaries in the therapeutic alliance?

3. Can you tell me of your experience of becoming aware of erotic transference?

4. Do you think that your training prepared you for handling erotic transference?

5. Were you surprised, when a client expressed attraction towards you?
   - Or when you felt attracted to a client?

6. Do you think an element of attraction enhances the therapeutic relationship?
   – Or is a hindrance to the therapeutic relationship.

7. Can you remember a time when you experienced uneasy feelings about having to deal with erotic transference? – Did you feel like ending the therapy?

8. Are there any circumstances when you feel it is inappropriate to acknowledge erotic transference?

9. What have you learned through dealing with erotic transference?

10. How do you present these issues in supervision?

11. Is there anything you would like to ask or add, that will further this research

Appendix 4. Sample E-Mail Request for Volunteers:

Dear XXXXXX Therapy Centre,

I would be very grateful if you could circulate my request for research volunteers among therapists working at your centre.

My name is Peter Casey, I am a final year student, studying for an MA in Counselling and Psychotherapy at Dublin Business School. My research is on how therapists engage with erotic transference and its impact on the therapeutic encounter.

I am inviting interested psychotherapists to volunteer and take part in my research by participating in a qualitative interview that will take approximately forty-five minutes in duration, at a mutually agreed time and location.

I am seeking to interview female psychotherapists who have at least three years experience post qualification, and whose training is humanistic and integrative in orientation.

I would very much appreciate your participation in this research.

I can be contacted by email: XXXXXXXXX@gmail.com or by telephone: 086 - ZZZZZZZZ.

Thank You,

Peter Casey.

Appendix 5. Sample of Thematic Analysis Coding Process:

Condensed Transcript	Code 1.	Code 2.	PossibleTheme
Researcher: Were you surprised, when a client expressed an attraction towards you?			
Male client wanted a relationship. Referred on, he had stopped working on his own stuff. It was a big transference he had. I refused his flowers and chocolates. I had to disguise my route home, in case he found out where I lived. Caused hell in my marriage.	Experience of previous women, was now kicking in. Expecting a backlash.	Firm approach But Uneasy	Uneasy Un-grounding
Researcher: What have you learned through dealing with erotic transference?			
It's not comfortable but it is manageable. It's not comfortable for them either it's really embarrassing to have it known that you have these feelings.	There's blushes, shame and exposure of the needy soul part.	Uneasy but manageable	Regard for client Memories
My training was that sexuality is always in the room, yeah that's true but, actually then experiencing, going through it is completely different, very challenging when it comes up.	Its different when it is happening to you.	Training doesn't prepare you.	Will training help?
Researcher: Can you tell me of your experiences of becoming aware of erotic transference?			
It's shaming, I found it. It's like a teenage blush came on me, out of the blue. I liken it now to menopause when a hot flush comes over you. You're flapping away trying to wonder how it's going to go away, and can everyone see it? It's like oh my God, can he see it?	Out of the therapist's control Shaming Embarrassing Inconvenient Distracting	Shamed Distracted Loss of contact	Uneasy Memory Shame
Researcher: Do you think that you're training prepares you for handling erotic transference?			
No, definitely not, and the best therapists love their clients. I think it's all about that and then with love comes the necessity for boundaries. Yeah and they're putting you up on this pedestal you know so, no definitely not**.**	No, training didn't. It is all about love. Love brings boundaries.	Love and boundaries.	Regard for client
Not my early training, no. I don't I don't recall much of anything on erotic transference or countertransference. A lot of my learning was actually via experience and then my supervision. I think even though they're not going to cover some	Training didn't cater for erotic transference.	Trained myself	Supervision and experience

courses it might be a very good idea to really flag it**.**			
Researcher: Are there any circumstances when you feel it is inappropriate to acknowledge erotic Transference?			
I think it enhances it. Say it's a maternal transference countertransference I'm having for a client. I suppose I would like to think that the mother falls in love with her child and the child falls in love with the mother. To me that's all very healthy.	A mother child transference is very healthy.	It's very healthy and enhances the relationship.	Regard for client for the mother relationship.
So, they'll make us whoever they need to make us to be in the transference. it can be a straight client, gay, trans gender male or female, it actually doesn't matter, and it doesn't matter what the therapist is either. I'm curious so that that comes in differently with women.	Differences do not make a difference. Women deliver it differently.	Curiosity about what influences genders.	Female clients' approach
Researcher: Can you remember a time when you experienced uneasy feelings about having to deal with erotic transference? – Did you feel like ending the therapy?			
Male told me that he'd be very flattered if I had very strong feelings for him and he tried to come onto me, and I found that very uneasy, I really wasn't comfortable.	He tried to come on to me, uncomfortable.	Uneasy	Confronted uncomfortable
There was one female client, well this one was more, who ended it because she could she couldn't handle staying with the feelings she had for me and am that, that was one of the more difficult ones because actually there was occasions afterwards where in different sort of social settings, where we bumped into each other and even though she was a past client am, I had to obviously hold the boundary.	Female ended therapy due to feelings for her therapist.	Couldn't manage feelings for therapist.	Uneasy feelings remain after therapy has ended.
There were two male clients, where they were disclosing in the session more their fantasies, it's about, around, raping me and again that was very tough work with my supervisor. One man in particular, I'm remembering we continue to work together for a number of years afterwards.	One man had a lot of misogyny. We worked through his hatred of women.	Rape, misogyny hatred	Eroticised feelings.
Researcher: How do you present these issues in supervision?			
They're still would be that little voice in my head saying '*God almighty are you not able to manage your emotions and feelings'.*	Fear of being judged in supervision.	Guilty feelings	Uneasy Shame

t