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Erotic Feelings

How They Help or Hinder the Therapeutic Process

> The term *erotic transference* has a reassuring clinical ring to it. By contrast, to hear a patient say, "I love you," sounds too personal, too close for comfort.
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> —Glen Gabbard (1994, p. 156)

I recall feeling routinely overstimulated as a young therapist when my clients declared deep feelings of love or romantic interest in me. One of my first clients in private practice, whom I will call John, was 5 years younger than I was and chose a female therapist because his father had been denigrated in the family. His mother was uneducated but fiercely intelligent. She engaged John in intellectual debate from the time he was a boy and he considered her responsible for his success as a corporate attorney. John idealized me from the onset of treatment and soon proclaimed his feelings of love for me. He regularly informed me that he was a wonderful lover, but perhaps a bit overconcerned about pleasing women due to his need for his mother's approval.

One day he turned to me and spoke of his desire to be close to me and please me sexually. He related a fantasy he had centering on a tender and loving event of sexual pleasure for me. I was immediately aroused, and then blushed with shame over my feelings of arousal. John noticed my reaction, stopped talking, and then changed the subject.

John's change of topic was both a relief and a shameful confirmation that he had observed my reaction. We both muddled through the rest of the session without incident. Afterward I tried to process what had happened between us. I knew John was sincere in his affections for me, but his overt seduction also meshed with past comments he had made that indicated he was competitive with me and needed to have more power in the relationship. I observed in his relationships with women he seemed to need to dominate them, but veiled this by being sensitive to their needs and always promoting their interests and noting their talents. Did John simply want to dominate and covered this need with pseudoaltruistic motives? Or did he want to be intimate and nurturing, but felt too vulnerable if he didn't also have the upper hand?

And why was I so embarrassed and discombobulated? Did I need to be in control and couldn't cope with John turning the tables on me? Or was I just too unprepared for feeling aroused by a client? Although I learned to manage my feelings better as his treatment progressed, in that moment I was unable to help John explore his feelings for me, and inadvertently declared them shameful through my response of blushing and general discombobulation. I am presenting this case example as an introduction to the following in-depth discussion of erotic transference–countertransference, which includes the power dynamics that may be involved.

At the time I was treating John it was considered unseemly for therapists to have sexual feelings in response to their clients. Moreover, clients who persisted in feelings of love and sexual attraction to their therapists were considered to be acting defensively and "resisting" the real work of treatment. Therapists who reciprocated even a modicum of love or a hint of physical attraction were considered to be caught up in a moment of unenviable weakness. At the same time, it is clear that some clients, and some therapists, do focus on the erotic aspects of the relationship as a way to avoid vulnerability and gain power. This chapter is devoted to exploring this complex issue and helping therapists better understand both their clients' and their own sexual feelings in treatment.

Historically, the prevailing question on this topic has been: What is the underlying meaning of expressed erotic or loving interest? This question used to be answered solely in terms of the client's motivations, without regard to any provocation by the therapist, and was most often regarded as defensive. Now we are more willing to consider that erotic or loving interest has as much potential for being a healthy expression of the client's adult capacity for attachment as it does for being defen-

sive or pathological. The therapist's role in creating an erotic or loving relationship has also been recognized.[1]

Gabbard (1994) has said that the old attempt to distinguish between transference love and love outside the treatment is essentially a waste of time. I agree with Gabbard that it is gratuitous to question the validity of the client's feelings when they "sue for love," and as equally gratuitous and defensive for therapists to deny their love and sexual feelings for their clients. Maintaining appropriate boundaries, including refraining from expressing sexual interest in clients, does not preclude accepting and being curious about these feelings when they do occur.

As with any deep emotional issue, the therapist ideally maintains a delicate balance between avoidance and indulgence. It is common for beginning therapists to feel overwhelmed by their early experiences with clients falling in love with them. From my perspective, the less guilt about this, the better. The ideal therapeutic goal is to bring the same respect for the client's feelings and the same open attitude of curiosity and matter-of-factness that you would bring to any of the client's emotional experiences. Neophyte therapists often have to process much of their countertransference outside of the sessions, particularly when a favorite client declares undying love or a desire to have sex.

New therapists may alternately feel guilty, aroused, generally overstimulated, afraid of being out of control, or even defensively angry. As Gabbard (1994) implies, therapists receiving expressions of love from their clients may be overwhelmed, finding it difficult to integrate these very personal feelings into the professional relationship. Or they may find their clients' love too gratifying, and encourage it to their clients' detriment. It is up to the therapist to accept the client's feelings while still maintaining his or her own equilibrium and maintaining the boundaries.

MAKING THE DISTINCTION BETWEEN THERAPEUTIC AND NONTHERAPEUTIC EROTIC TRANSFERENCE

Much of this chapter is devoted to the difficult issue of determining how much erotic interest on the client's part is therapeutic and, like

[1] I recommend Maltz's (1997) extensive review of the literature on erotic transference–countertransference, with an emphasis on its positive contributions to the overall therapeutic experience. For more elaborated discussions of love in the therapeutic relationship, see Coen (1994, 1996) and Bridges (1995).

regression, when it ceases to be therapeutic and become an obstacle to any real treatment taking place. Even clients who usually express their loving or romantic feelings in a constructive way may fall into using these feelings defensively at times to avoid grieving. The grieving being avoided may involve the unavailability of the therapist for a real relationship, or it may be another loss that feels overwhelming to the client. When the client who at first seemed taken with the therapist in a manageable, therapeutic way becomes obsessive, it is time to wonder about what he or she might be avoiding.

From my experience, all obsessions represent an avoidance of something more painful. A client who obsesses about wanting a personal relationship with the therapist is probably defending against unbearable feelings of loss or emotional annihilation. But sexual obsession may also mask envy, hatred, or competition with the therapist. This is where the uniqueness of each relationship comes into play. It pays to have an open mind about what the client may be avoiding. To paraphrase an earlier quote from Ferenczi (1976), the therapist would do well to keep an eye open for any unconscious negative reactions to the therapist and bring them relentlessly into the open. I think this applies particularly when the client obsessively "loves" the therapist.

Other signs of a problematic erotic transference include any type of spying on the therapist or certainly stalking him, demands for personal information that keep escalating, demands for extended or additional sessions, demands for physical contact, or demands for disclosure of any sexual interest on the therapist's part. Both therapist and client may be aware of an erotic aspect of their relationship and not realize it is out of control until some untoward event occurs. The therapist may wonder how this happened. Why is the client defending so wildly against being vulnerable in the treatment? What, if anything, is the therapist doing to stimulate these feelings and behaviors? And how are these issues resolved, particularly if the client is reluctant to examine them?

When the erotic transference becomes nontherapeutic, it is critical that the therapist be willing to consider how he or she may have contributed to this dilemma. Langs (1974) outlines seductive behaviors on the therapist's part that help create a nontherapeutic erotic transference. These include comments on the client's attractiveness; excessive interest in the client's sexual behavior and fantasies; deviation from normal practice as a special indulgence for that client; overemphasis on the client's sexual interest in the therapist; self-disclosure of erotic feelings toward the client; and touching the client. Errors or overinvolvement with a client are often only identified after a problem mani-

fests itself. This is especially true for new therapists who must painfully learn from their mistakes. A well-intentioned therapist who suddenly realizes she has been seductive with a client will appropriately cease these behaviors.

However, a new problem may arise when the therapist attempts to correct her therapeutic error. The therapist may precipitously distance herself from the client, as mentioned previously, resulting in an experience of painful rejection for the client. It is vitally important that the therapist not compound the original error of having been too seductive by then becoming rejecting, cold, and abandoning.

A poignant example of this latter point can be seen in Carter Heywood's (1995) *When Boundaries Betray Us*, which documents the mutual seduction by Heywood and her therapist, ending in traumatic rejection for Heywood. Following many sessions during which both of them sat on cushions on the floor amid a room filled with lit candles, Heywood proclaims her love for her therapist, and wants the promise of a friendship after termination. The therapist responds by panicking and distancing from Heywood, never returning to the blissfully sensual state in which they had previously functioned. Heywood's sense of betrayal is palpable and understandable. Her therapist seduced and abandoned her. Heywood argues that her therapist should have agreed to a friendship after termination, but I disagree. Her therapist shouldn't have established the romantic relationship between them in the first place. Once created, it served as a huge obstacle to Heywood giving her therapist up and doing the requisite grieving over this loss.

The phenomenon of the therapist who engages in mutual seduction with a client, then dumps her when things get out of control, is not uncommon. Nor is it uncommon for a client to seduce and abandon her therapist. I find that few therapists are prepared for this scenario and have significant difficulty when they realize what has happened. The lack of closure in the relationship produced by abandonment can be equally troubling to the therapist who has been abandoned. The client or therapist who fears vulnerability, but wants to be loved, may routinely seduce and abandon others.

DEALING WITH THE CLIENT'S RELUCTANCE TO DISCUSS EROTIC FEELINGS

Many clients resist the idea of talking about feelings that can never be acted on. They often say, *"What's the point?,"* which is just another way

of saying that they feel embarrassed or even humiliated by pursuing this subject and wonder what the therapist's motivation is for encouraging it. The client wonders, "Do you wish to make a fool of me? Or do you take sadistic pleasure in my being so exposed and vulnerable? Or do you enjoy the admiration or sexual arousal that you feel when I speak of my feelings for you?" The client may say, "Okay, I understand why we can't have a sexual relationship, but then let's drop it and go on to other things. Why should we keep talking about it?"

It is at this point that the therapist discusses with the client the need to express any and all feelings for the sake of self-awareness, acceptance of feelings, affect management, the acquisition of insight, and the opportunity to grieve what cannot be. Exploring the client's fears of humiliation, objectification, rejection, and overstimulation can help her to understand why it is necessary to express whatever strong feelings she is having. Not surprisingly, many clients who resist the expression of their romantic feelings for the therapist harbor a secret fear that they will succeed in seducing the therapist and destroying the treatment. Others consciously or unconsciously know that they have been seduced and are resisting this power move on the therapist's part.

LOVE OR POWER?

Although I have made the point here that genuine loving and romantic feelings can be part of the therapeutic process, there are clearly some clients who are seductive in the interests of conquest. They are aggressively sexual, combining a demanding hunger for power and control with their sexual desire. These clients are the ones who have great difficulty accepting the asymmetry of the therapeutic relationship. They fear helplessness, rejection, dependency and, ultimately, psychic annihilation. Wry and Welles (1994) describe this attitude as "erotic terror" and Kumin (1985) as "erotic horror." Often having been physically and/or sexually abused as children, these clients essentially protect themselves in the therapeutic relationship through the zealous seduction and courtship of the therapist.

This type of aggressive erotic approach manifests a desire for pure power, typically begins very early in the relationship, and is not the constructive, positive burgeoning of loving and sexual feelings that most authors are referring to when they speak of a healthy erotic transference. In accordance with mutuality, it is fair to note that some therapists

have similar fears of intimacy and vulnerability and need to sexually seduce their clients for their own protection.

In his classic paper Blum (1973) attempted to distinguish between the more expectable loving, erotic transference and the sexually aggressive, power-driven one. He created a different category for these difficult clients and did so by coining the term "erotized transference" versus the standard "erotic transference." Blum cites Gitelson (1952) when he describes those with erotized transferences as "people who demand to be loved in the absence of a capacity for love" (p. 62). Elaborating on the nature of their attachment, he remarks:

> These are not ordinary reactions of transference love, and these clients can resemble intractable love addicts. Their erotized transference is passionate, insistent, and urgent. While conscious discomfort and guilt may be present, the guilt may be isolated and unconscious. The conscious fear is not of regression or retribution, but of disappointment and the bitter anguish of unreciprocated love. Through projection and denial they can assume their therapist indeed loves them. For the borderline clients manifesting this reaction, transference and reality may be dangerously confused. There is the threat of regressive loss of reality testing. (p. 64)

When Blum says that such clients defensively imagine that the therapist reciprocates their feelings, the implication is that the therapist clearly does not. Instead, the therapist experiences the client as aggressive and assaultive. Making the distinction between loving and aggressive erotic transferences may seem simple at first glance. But many people appear at first to be gentle and loving, only becoming aggressive well into the treatment, when the threat of emotional annihilation surfaces or when the therapist herself becomes too seductive and overstimulating.

Distinguishing between an intense but essentially positive erotic transference and a defensive or aggressive one can be especially difficult if the client fluctuates from one to the other. I think a key variable in making this discrimination is the countertransference. When I treat a client with the aggressive sexual transference described by Blum, my reactions range from curiosity and interest to irritation and frustration, and eventually to helplessness and rage. Even during more peaceful or enjoyable moments with the same client, I rarely reciprocate the feelings of love and sexual desire.

I can know something about the client's motivations through my own internal emotional responses. Something is wrong when a client

persists in declaring undying love for me and I *do not feel loved at all*. As Blum points out, those who demand love are usually incapable of it. Instead of feeling loved, I usually feel assaulted, and work overtime to maintain proper boundaries in the face of all manner of intrusions on my privacy and attempts by the client to control the treatment.

The example of Nancy, whom I spoke of earlier in the discussion of countertransference anger, fits well into this discussion. Nancy wanted everything from me. She alternately wanted me to be her mother, her best friend, or her lover. The reader may remember that I said I distinctly did not feel loved when Nancy was berating me for not loving her enough and not being willing to fulfill any of these roles in her life. After much consideration, I ended up telling her what I really felt in these moments, which was frustration, anger—even hatred. Similarly, in the case of Susan, who wanted me to love her and hold her, I had to let her know directly not only that I was not going to provide the physical contact she demanded or pleaded for, but that I did not really want to.

With a client who seeks love more than power, my countertransference is different. I feel a warm expectation of seeing the client whose love is not essentially defensive and who inspires a reciprocal deep affection or love in me. If I feel any anxiety or apprehension, it is born out of a sense that I might lose my emotional equilibrium. As a new therapist I often became uncomfortable—even going so far as to change the subject. I did not receive any education during my training about having, and managing, sexual or loving feelings toward my clients.

When I felt aroused by a client's expression of sexual interest in me, I felt guilt or even shame. As a young therapist, I'm not sure I knew the difference between feeling the pull to act on my feelings and actually acting on them. So I had to cut them off. Without really thinking it through, it seems that I felt that having my sexual and loving feelings toward a client might lead to abusing a client—something I could never accept doing.

Early in my career I did not realize that a degree of emotional gratification for the therapist is not necessarily unseemly. I believe I would have been less disturbed by my erotic and loving feelings toward my clients had I realized that without *some gratification* (Maroda, 2005), there is no relationship. The delicate balance in the therapeutic relationship is one of finding enough gratification to keep therapist and client invested, yet frustrating both therapist and client in their deepest desires, which often center on filling voids from the past. The gratifications I speak of do not involve crossing the professional boundaries

in any way. Rather, they revolve around the acceptance of loving and erotic feelings, experiencing and allowing the pleasure of those feelings without feeling guilt or shame.

Searles's (1979) famous comment about feeling in love with all of his patients, male or female, at some point in the treatment (and even imagining marrying them) speaks to the naturalness of loving and erotic feelings in a deep psychotherapy. Searles never acted on these feelings, never expressed them to his clients, and made it clear that he did not advocate doing so. Searles understood that the ideal therapeutic stance was one of manageable affect engagement.

Erotic or loving feelings are not problematic unless they become consistently obsessive, interfere with the therapist's ability to keep the boundaries, or lead the therapist to defensively withdraw. Searles talked about how parents who notice their children too much as they are developing sexually may defensively withdraw from that child or become sadistic and rejecting. When a client re-creates that scenario in therapy, it is critically important that the intensely engaged therapist not make the same mistake as the parents did, thus repeating past damaging events. In order to accomplish this, the therapist must be capable of accepting the loving and erotic feelings without experiencing the guilt that forced the parent(s) to withdraw.

In the event that either therapist or client cannot manage these feelings, which I do not believe needs to happen as often as it does, it may be necessary to think about referring the client out to someone else.[2]

ACCEPTING AND MANAGING THE EROTIC COUNTERTRANSFERENCE

Much remains to be explored regarding the productive use of sexual feelings in the therapeutic endeavor. When a client expresses love or sexual desire toward me, as with everything else, there is a part of me that rightly asks, "Why now?" This attitude is not inconsistent with being emotionally available. There is plenty of room to receive the client's feelings, accept my own feelings, and still ask, "Why now?" Within the relational paradigm, the answer to "Why now?" may or may not have as much to do with the therapist as the client. Unfortunately, the literature is replete with examples of therapists who, in examining there own sexual feelings toward their clients, inevitably attribute the origin of their feelings to the client's conscious or unconscious seductions. Traditionally, the therapeutic attitude was, "If I am sexually aroused, then the client is seducing me." While this may be true at times, it certainly cannot *always* be true. Often, the reality is that the seduction is mutual, as it is in most human relationships. At other times it is the therapist who is the seducer.

[2] I spoke in *The Power of Countertransference* (1991) about the importance of doing this with the aid of consultants and avoiding a precipitous ending that might traumatize the client.

Now that love and desire are accepted in the therapeutic relationship, curiosity, rather than guilt or shame, has become the order of the day. Therapists can examine the potential contributions of both therapist and client, clearly aware of the issues and underlying vulnerabilities, yet still assign some responsibility. For example, persons who have been sexually molested are more likely to be seductive with everyone, including their therapists, because this is the relational pattern they know (Mitchell, 1988). Moreover, these individuals are much more likely to have sex with their therapists than those who have not been sexually abused (Pope, Sonne, & Holroyd, 1993). A less well-known reality is that therapists who have been sexually molested are also much more likely to have sex with their clients than those who have not (Margolis, 1994; Kernberg, 1994). Indeed, they are more likely to have sex with a client who is also a therapist. Keeping in mind the vulnerabilities of both therapist and client can help to prevent boundary violations and failed treatments.

Although the aggressively sexual clients described by Blum may present the most difficult situation of erotic transference, this type of client is the exception rather than the rule in most practices. Lester (1985), Goldberger and Evans (1985), Altman (1995), and Gabbard (1994) have stated previously, and I concur (Maroda, 1991), that the therapist who has sex with this type of client often does so as much out of rage and a desire to punish the client as anything else (Searles, 1979; Celenza, 2003, 2007). It is when the countertransference frustration and rage go unexpressed and unresolved that aggressive sexual events occur. So this type of case might be better discussed under the rubric of "countertransference aggression."

Whether dominated primarily by love or aggression, Person (1985) reminds us, sex is power. So when the therapist asks herself, "Is this client trying to influence me through his erotic feelings," the answer is inevitably "Yes, of course." The literature on affect tells us that one of the purposes of *any* emotion is to influence the receiver. Therefore, a more constructive question is, "What does this client

want from me at this moment in time?" Or, if the countertransference is being examined, "What do I want from this client at this moment in time?" In what direction is each of us attempting to move the relationship?

Gabbard (1995) points out that the more mature, reciprocal feelings of sexual attraction and love often come as the client is approaching termination. In the throes of separation anxiety and anticipated loss, both parties may find themselves experiencing longing and sexual desire. But this does not preclude such feelings from occurring at any point in the therapeutic relationship. I have personally found that I am more likely to be sexually attracted to clients during the early "honeymoon" period. Later, as the inevitable conflicts arise, I find that my clients' litany of my faults or deficiencies serves as a cold shower.

Are erotic feelings part of the natural flow of the relationship, moving it along toward greater depth and understanding? Or is this an interruption? Is it an attempt to block any meaningful emotional connection? Is it a defense against anger or grief? Is it an attempt to feel powerful rather than weak and dependent or afraid? Has either party slipped into the gray zone of a fantasized sexual healing taking place if only they could become lovers? These are all appropriate questions for the clinician to ponder when a strong erotic and/or loving relationship develops in treatment.

TRAUMA VICTIMS AND "OEDIPAL WINNERS"

Trauma counselors report that clients who have been sexually molested at an early age are more likely to be seductive with everyone, including their therapists. In the past, therapists had a tendency to blame the client for relating to the therapist in a sexual way. This was seen as an attempt to destroy the treatment rather than as an attempt to build a meaningful therapeutic relationship. But after decades of studying the effects of parental seductiveness on children, therapists now understand that clients whose primary attachment figures were seductive naturally attach this way to others. Seductiveness becomes ingrained in the attachment style and is simply what the client knows and unconsciously repeats as a way of connecting with others.

Having learned this way of relating at an early age, clients who are either victims of sexual abuse or who are "Oedipal winners" will be more seductive in the therapy relationship. The term "Oedipal winners" as it is used here refers to persons who were highly favored, and perhaps overvalued, by a parent who did not molest them, but injected sexual overtones that were not appropriate to the parent–child relationship. Their seductive relational style may mimic that of clients who have been abused, which sometimes leads therapists to inaccurately assume overt abuse where none exists. The term "double Oedipal winner" was coined to describe the person who was the recipient of a sexualized overinvestment by both parents. These are outdated and informal terms, of course, but descriptive nonetheless.

One of my young female patients, Kristen, was seductive with both men and women. Her attachment style was infused with a high degree of sexuality. When I asked about her childhood and the nature of her relationship with her parents, she said some of her father's behavior gave her the "creeps." She reported that he was always watching her in a way that did not seem "fatherly" to her, even though he never touched her inappropriately. He also watched pornography quite frequently and would guiltily switch it off when she walked into the family room. Both he and her mother were overprotective and obsessed with her comings and goings, as well as with her diet. As an only child, she was the singular focus of family life, and experienced her parents' attention as extremely intrusive and "odd." She had never been molested, but found herself engaging in sex play with other children by the time she was 10 years old.

In her early relationship with me she was constantly adjusting her clothing and sweeping her long hair back and forth during her sessions. She did not dress inappropriately for her sessions, but she crossed and uncrossed her legs frequently and touched herself more often than most people do. My reaction to all of this was to simply ignore it, which seemed quite relieving to her. I noticed her behavior, of course, noting that it seemed more like how a young woman would behave on a first date.

But I recognized this as being her normal style of talking and gesturing and did not make any reference to it at all. Nor did I find it uncomfortable. Had she been dressed inappropriately, or touched herself inappropriately, that would have been a different matter. Under those circumstances I would have mentioned it to her as gently as possible, so as to make her aware of her behavior, but minimize the potential for hurting or humiliating her. As an addendum, as her therapy progressed and our relationship became more secure, her flirtatious behaviors became infrequent and barely noticeable.

THERAPISTS WITH A SEXUALIZED ATTACHMENT STYLE

The literature has alternately reported that therapists who have been molested are more likely to have sex with their clients (Pope, 1994; Kernberg, 1994), and that they are *not more likely to do so* (Celenza, 2007). Perhaps it is the therapist with a sexualized attachment style who is more likely to engage in abuse. Therapists who do commit sexual boundary violations often do so with another therapist (Margolis, 1997). Why this occurs so frequently is unknown, but it may be linked to the early childhood experience that is shared to some extent by persons who become therapists. It seems likely that therapists would be more likely to attach strongly to each other, especially since both could potentially be highly empathic in their responses. This last point fits with the description of the typical victim of therapist sexual abuse provided by Celenza (2007), who contradicts the notion that most victims are very difficult people:

> Another myth that must be dispelled is the notion that all victims of sexual boundary transgressions are borderline women. ... The victims of sexual boundary transgressions span the full range of diagnostic categories and the majority are highly appealing women who tend toward meeting others' needs at the expense of their own. (p. xxiv)

A number of therapists have reported to me that they became involved in sexual or social relationships, during or after treatment, with their therapists. And most of them said they had *not reported it*. The chief reasons for this appear to be avoiding being seen as a victim; avoiding being exposed to subsequent negative publicity in their communities; and avoiding being seen as attacking their therapist—who is usually a well-respected, established member of the local mental health community. So it seems advisable for any therapist to be keenly aware of the potential for boundary violations when treating another mental health professional, as well as when going for one's own therapy.

GENDER DIFFERENCES IN EROTIC TRANSFERENCE–COUNTERTRANSFERENCE

Person (1985) was the first to note the differences in expression of erotic transference on the basis of gender. She reports that "women in general

appear to experience more intense and fully developed erotic transferences" (p. 166), regardless of the sex of the therapist. She says that heterosexual men are less likely to have an openly erotic transference, even with a female therapist, ostensibly due to the power dynamics involved—a social concept seconded by Wry and Welles (1994) and by most clinicians in their daily experience. Gabbard (1994) notes another apparent gender difference. He says that male therapists often respond to their female clients' tears with sexual arousal. This may be a power response: a deep show of vulnerability and surrender often elicits sexual feelings in men, but apparently not in women.

Again, I think this has more to do with social roles and expectations than simply the desire to dominate and be aroused by domination. Granted, some male therapists may take sadistic pleasure to the point of arousal in their female clients' suffering. But some may also be simply responding out of the intimacy and tender feelings of the moment. The fact that female therapists are not as likely to feel aroused under the same conditions may have more to do with the fact that the man who is crying is often embarrassed or ashamed, and quite uncomfortable in this position. This self-rejection, combined with the female therapist's own social conditioning regarding what is sexually desirable in a male, may result in the female therapist's tendency not to find this situation arousing.

Pope, Sonne, and Holroyd (1993) have reported that male therapists are more likely to be sexually aroused by a client who is physically attractive, female therapists by male clients who are "successful." So a female therapist may feel great empathy for a man or a woman who is crying, but due to social conditioning is not likely to be sexually aroused.

HETEROSEXUAL ROMANCE AS A DEFENSE AGAINST HOMOSEXUAL FEELINGS

Blum (1973) and Person (1985) note that the intense heterosexual romance within the therapeutic dyad is not always what it appears to be. They argue that sometimes the passionate mutual heterosexual romance is actually a defense against underlying homosexual feelings. In these cases both client and therapist harbor rescue fantasies, conscious or unconscious, that they will finally be able to truly be in love and aroused by someone of the opposite sex—something that has eluded them in spite of their marital status or heterosexual history. The

unavailability of the other helps fuel these unrealistic fantasies, often culminating in open declarations of love that destroy the treatment.

Regarding same-sex pairings, Tyson (1985), Kernberg (1994), Gabbard (1994), and Mann (1997) suggest that social homophobia expectably re-creates itself within the therapeutic situation. Frequently both therapist and client defend against homosexual feelings and fantasies. Male client, male therapist dyads are particularly reluctant to experience homosexual longings. As mentioned previously, Person (1985) and Wry and Welles (1994) note the ease with which women can feel and express erotic feelings toward each other.

The working out of sexual identity conflicts by both therapist and client is a real issue that has not been sufficiently discussed in the literature. Gabbard and Lester (1995) admit that some therapists appear to use their clients to explore their own sexual conflicts and confusion. Citing a study by Benowitz (1995) of therapist–client sex when both are female, they reported that only 40 percent of the female therapists identified themselves as lesbian. The rest identified themselves as heterosexual, bisexual, or confused. Twenty percent had never had sex with a woman before. They also note that Gonsiorek (1989) reported a similar pattern in male therapist–male client dyads. These statistics are remarkable and clearly demonstrate that the therapist who has unresolved issues regarding his or her sexuality is more likely to sexually abuse a same-sex client than a therapist who has self-identified as gay or lesbian.

DISCLOSURE OF EROTIC COUNTERTRANSFERENCE

Most people writing on the subject of erotic countertransference agree that disclosing it is generally not a good idea (Gorkin, 1985, 1987; Mann, 1997). I am really against disclosure of erotic countertransference, with rare exceptions. The verbalization of mutual sexual attraction almost always contains the threat of destroying the therapy relationship. In the normal social context couples reveal their sexual feelings to facilitate either ending or consummating their relationship. Neither of these normal consequences of self-disclosure are applicable to the therapeutic setting.

In *The Power of Countertransference* I cited a case report by Atwood, Stolorow, and Trop (1989) where the client of a supervisee needed her therapist to verbally acknowledge that he found her attractive, having been denied acknowledgment of her burgeoning womanhood by her father during adolescence. She told him repeatedly that she was not seeking any type of sexual encounter with him. She simply wanted her reality validated. (And she was right, by the way. He was attracted to her.) I cited this as one of the rare instances where I would answer the client's repeated, rational, and well-thought-out request for information of a sexual nature. In line with my guidelines for any disclosure, the client *asked for the information*. The therapist did not volunteer it. I continue to believe that the client who asks the therapist to reveal her attraction toward the client for reality-testing purposes, with no expectations or fears of sex occurring, is the exception rather than the rule.

ACCEPTING THE EROTIC AND LOVING COUNTERTRANSFERENCE

I have stated previously (Maroda, 2002) that the client always knows what we are really feeling, and often it is enough for us not to deny these feelings or to show discomfort when the client accurately identifies our feelings or expresses her own strong feelings. As Kohut (1971) suggested, sometimes it takes great effort simply to sit quietly, fine-tuning our narcissistic equilibrium, as we are told that we are loved beyond words, or found to be beautiful or handsome beyond compare, particularly if we do not feel worthy of such admiration and devotion. Acceptance of the client's feelings lies in the ability to stay with the client, and to stay with our own feelings without undue discomfort. If the therapist feels aroused and then guilty, he is likely to truncate his emotional experience. Furthermore, in the process of distancing himself from his feelings, he necessarily distances himself from the client in that moment.

I must admit that as a mature therapist I infrequently have to deal with any intense sexual transferences. As a young therapist I often faced the romantic and sexual feelings of my clients, perhaps mostly because we were all young and more inclined to be vulnerable, and to welcome romance in our lives. Also, a large number of my clients were unattached.

I was no doubt more seductive than I realized, and so were my clients. As a result of age and experience, as well as clients coming fewer times per week, strong erotic transferences began to disappear from my therapeutic work. Since many of my clients come to me with the knowledge of my reputation and writing, I think they are also reluctant

to express anything that might seem "disrespectful." I have not seen any research on this issue, but I imagine I am not the only older woman who has ceased to inspire strong sexual responses in her clients.

So for the purposes of illustration, I will give an example from earlier in my career. One young woman I treated noticed that she was preoccupied with me and found me sexually attractive. She was married and pregnant with her first child, so she found this experience a bit confusing. She knew that I was a lesbian and wondered out loud if this made it more likely for her to make some kind of erotic connection to me, regardless of her own sexual orientation—a thought that I have pondered many times and find interesting. What bothered her more than anything else was her subsequent realization that I am close to her mother's age. "Does this mean that there were sexual overtones to my relationship with my mother?" she asked. Given that her mother has always been extremely possessive of her and that during her pregnancy her mother announced to a group of friends that her daughter was having "my baby," this hypothesis had potential.

I find the whole notion of the erotic transference–countertransference to be a fascinating one to explore, having been relieved of my guilt and shame for being attracted to my clients, as well as understanding that I need not fear that I will act on those feelings. Even though I agree with Gabbard (1991) when he essentially says, "Never say never," the possibility of my acting on any sexual feelings with a client seems more remote after 25 years of practicing without having done so. I feel certain that I could have done a much better job with erotic transference–countertransference had it been part of my early training. Feeling guilty about my erotic countertransference, and having no introduction to responding constructively to erotic transference–countertransference, made this aspect of therapeutic treatment much harder than it had to be.

Ultimately, each clinician must assess his or her own vulnerability in this arena, as well as his or her strengths. When a client falls in love with the therapist, what does that mean about the therapist's conscious or unconscious wishes? Are some clients, and some therapists, essentially more focused on sexual issues and feelings than others? If so, where does this originate? And what constitutes a good match?

Given the emphasis on mutuality, is it possible for a client to be in love with a therapist who is not at least a little in love with her? Is the therapist's claim of nonparticipation believable, especially in extreme circumstances, such as being stalked, kissed, or finding his client in a state of partial nudity? Are untoward developments in the erotic transference–countertransference more about power than sexual longing or love? And what is the difference between the therapist encouraging the client to freely express his or her loving and sexual feelings versus establishing an ongoing scenario of sex talk that is sexually gratifying for both therapist and client?

As with everything else I have discussed in this volume, I believe that the progress in therapy, regardless of the issue at hand, can be assessed through a careful reading of the client's responses. Being alert to overstimulating or titillating a client is something that is not often taught, yet is an essential tool for any therapist. Therapists must be equally alert to any interventions causing hurt or humiliation. Therapists who accept their daily mistakes with a sense of acute responsibility while avoiding self-blame and self-flagellations are in the best position to quickly correct these errors.

MUTUALITY AND ASYMMETRY

As a great believer in mutuality, I think that the clients who have loved me or felt sexually attracted to me sensed that these feelings were shared to some extent. The exception I make is the sexually aggressive clients noted by Blum (1973), who typically have a sexualized psychotic transference that includes a defensive illusion that I share their feelings. These clients fear being destroyed by the therapist and seek to protect themselves through sexual conquest.

FACILITATING THE CLIENT'S EXPRESSION

Regarding the expression of sexual feelings, fantasies, and dreams, I encourage my clients to disclose this information if they allude to it or bring it up directly. When these feelings are not a defense against experiencing weakness, dependency, or some other unwanted emotion, then how should healthy expressions of feeling be treated? How does a therapist respond well to a client who asks if she is loved or found attractive? How much expression of eroticism in the therapeutic session is healthy, given that the normal culmination of mutual attraction is not allowed? When are therapists encouraging clients' expressions of adult, sexual relatedness and when are they teasing them or having "virtual" sex in the sessions? Facilitating their self-expression is one thing, engaging in mutual, ongoing seduction is another.

If a client becomes too graphic when discussing sexual matters, I usually try to refocus on what he is feeling. I have never found endless details about a fantasized sexual act to be anything other than a substitute for sex itself. As Bollas (1994) says, "Reporting an erotic fantasy is in some respects an erotic event in its own right" (p. 573). Yet there is no doubt that the tolerance for eroticism can be a highly idiosyncratic trait, depending on the client's and the therapist's views about sex and the body. So how far do you let a client go? How much do you encourage further expression from a client who is prudish and reluctant? I think the level of comfort of both persons is extremely important. If either client or therapist is feeling embarrassment, violation, or sexual overstimulation, this is reason enough to curtail the conversation. Certainly, compatible attitudes about sexuality are aspects of a good therapist–client match. And a sexually restrained therapist may enjoy the contrast between herself and a client who is freer or vice versa. Therapists and clients do not have to be the same, but should be similar enough to reach a comfort level that allows the client to express his sexual feelings, within and outside of therapy, in a healthy, constructive way.

DEALING WITH EROTICISM IN THE TRANSFERENCE–COUNTERTRANSFERENCE

Certainly, sexual and loving feelings can be dealt with better than they have in the past. Interpreting the desire to have sex as nothing more than the child's need to fuse with the mother can be replaced with a more honest and direct acknowledgment of the client's desire to know the therapist physically and to have his or her adult sexuality affirmed. Therapists can become more comfortable with their own sexuality, understanding that they will be attracted to their clients, allowing themselves to have these natural feelings without guilt or shame. Therapists also need to be realistic about their own potential for stimulating sexual feelings in their clients. Those who seem to stimulate their clients too little or too much may choose to examine this issue further in their own treatment.

But in the end the issue of erotic transference–countertransference will always be challenging because of the necessary inhibition of sexual behavior. Responding to the client's erotic feelings is no easy task, as Elise (1991) has pointed out previously. The normal social discourse during such moments must be denied in psychotherapy. Therapists

cannot speak of mutual love or attraction for a client, nor can they reject the client's expressions of unrequited love. So what should they say?

I have found that relaxed and easy exploration on my part puts the client at ease, yet is not seductive. I will ask my client to describe his or her feelings, but never ask for specific sexual details. After all, it is the emotional meaning that is important. As I stated previously, if the client volunteers too much graphic material, I steer him toward feelings instead. I find that the verbalization of this material is very sensitive and I am careful to follow the client's lead regarding when, how much, and in what way we talk about it.

When a client asks how I feel about his or her expressions of love or attraction, I usually say that I am moved, or flattered, or both. I find that most often my clients simply want to know that their feelings are received with understanding and warmth. They want to know that I am neither unreceptive nor overwhelmed.

I recall another client I treated a number of years ago who periodically proclaimed her love for me in a very heartfelt and tender way. I felt touched and saddened when she said how much she wished she could be with me. I just looked at her empathically and said nothing. I literally could not think of one thing to say in that moment that would not diminish the power of her feelings for me, or mine for her. After looking at her for a long time, I finally said, "I don't know what to say right now." She replied, "Just say, 'I know.'" And from that time forward we had an understanding that all I needed to say to her during those moments was —"I know."

SUMMARY

The presence of erotic feelings, often accompanied by love, can serve to open up both therapist and client to an intense, transforming, positive experience. Yet the old warnings about eroticism and proclamations of love as potentially defensive—used to control rather than reveal—must be taken seriously as well. The relational and interpersonal approaches acknowledge that the client, however, is not the only person in the dyad who can use eroticism to derail the treatment rather than deepen it.

Both therapist and client may feel love and attraction for each other for all the best and all the worst reasons. The therapist benefits from examining his or her own behavior and needs, as well as the client's, when the erotic transference–countertransference seems out of control.

Accepting that being loved and desired is gratifying and is often

present at some point in a successful treatment can help therapists to be more comfortable with sexual feelings in the relationship. But acceptance on the therapist's part should not be confused with gratuitous self-disclosure of sexual interest in the client, which is potentially damaging. As with all interventions, the key to knowing what is working and what is not is the client's asymptomatic response to our interventions, along with an ability to move deeper and gain insight.

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Empowering the Client

The Road to Independence

> There is no golden rule which applies to everyone; every man must find out for himself in what particular fashion he can be saved. All kinds of different factors will operate to direct his choice. It is a question of how much real satisfaction he can expect to get from the external world, how far he is led to make himself independent of it, and, finally, how much strength he feels he has for altering the world to suit his wishes.
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> —Sigmund Freud, *Civilization and Its Discontents* (1930, p. 83)

This remarkable quote from Freud appears in stark contrast to his theory of psychoanalytic treatment. Clinical psychoanalysis traditionally focused primarily on the individual and his ability to resolve *internal* conflicts and integrate emotions. Yet Freud demonstrates in this essay his acute awareness of the ongoing negotiations between the individual and society. He goes so far as to say that an individual's ability to save himself hinges on his expectations of the world, his ability to move in and out of the larger world, and his ability to influence others. He sees salvation lying not only in self-understanding, but in applying an equal awareness to the outside world, and formulating a way of moving in the world that works.

Civilization and Its Discontents still holds up as an incisive treatise on the individual versus society, noting the inevitable symbiosis and its subsequent demands. Implicit in Freud's words is that knowledge of oneself is insufficient. One must also understand the individuals