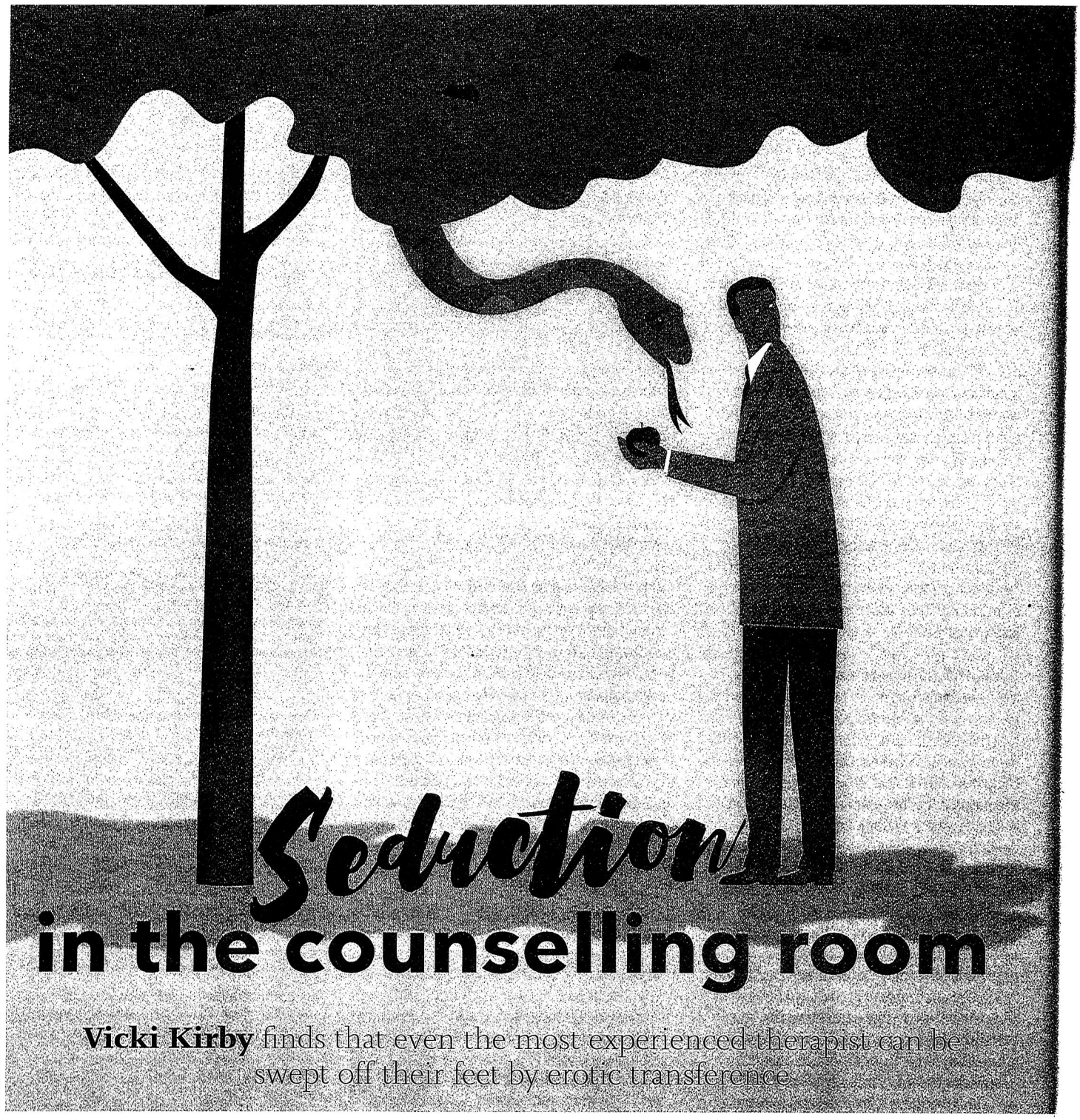

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Seduction in the counselling room

Vicki Kirby finds that even the most experienced therapist can be swept off their feet by erotic transference

Humans are driven by a desire to feel seen, respected, wanted and needed. We long to be understood and seek to understand others. We crave the chance to love and be loved and are excited by lust. These primal, relational emotions have the power to animate, thrill and fulfil us. So, it is inevitable that such feelings will be evoked within our therapeutic relationships from time to time, given how emotionally intense and highly intimate these relationships can be. And yet, how often do we talk about and openly reflect on these personal feelings as they arise in our professional work? And if we are not regularly engaging in reflective discussions about them, do we risk losing ourselves in these feelings? What might be the cost to our therapeutic work and our clients' wellbeing?

I was inspired to research therapists' experiences of working with erotic transference by two short-term pieces of therapeutic work: one as a client and one as a therapist. In both, I found myself experiencing a connection with the person with whom I was working that seemed to transcend the walls of the therapy room. It was as if we both simultaneously experienced a sense of being seen and understood and of belonging together. Being in these relationships made me feel not only safe but elated. However, I also felt confused,

because I did not fully understand my feelings. The work also triggered within me a deep sense of longing, because these relationships could not continue outside the therapy room.

These experiences left me questioning how a therapist (or, indeed, client) knows what is real when erotic feelings enter the therapy relationship. I found myself asking whether, and to what extent, erotic feelings might belong to the actual relationship in the room, and not simply represent the client's early attachments and inner conflicts. I wondered what the therapist might be bringing to the erotic dynamic. How might their own feelings and emotional needs interact with, fuel and feed off those of their client?

Common themes

To explore these questions, I conducted qualitative research using an interpretivist approach. This involves exploring the subjective meaning that life experiences have for people. I interviewed six qualified therapists and asked them to talk about their experiences of working in the here-and-now with erotic transference. I analysed the interview transcripts, searching for common themes that would help me understand their experiences. My purpose was not to reach a conclusion on how all, or even most, therapists work with erotic transference, but to delve deep into the experiences of these six who chose to speak to me. I encouraged my participants to adopt a broad definition of 'erotic' to include feelings of longing and desire, sexual or otherwise. The examples they gave were wide-ranging.

It is important to state at the outset that none of these therapists crossed any boundaries, and all gave examples of effective therapeutic work with their clients. They described clients as embodying unspoken erotic feelings through their eye contact and body language. They spoke of clients showering them with compliments, dropping hints about meeting outside sessions, trying to glean personal information about them, and awarding them the role of their 'only friend'. They even described them flirting, initiating physical contact and implying a desire for a sexual relationship.

Although the clients' presentations varied, they had several characteristics in common: all were described as having a strong attachment to their therapist; all hinted at rather than declared their erotic feelings directly, and all tried to push the boundaries of the therapeutic relationship in some way.

Mixed feelings

What was striking was that five out of the six therapists allowed the erotic feelings to thrive silently in the background as they pressed ahead with their client work, rather than addressing them openly. There were many reasons for this avoidance, and the picture painted was, unsurprisingly, complex. However, one thing was clear: erotic feelings are enjoyable. After all, we all like to feel wanted and respected. Who does not relish, at least a little, the sense of professional and personal pride that comes from working with a grateful client? As one participant put it: 'You know that... they... like you, and that... provide(s) a sense of warmth, and of being wanted.' Another admitted that 'the super-praising... felt very good!'

This enjoyment of erotic feelings was not presented as straightforward, however. One participant described how their client engaged in a deliberate, yet unconscious, process of seduction, and that they fell for it ('I think I got seduced by the flattery'). Others described a strong sense of relationship with their client, through shared characteristics, such as sexuality and social class, or shared life experiences, and said this evoked feelings of warmth, familiarity and connectedness that were no less seductive. Sometimes the closeness and adoration that the therapist experienced in the room was just too delicious and important to let go, particularly if they too had some vulnerability ('I don't want to upset him and change the way he looks at me... if he were to reject me... I would find that really tough'). Others found themselves flummoxed by their own desire for physical comfort from their client ('Those arms, they would protect me').

'We all like to feel wanted and respected. Who does not relish, at least a little, the sense of professional and personal pride that comes from working with a grateful client?'

However, these participants also voiced embarrassment and shame as they talked about messy, painful and disempowering experiences. Some described their clients' presentations as 'draining' and 'invasive' and communicated a sense of their client wanting to hold on to and even consume them. Some of the female therapists felt their femininity, sexuality and vulnerability exaggerated by their male clients' sexualised hints and flirting ('I would sit there feeling smaller and more female than ever before'). Some were confused by their own feelings of attraction and lost trust in their ability to read their clients ('Is it just me?... Am I imagining it?').

The therapists also commonly found themselves drawn into difficult power dynamics with their clients. They described resenting what they perceived as their clients' attempts to wield power over them, yet also experienced a deep sense of empathy because they knew this behaviour was driven by the client's pain and emotional fragility. Some described how, at a particular point in the work, they were mortified to realise that they had been ignoring how much power they actually held within the relationship. This was especially pronounced for those working in private practice. One participant recounted her horror when she began to worry that she might unwittingly be financially exploiting her client, when she considered the possibility that the client had continued attending therapy she could not afford in the hope that a friendship, or even relationship, might develop from it.

Swept away

A few of my participants gave examples of how they eventually managed to address these erotic feelings with their clients in ways that not only avoided rejection but also allowed the client to understand themselves better. However, more commonly, they described being swept up by the challenging dynamics playing out in the room and losing their ability to remain simultaneously an active participant in and empathetic observer of them. They related how they often told themselves they were protecting their clients ▶

from embarrassment and rejection by not addressing the erotic feelings, while also being aware that they were attempting to protect themselves from embarrassment and rejection. Ironically, this avoidance meant the therapists and their clients were both disempowered: the therapists felt awkward and frustrated, and the clients were left with deep feelings of longing that were not acknowledged and that they felt confident only to hint at and fantasise about.

These therapists all demonstrated a strong theoretical knowledge about erotic transference. Every one of them was able to unpick how their client's erotic presentation was an enactment of their inner conflict, how it related to the client's early experiences of receiving care, and how it mirrored their other relationship patterns outside the room. Interestingly, in each example, the characteristics of the therapist, in terms of age, gender, sexuality and personality, also played a part in the relational dynamics. Furthermore, all the participants were able to reflect on how their own needs, desires and vulnerabilities came alive in the work. Their erotic countertransference, which was both a response to the client's projections and an expression of their own inner worlds, had a powerful impact on them. Their emotional triggers and reactions danced and played with those of the client. They were not simply a trained professional in the room; these were men and women experiencing fear, longing and exhilaration.

Bridging the gap

Perhaps you recognise some of your own experience in these descriptions. Or maybe you believe that you would never fail to address strong erotic feelings. My participants had 54 years of experience between them. They demonstrated a strong desire to work relationally. They were fully able to own their experiences, reflect on their work and understand the ways in which not speaking about erotic feelings was potentially damaging. My research highlights the gulf between the theoretical understanding of these highly experienced therapists and their ability to think clearly when caught in the tangled webs of difficult relational dynamics and lost in the throes of the primal feelings that the erotic transference evoked in them.

AVOIDING THE RISK

An article in a previous issue of *Therapy Today* offers helpful guidance on reducing the risk of erotic transference (referred to below as adverse idealising transference, or AIT):[1]

- Inform clients about the phenomenon at the beginning of the therapy.
- Carry out regular reviews in which the potential for AIT is monitored.
- Maintain consistent professional boundaries and refrain from personal disclosures that could encourage idealisation.
- Refrain from making the client feel special.
- Be clear that the relationship can only ever be professional.
- If the potential for AIT becomes apparent, discuss it with the client in order to work out the best way of tackling it.
- Take it to supervision and seek external consultation if it persists.
- Take responsibility for any actions that contributed to the AIT.
- Refrain from acting defensively by blame, rejection and sudden rigid boundaries, or terminating the therapy without the agreed notice period.

The BACP Good Practice in Action 077 resource, *Dual Roles within the Counselling Profession*, also covers sexual relationships with current or former clients (see paragraph 3.7: Dual relationships of a sexual nature).

The subject is also covered in the BACP *Ethical Framework* ('Good Practice: building an appropriate relationship', paragraphs 34 and 35):

> *34. We will not have sexual relationships with or behave sexually towards our clients, supervisees or trainees.*
> *35. We will not exploit or abuse our clients in any way: financially, emotionally, physically, sexually or spiritually.*

These resources are all available on the BACP website.

1. Devereux D. Transference love and harm. Therapy Today 2016; 27(7): 8-13. bit.ly/2GJxgqO

What, then, can be taken from this research? How do we bridge the gap between theoretical understanding and the realities of daily practice? I contend that it is not enough to address erotic transference from a theoretical standpoint in core training, CDP and supervision. Rather, we must bring our vulnerabilities into these spaces and encourage each other to reflect honestly on the primal needs and emotions that are triggered in our work. Instead of feeling ashamed that these emotions have the power to overwhelm us, we need to support each other to understand that they are a natural and inevitable part of being human. I believe it is only when we are able, honestly and fully, to express how powerful these feelings are that our peers and mentors can help us step back from them, understand them and use them to the therapeutic benefit of our clients. ■

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About the author

Vicki is an integrative counsellor. Her research was conducted as part of her MSc in Therapeutic Counselling at the University of Greenwich. She currently co-ordinates the counselling service in an NHS sexual health clinic offering short-term counselling. She also runs her own private practice.