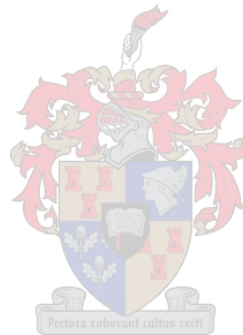


**THE DYNAMICS AND MANAGMENT OF EROTIC TRANSFERENCE IN  
THE PSYCHOTHERAPEUTIC SETTING: A REVIEW**

ZOË ABRAHAMS

Research assignment submitted in partial fulfilment of the requirements for the degree of Masters in Clinical Psychology in the Department of Psychology, Stellenbosch University.



Supervisor: Chris Petty

November 2005

I declare that *The dynamics and management of erotic transference in the psychotherapeutic setting: a review* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Zoë Abrahams

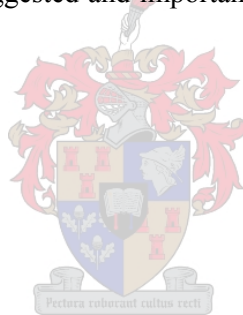
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## ABSTRACT

Sexual relationships in the psychotherapeutic setting have always been regarded as unethical and sexual attraction between therapist and client has generally proved to be awkward and anxiety provoking for those involved. Although research indicates that these relationships do occur, and that sexual feelings between therapists and clients are not infrequent, there is little conceptual clarity on the dynamics thereof. Consequently, the available guidelines and ethical rules regulating such sexual contact generally take the form of “thou shalt not...” and provide limited assistance to therapists in managing such situations in a manner that protects the integrity of the therapeutic relationship. This review assumes the presence of the psychodynamic phenomenon of transference in all psychotherapeutic relationships, and constructs sexual attraction and contact as the product of the sub-concept of erotic transference. Against this background, the review presents the dynamics of erotic transference in terms of its nature, impact and management. On this basis, current ethical codes and training issues are reviewed, guidelines for proper prevention and management are suggested and important directions for future research are identified.



## OPSOMMING

Seksuele verhoudings in die psigoterapeutiese konteks word deurgaans as oneties beskou en seksuele aangetrokkenheid tussen terapeut en kliënt word oor die algemeen as ongemaklik en angswekkend ervaar deur die betrokkenes. Alhoewel navorsing toon dat sodanige verhoudings wel voorkom, en dat seksuele gevoelens tussen terapeute en kliënte nie ongewoon is nie, bestaan daar beperkte konseptuele helderheid oor die dinamiek daarvan. Gevolglik, verskaf beskikbare riglyne en etiese reëls, wat gewoonlik die vorm van “jy sal nie...” aanneem, weinig ondersteuning vir terapeute in die bestuur van sulke situasies op maniere wat die integriteit van die terapeutiese verhouding beskerm. Hierdie oorsig veronderstel die teenwoordigheid van die psigodinamiese fenomeen van oordrag in alle psigoterapeutiese verhoudings, en konstrueer seksuele aangetrokkenheid en kontak as die produk van die sub-konsep van erotiese oordrag. Teen hierdie agtergrond word die dinamiek van erotiese oordrag in terme van die aard, impak, en die bestuur daarvan aangebied. Op hierdie basis word huidige etiese en opleidingskwessies ondersoek, riglyne vir behoorlike bestuur word voorgestel, en belangrike rigtings vir verdere navorsing word uiteengesit.



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## **1. INTRODUCTION**

The therapeutic relationship is a unique human relationship. Generally, like friendships and other human relationships, it is aimed at fulfilling basic needs. When broken down into their basic components, these relationships look very similar (Brammer, 1973). A therapeutic relationship may, for example, consist of the same fundamental elements as a friendship. In a friendship caring, understanding, and compassion are essential components of a mutually satisfying friendship. In the therapeutic relationship, these elements are important for a successful therapeutic outcome (Brammer, 1973).

Even though there are features that are common to the therapeutic relationship and other human relationships, there are also significant differences, such as the limitations on the amount of time spent on the relationship, and the financial gain of the therapist (Brammer, 1973). There are also significant power differences, but one of the most significant differences between these relationships is the limited physical contact in the therapeutic relationship. The difference is especially relevant regarding sexual contact. When sexual contact does occur it is viewed as the enactment of the erotic transference (Brammer, 1973).

According to the ethical code of the Professional Board for Psychology sexual contact between therapist and client constitutes unethical behaviour. The frequency of this behaviour may be difficult to assess as it is possible that there are cases that are unreported. In their study on the nature of ethical complaints related to unethical behaviour Scherrer, Louw and Möller (2002) found that 11.5% of all complaints lodged against South African psychologists between 1990 and 1999, were related to improper conduct. Falling in the category of improper conduct are sexual relationships with clients, consultations with a patient of a colleague, as well as acting impolitely towards a client (Scherrer et al., 2002). It is, therefore, not clear how many of these cases were instances of sexual relationships between a therapist and client.

A guideline to understanding the dynamic origins of sexual relationships between therapist and client was first provided by Freud (1915) when he introduced the phenomenon the erotic transference, and has been used by various theorists since its

first introduction. The concept of transference is traditionally viewed as a psychodynamic theoretical construct. Non-dynamic theories do not acknowledge the existence of the transference and do not have any similar constructs. This review assumes transference to be present in all therapeutic contexts, as it is a useful means of understanding client-therapist interactions in therapy. More specifically to this review, the erotic transference will be used as the theoretical construct from which to understand sexual feelings in therapy.

The first attempt to define erotic transference comes in the form of a paper written by Freud entitled "Observations on transference-love" (1915) and it remains the most influential and recognised piece of literature on the topic. This is evident in the frequent references to this paper in a significant amount of the subsequent literature. The paper, however, partly because of Freud's own difficulty in coming to terms with the nature of erotic transference, still leaves many questions unanswered. Since Freud, few attempts have been made to provide therapists, not only classic psychoanalysts, but also those of non-dynamic theoretical orientations, with a framework to understand and manage the erotic transference and countertransference. The few attempts to describe the phenomenon of the erotic transference include Book's definition, "...any transference in which the patient's fantasies contain elements that are primarily reverential, romantic, intimate, sensual or sexual" (1995, p.505), and is a fair representation of most other definitions.

The phrasing that most professional codes of ethics use for the prohibition of sexual contact between therapist and client, still creates confusion. The phrase "during therapy" is commonly used when referring to prohibited behaviour. This can be interpreted to mean that behaviour such as sexual contact is allowed at any other time apart from in the analytic situation (Conte, Plutchik, Picard & Karasu. 1989). Also, different authors have used a number of terms when referring to sexual contact, for example, erotic contact, sexual activity, sexual intimacy, sexual relationship, sexual involvement, sexual boundary violations, and sexual misconduct (Berkman, Turner, Cooper, Polnerow & Swartz 2000). Berkman *et al.* (2000) point out that although these terms are frequently used, they are not always clearly defined in professional codes of ethics for psychologists. According to Gechtman (1989, cited in Berkman *et*

*al.*, 2000) sexual contact includes one or more of the following activities: erotic fondling or petting, oral-genital stimulation of or by clients, and sexual intercourse.

Freud initially advocated the repression of the erotic transference, fearing it may lead to therapist and client acting on their sexual feelings. More contemporary views include those of Garret (1999), who argues that erotic transference should be viewed as a frequently occurring phenomenon, since the perspective that it is a unique, occurrence, would be more likely lead to a sexual relationship between therapist and client. According to Gutheil and Gabbard (1992), the very real problem of sexual contact between therapist and client is reflected by the substantial malpractice litigation against psychologists following a sexual relationship between a psychologist and their client.

Informing our understanding of sexual misconduct is the trend, observed by Schultz-Ross, Goldman and Gutheil (1992), towards a more disease-based model, in which the client is viewed as being medically ill. This conceptualisation of the therapist - client relationship has special implications for the understanding of sexual misconduct in therapy. Psychoanalysis traditionally recognized that the therapist has flaws in his or her personality in the same way the client does. Recently, however, the medical model has contributed to a conceptualisation of psychotherapy in which the therapist is viewed as being psychologically intact without any real flaws or vulnerabilities. The implication this conceptualisation has for our understanding of sexual contact in therapy is that the occurrence of sexual contact will be viewed as a result of the client's behaviour, rather than as a result of inadequate management of sexual feelings by the therapist. The therapist is then denied the chance of learning how to manage sexual feelings in therapy and avoid a similar situation in the future (Schultz - Ross et *al.*, 1992).

This highlights the need for guidelines and training for therapists on how to deal with the erotic transference and countertransference without compromising professional standards. While therapists who work psychodynamically may be guided by theory when confronted by the erotic in the therapeutic setting, non-dynamic therapists rely on ethical codes and their clinical training in these situations.



The extent to which therapists are able to rely on ethical codes and their clinical training will be assessed first. Second, the theoretical perspective of classic psychoanalysis will provide a framework for the understanding and interpretation of sexual feelings in the therapeutic setting. Third, the current perspectives on the impact of sexual feelings in the therapeutic setting are explored. Fourth, is a review of current ethical codes and training program issues will be identified, to provide an understanding of their position on erotic transference. Fifth, suggestions as to how sexual misconduct may be prevented in therapy, is followed by a conclusion. The conclusion will provide a brief overview of the main points made by this literature review, to facilitate an understanding of the extent to which ethical codes and training programs may assist therapists in dealing with their sexual feelings.

This review is aimed at highlighting the need for current training programs and ethical codes to incorporate understandings of the erotic transference to provide practicing therapists, and those in training, with guidelines which are informed by a theoretical framework and are of therapeutic value when working with the erotic transference.

This review is limited by insufficient information on current training programs, as the available literature is limited, which could have facilitated a more complete exploration of their approach to the management of the erotic transference. Also, the lack of data relevant to the South African context means that this review relies mainly on the views of authors speaking from their experience in foreign contexts.

## **2. THEORETICAL PERSPECTIVE**

To better understand the occurrence of sexual contact in therapy, Freud's theory of classic psychoanalysis will be used. Freud attributed the occurrence of sexual feelings in therapy to what he called transference -love or erotic transference. To understand erotic transference, it is important that the phenomenon of transference itself is understood.

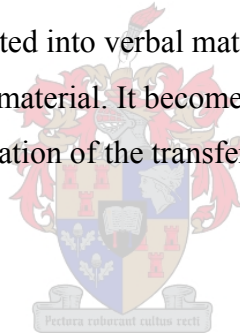
Transference was first introduced by Freud as part of his theory of classic psychoanalysis. The source of transference can be traced to one of Freud's defence mechanisms, namely projection. When a client projects aspects of him or herself or significant others towards the therapist, it is considered to be transference. When the therapist, on the other hand, projects his or her unconscious feelings or characteristics onto a client, it is considered to be countertransference. The aim of psychoanalysis is largely to make what is unconscious conscious. One way in which it can be achieved is through the analysis of transference, which makes it a very useful therapeutic tool (Sharf, 2000). As Person (1993) states, "Transference analysis appears to have replaced dream analysis as the "royal road" to the unconscious," (p.5).

Freud provided two approaches to understand the issue of the dynamics of transference (Packer, 1968). The first approach is to view transference as an every day occurrence outside the analytic setting. The second is to view it as an aspect of psychoanalytic therapy. According to Freud, there are two causes of transference that occur outside the analytic setting (Brammer, 1968). Firstly, in childhood, everyone acquires a way of "living his love": through interactions with others a pattern of the expression and experience of emotions is formed. This pattern is repeated throughout a person's life as they form relationships with other individuals. Secondly, unconscious fixation leads to a lack of libidinal satisfaction which creates a libidinal need which the person then directs towards the people s/he meets. In psychoanalysis, Freud explains transference by its relation to resistance. According to Freud, the fact that transference serves resistance explains its duration and intensity in the therapeutic relationship (Racker, 1968).

A brief look at the psychoanalytic therapeutic process will serve to illustrate the central role which transference plays. The process of therapy can be divided into four phases (Gilliland, James & Bowman, 1989): 1) The opening phase; The first part of this phase is used to determine the client's problem, and to decide on the appropriateness of analysis. The second part is used to compile as much knowledge as possible, to be used to facilitate insight in the later phases. 2) The development of transference: How the client perceives, interprets, and responds to the therapist, demonstrates patterns of past behaviour. By understanding how past behaviour

influences and determines the present, the client learns how to make more appropriate decisions. 3) The working-through phase: Working through the transference usually leads to the client recalling a significant event that leads to further insights. Verbalizing feelings and fantasies further facilitates the process of developing insight. With every evolution of this process further clarification and understanding is gained. 4) The resolution of transference: During this phase the client's neurotic attachment to the therapist is resolved.

Transference, however, is not always easily interpreted. In psychotherapy the traditional meaning that transference has, i.e. "transferring" psychic material, has been explored by many theorists. The other meaning of transference, i.e. transference as translation from one language to another, has received less attention. The languages being referred to are not really languages, but rather different kinds of material, such as visual material and verbal material. According to Freud, some visual material cannot be translated into verbal material. It is, therefore, impossible to interpret certain unconscious material. It becomes important then, to make a distinction between the interpretation of the transference and interpreting in the transference (Stanton, 1999).



## **2.1 Erotic Transference**

This section will focus on erotic transference, and also look at erotic counter-transference. Apart from attempting to define the term erotic transference, this section will explore the development of the erotic transference in therapy, provide an historical overview of erotic transference, as well as explore the possibility that erotic transference may be a form of resistance.

### **2.1.1 Defining erotic transference**

In attempting to clarify the term "erotic", Mann (1997) proposes that the erotic, despite it being associated with sexual excitement, is not physical, but rather psychological. He explains this through a comparison of the sexual experiences of animals and humans. Animals do not, as far as we know, bring underlying erotic fantasies to their sexual experiences. The sexual experiences of humans, however, have a psychological component, whether conscious or unconscious. Mann

(1997), sums it up as "...psychological experience independent of sexual reproduction and the desire for children," (p.5). According to this understanding of the term "erotic", it would be incorrect to associate it with physical arousal alone.

The term erotic transference was first defined by Freud in his paper "Observations on transference love" (Stirzaker, 2000). In it he defines erotic transference as something that occurs when the patient openly declares that she has fallen in love with the analyst. Freud's original definition has been revised by others, such as Book (1995), who defines erotic transference as "...any transference in which the patient's fantasies contain elements that are primarily reverential, romantic, intimate, sensual or sexual" (p.505).

Schaverien (1995) broadens the original definition of erotic transference by the introduction of the term eroticised transference. A distinction between these two terms is often made in the literature. Erotic transference is viewed as a natural phase of the therapeutic process. It reveals past patterns of relating to others which are not necessarily sexual. According to this definition then, it would be reductionist to view the erotic as sexual, as the erotic in this sense refers to needs, emotions and thoughts that are not necessarily sexual in nature, and do not lead to the desire for sexual gratification from the therapist. When defined in this way, the erotic transference could then be seen as part of any therapeutic context.

On the other hand, eroticised transference is seen as a delusional form of transference. There is no symbolization present, therefore, the transference is experienced as something real. The client may start to demand gratification, which destroys the therapeutic alliance. Consequently, the potential for growth is lost (Schaverien, 1995).

### **2.1.2 Historical overview of erotic transference**

The early psychoanalysts, some of them inadequately trained, needed to put limitations on what they permitted themselves to experience with their clients. There were, however, a number of them who, instead of analyzing their feelings towards clients, acted on them (Coen, 1996). It is reported that Carl Jung was involved with

two patients, Toni Wolff and Sabrina Spielrein (Tansey, cited in Schamess, 1999). It has been reported that Jung's relationship with his colleague Freud apparently ended largely due to these relationships. Other well-known analysts who pursued sexual relationships with patients include Otto Rank who was involved with his patient Anais Nin; August Eichhorn with his patient Margaret Mahler; Karen Horney with a younger male patient; and Frieda Fromm-Reichmann, who terminated therapy with a patient in order to marry him (Tansey, cited in Schamess, 1999).

It was Josef Breuer's work with Bertha Pappenheim, better known as Anna O., which eventually formed the basis of Freud's theory of psychoanalysis (Malan, 1979). Anna O., who came from a wealthy, Orthodox, Jewish family, started therapy with Breuer at the age of 21 in 1880. She had a strong attachment to her father but a difficult relationship with her mother. Her family contacted Breuer when she became anorexic and developed an "hysterical cough" while nursing her father who was suffering from a chest infection. As a result of her illness she was banished from her father's room by her mother and brother. In April the following year her father died. Anna O.'s reaction was one of anger, particularly directed towards her mother. With Breuer's help her condition improved, but deteriorated when Breuer left for a few days, and left Anna O. in the care of Dr Richard von Krafft-Ebing. On Breuer's return, her condition improved once more (Britton, 1999). At this stage Breuer's wife, Mathilde, became jealous of the amount of time he was spending with Anna O. Breuer then decided to spend less time with Anna O. During this time she was hospitalized against her will and became suicidal when Breuer was not present. The link between Anna O's behaviour and Breuer was now becoming clearer (Britton, 1999). In his own words, Breuer describes other instances where this link is made obvious. During one of Anna O's particularly bad patches, for example, Breuer noted that, "I was the only person she always recognized when I came in; so long as I was talking to her she was always in contact with things and lively, except for the sudden interruptions caused by one other hallucinatory "absences". (Breuer & Freud, 1895, p.26). On another occasion, when Anna O. refused to eat, Breuer was the only person allowed to feed her.

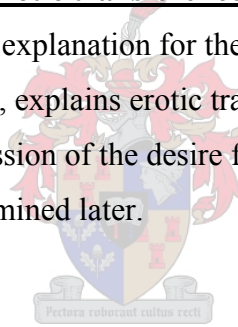
Breuer last visited Anna O. on 7 June 1882, He found her writhing in pain with

abdominal cramps. Breuer asked her what the matter was and she replied, "Now comes Dr B's child". In shock, Breuer left Anna O. in the care of a colleague, and gave up that kind of work altogether. Commenting on the incident Freud said that "... at that moment Breuer held the key in his hand but he dropped it" (Britton, 1999, P.7).

On his decision not to pursue any further analytic work with neurotic cases Breuer said, "I at the time learned a great deal - much that was of scientific value, but also the important practical lesson that it is impossible for a "general practitioner" to treat such a case without his activity and the conduct of his life thereby being completely ruined. I vowed at the time *never* to subject myself to such an ordeal" (Grubrich-Simitis, 1997, cited in Britton, 1999, p.26).

### **2.1.3 The development of the erotic transference**

There is more than one possible explanation for the emergence of the erotic transference. Freud, for instance, explains erotic transference in terms of resistance, while others view it as an expression of the desire for growth and change (Mann, 1997). This point will be re-examined later.



#### **a) Primal seduction**

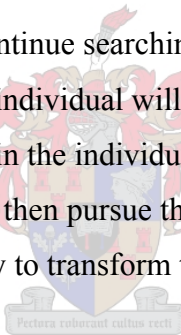
According to Laplanche (1989), the relationship shared by mother and infant has a seductive quality, which the infant, without the power of language, is not yet able to understand. Later in the individual's life, s/he will be prone to other seductions in an attempt to understand the first, or to use Laplanche's terminology, the primal seduction. The infant is seduced by the mother during erotic games, and the infant becomes the mother's erotic plaything. While caring for her infant, the mother derives erotic pleasure (unconsciously) from activities such as feeding or changing her baby. The infant also enjoys these activities intensely, but has to wait until s/he is able to master language to make sense of these experiences. The erotic, however, is not easily explained and the individual is left with a sense of longing for something which remains mysterious and exciting (Weatherill, 2000).

The analytic setting, which is often seen as very mysterious, activates the individual's longing to be an erotic plaything again (Weatherill, 2000). As Laplanche puts it "... the basis of the primal relationship with the other is one of primal seduction, and the basis of the relationship with the analyst reactivates that relationship (1989, p. 160).

b) The transformational object

Infants, due to the prematurity of human birth, are completely dependent on their mothers for survival. The mother, through interactions such as feeding and changing her infant, transforms the baby's internal and external world- and 'holds' the infant in an environment that she creates. The infant, therefore, rather than identifying the mother as an object, identifies her with the transformations that take place in the infant's world (Bollas, 1987).

In adult life, the individual will continue searching for the transformations experienced in early infancy. The individual will search for an object that could bring about these transformations in the individual's internal and external world. In the analytic setting, the client may then pursue the therapist for what the client believes to be the therapist's ability to transform the client (Bollas, 1987).



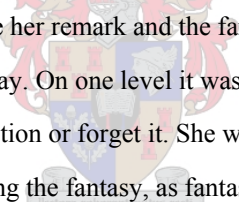
#### **2.1.4 Erotic transference as resistance**

Freud, in his paper "Observations on transference-love" makes it clear that he views erotic transference as resistance by stating "There can be no doubt that the outbreak of a passionate demand for love is largely the work of resistance" (1915, p. 162).

Freud also seems to encourage others to see it as such when he says, "A little reflection enables one to find one's bearings. First and foremost, one keeps in mind the suspicion that anything that interferes with the continuation of the treatment may be an expression of resistance." (Freud, 1915, p. 162). Freud (1915) observes that a client very often declares love for a therapist at a point in therapy when the therapist is trying to get the client to deal with a very distressing repressed memory, Freud (1915) feels that when this happens, the client may have been in love with the therapist for some time, but that the client's love is now being used to serve the resistance, in order to hinder the therapeutic process.

Mann (1997) disagrees with Freud's idea that the erotic transference is a form of resistance, when he states that through the emergence of the erotic transference, the client is expressing a deep desire for growth. As with a person who is in love, the client wants to change what is undesirable about him or herself. Mann (1997), therefore, sees the erotic transference as "...potentially the most powerful and positive quality in the therapeutic process." (p. 10).

Elise (2002) points out that even though it is possible to view erotic transference as a defense against other layers of material, a resistance to the erotic transference is also possible. She continues by illustrating, with an example from her own work, how detrimental resistance to the erotic transference can be to the therapeutic process. In this example, the client has suggested that she and the therapist take a trip to Greece together:



When I tried to explore her remark and the fantasied travel together she quickly backed away. On one level it was a real proposal: She wanted to put it into action or forget it. She was not interested in symbolically elaborating the fantasy, as fantasy.

As I pondered her failure of imagination and quick abandonment of an exciting fantasy. I was able to link this transference interaction with her foreclosed writing efforts and to her difficulty developing a rewarding love relationship in her personal life. There was little fruition to many aspects of her life and other desires, *she stood herself up*, she did not show up with her imagination to forward her own wishes. If a wish could not be put into immediate action and quickly gratified, she left the scene in her mind (Elise. 2002. p. 167).

It is very clear in this example how the client's resistance to exploring the erotic resistance has robbed her of an opportunity of successful analysis of other problems.



After initially advocating the repression of the erotic transference Freud (1915) later also recognized the importance of not resisting the erotic transference. According to Freud, if the client is encouraged to suppress his or her erotic transference, the chance for making great progress is lost, since repressed material which has become conscious, is once again repressed. Freud also warns that if this happens, the client may feel humiliated and act out against the therapist (Freud, 1915).

It is just as important for the therapist that the erotic transference is dealt with effectively, as is illustrated by Jung's experience with Sabina Spielrein. It has been reported that after Jung's treatment of Sabina, he appeared to suffer a psychotic breakdown. He also continued to develop erotic transferences to his female patients (Covington, 2001).

### **2.1.5 Erotic countertransference**

In any analytic setting it is important that the therapist be aware of any countertransference feelings. As far as erotic countertransference goes, Freud warns that the therapist should resist any tendency towards acting on these feelings in the analytic setting, as this would compromise the therapist's neutrality. This would mean that the potential for the client to benefit from the therapy is destroyed (Gerrard, 1999).

Gerrard (1999) disagrees with Freud and argues that unless the client experiences love from the therapist the client will not be able to develop fully. Gerrard (1999) believes that most clients, at some level, don't feel lovable, and that it is only when a client can arouse feelings of love in a therapist that a positive therapeutic outcome can be expected. Doctor (1999) agrees that it is healthy for the therapist to experience erotic feelings, but adds that these feelings are only healthy if the therapist analyses these feelings and accepts that all feelings of love towards clients are neurotic.

Field (1999) uses an example from his own work to illustrate the dangers that a failure to accept erotic feelings poses to the therapeutic process. He describes how he terminated therapy with a woman for whom he had developed erotic feelings. By

following the rule of abstinence, he feels that he was sending the message to his client that he didn't love her. He feels that if he had allowed the erotic feelings to develop within professional boundaries, his client may have experienced a positive therapeutic outcome. Instead, she married a man who she didn't love, and blamed her therapist for withdrawing his love, which caused her to seek love elsewhere (Field, 1999).

There seems to be, therefore, a link between feelings of love between the therapist and client and a positive therapeutic outcome. Harold Searles (cited in Field, 1999), found this to be the case in his own work and said that, "Since I began doing psychoanalysis and intensive psychotherapy, I have found, time after time, that in the course of the work with every one of my patients who has progressed to, or very far towards, a thorough going analytic cure. I have experienced romantic and erotic desires to marry, and fantasies of being married to, the patient" (p. 104).

## **2.2 Freud and Jung's view of the erotic transference**

Since Freud and Jung remain the two most influential theorists on the subject of transference and erotic transference, it is important to this review that their views are explored. Freud's view will be the main focus of attention of this section, while the main points of Jung's views will be highlighted.

### **2.2.1 Freud's view of the erotic transference**

In Freud's writing he uses the terms erotic transference and transference-love interchangeably. To avoid confusion and to remain consistent only the term erotic transference will be used in this review, it is also important to note that when writing on the subject of erotic transference, Freud had a particular genderised model in mind, which is that of a male therapist and a female client. The client would fall in love with the therapist and then in a very open manner, or a more subtle one, make the therapist aware of other feelings. The therapist would then act out his feelings with the client (Joseph, 1993).

It has already been noted that Freud viewed the erotic transference as a form of resistance. It has also been mentioned that although Freud viewed the erotic

transference as a form of resistance, he recognized the potential therapeutic value which lies in the analysis of the erotic transference. In his paper "Observations on transference-love" he even offers his views on how best to manage and understand the erotic transference.

One of Freud's views, which he emphasises in his writing, is that the therapist "... must recognize that the patient's falling in love is induced by the analytic situation and is not to be attributed to the charms of his own person." (Freud, 19] 5, p. 161). He also comes down harshly on some therapists who encourage the development of the erotic transference in order to aid the therapeutic process, by calling the practise a "senseless proceeding". Freud feels that in so doing, the spontaneous element of the erotic transference is lost. Mann (1997) agrees with this and adds that there is no difference between encouraging the emergence of the erotic transference and seducing the client.

Coen (1996) observes that Freud struggled when trying to decide whether erotic transference should be viewed as real or unreal. The difficulty experienced by Freud may lie in the fact that, as he acknowledges himself, real love and erotic transference appear to be very similar. Freud, nevertheless, attempts to justify his stance that erotic transference should be treated as something unreal, by pointing out the differences between erotic transference, which is unreal, and real love which occurs outside the analytic setting. Firstly, erotic transference is brought on by the analytic setting. Secondly, resistance, which is dominant in the situation, intensifies the erotic transference. Thirdly, erotic transference is not based in reality, and the client involved is less capable of seeing the therapist as he or she really is (Freud, 1915).

Mann (1997) argues that all Freud has done here is point out that there are no significant differences between real love and erotic transference. Freud's view that erotic transference is "provoked by the analytic setting" is countered by Mann (1997), who feels that all love is "provoked by the situation", namely, being in the presence of the loved object. Mann (1997) also contradicts Freud's view that only love in the analytic setting is intensified by resistance, by saying that this is applicable to most other love relationships. Of Freud's view that erotic transference "lacks to a high degree a regard for reality" (Freud, 1915, p.68), Mann (1997) says

that Freud is ignoring the elements of which real love is made up, which are "no regard for reality, sensibility or consequences" (p.29). Mann (1997) also points that if the erotic transference were not real, then any growth or change that occurs as a result of the analysis of the erotic transference would not be possible since growth can only be effected by something real, not unreal.

Freud has, however, as Wallerstein (cited in Person, 1993) observes, contributed greatly to the understanding of erotic transference with the following insights; 1) Freud's identification of the high incidence of erotic feelings evoked in the treatment setting and the technical and moral dangers they pose, 2) His elucidation of a small class of patients for whom erotic transference is mobilized as resistance and proves incapable of resolution; 3) His establishment of technical prescriptions for handling such transferences - the "rule of abstinence" and neutrality on the part of the analyst (p.7).

Freud also provides three possible outcomes if the therapist finds that his or her client has fallen in love with him or her. Firstly, a lasting, legal union can be formed. Secondly, the therapy could be terminated. Lastly, the therapist could enter into a secret relationship with his or her client. The first and last possible outcomes, while allowing the client to continue with therapy, is prohibited by professional and societal standards. Freud continues by explaining that continuing therapy in spite of the erotic transference is possible, as long as the therapist adheres to the rule of abstinence. The therapist should also interpret the client's wishes for a relationship with the therapist, rather than satisfy or reject those wishes (Eickhoff 1993).

### **2.2.2 Jung's view of the erotic transference**

In her paper on the erotic transference, Schaverien (1998) explores the link that Jung makes between images discovered in an ancient alchemical text, the Rosarium Philosophorum, and the effects of transference in the analytic setting. One of these diagrams or images is of a man and woman engaging in sexual intercourse. This image, called the Coniunctio, is recognized by Jungians as a metaphor for what transpires between the unconscious of the therapist and of the client. Jung used ten of the original twenty images as an illustration of the unconscious relationship

between therapist and client (Schaverien, 1998).

Jung describes how, in therapy, factors such as the undivided attention of the therapist make a meeting between the unconscious of the therapist and the unconscious of the client possible. This meeting may lead to an intense and very often erotic form of relating to one another. This form of relating to one another may dominate for a while and lead to the erotic transference (Schaverien, 1998).

It is clear that Jung, unlike Freud, does not view the erotic transference as a form of resistance. Jung does, however, appear to be in agreement with Freud that the erotic transference is induced by the analytic setting. While Freud believes that the erotic transference needs to be directly addressed in order to resolve it, Jung seems to view it as being a phase of the therapeutic process, which will run its course until the next phase begins (Schaverien, 1998).

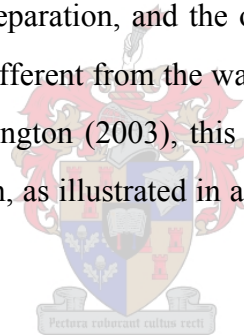
Jung's view of the erotic transference is further explored by Covington (2003), who highlights the dangers of the enactment of the erotic transference as pointed out by Jung. According to Covington (2003), Jung felt that engaging in a sexual relationship with a client prevents the "very psychological growth and separation that constitute the central analytic task" (p.255). The separation Covington (2003) refers to, is what Jung felt each individual's primary struggle in life is, to separate from the mother. The adaptive outcome of this struggle would be successful separation from the mother. When separation does not occur, the individual may either work in adult life to perform the task of separation, or may become involved in an enmeshed relationship with another, as a defense against separation. The latter scenario, when played out in the analytic setting, leads to the development of the erotic transference (Covington, 2003).

In his paper *The development of the personality (1915)*, Jung explains the meaning of sexual feelings in the therapeutic setting as an indication of a desire for psychic growth, and not sexual gratification,

The basic hypothesis of the view advanced in this work is that sexual interest plays a not inconsiderable role in the nascent process

of infantile thinking, an hypothesis that should meet with no serious opposition ...I also lay stress on the significance of thinking and the importance of concept-building for the solution of psychic conflicts. It should be sufficiently clear from what follows that the initial sexual interest strives only figuratively towards an immediate sexual goal, but far more towards the development of thinking. Were this not so. the solution of the conflict could be reached solely through the attainment of a sexual goal, and not through the mediation of an intellectual concept (Covington. 2003. p.257).

The task left to the therapist is to resist engaging in a sexual relationship with the client, as doing so is a re-enactment of early parental relationships where there is a desire to remain fused with another. This leaves both client and therapist still in the position of defending against separation, and the opportunity to discover that they can be loved in ways that are different from the way they experienced their primary love is lost. According to Covington (2003), this point of view arose from Jung's own work with Sabina Spielrein, as illustrated in a letter written by Spielrein to her mother,



[In this paper. Jung] shows that the choice of the future (love) object is determined in the first relations of the child with his parents. That I love him is as firmly determined as that he loves me. He is for me a father and I am for him a mother (his mother came down with hysteria when he was two years old); and he became so attached to the (substitute) woman that when she was absent he saw her in hallucinations, etc. Why he fell in love with his wife I do not know ...Let us say, his wife is "not completely" satisfactory, and now he has fallen in love with me, a hysteric; and I fell in love with a psychopath, and is it necessary to explain why? I have never seen my father as normal. His insane striving

"to know himself" is best expressed in Jung for whom his scientific activity is more important than anything in this world... (Covington. 2003. p.261)

According to Spielrein, she had an incestuous longing for a father and Jung for a mother. Their attraction to one another, therefore, is related to their early attachments to their parents. If they had recognized this earlier they may have been able to work through the past failures of early parental relationships (Covington, 2003).

### **3. THE IMPACT OF SEXUAL FEELINGS ON THE THERAPEUTIC PROCESS**

The theoretical perspectives outlined above reflect some of the points that will be covered in the section below by looking at contemporary views of the impact that sexual feelings may have on the therapeutic process. These points include:

1. The lack of research may be a consequence of the discomfort around the topic of erotic transference initiated by Freud's struggle with his own discomfort.
2. Varied research outcomes may be a reflection of the different understandings of the erotic transference, which result in different approaches to the management of the erotic transference.
3. Theoretical perspectives that the enactment of the erotic transference will have a negative impact on the clients as well as the therapeutic process is echoed by client reports of the negative outcomes of enactment.

  
Pectora roburant cultus recti

The fact that sexual feelings and sexual contact have an impact on the therapeutic process, as well as on the therapists and clients as individuals, is not disputed. Whether this impact is negative or positive is still debated, and whether the continuation of therapy is possible once sexual contact has occurred is also not clear. This section will look at the different ways in which the impact of sexual feelings and sexual contact in therapy may be interpreted.

#### **3.1 Research on the therapist's experience of erotic transference**

Findings of recent research indicate that most therapists at some point in their professional lives experience sexual feelings towards a client (Ladany, Melincoff, O'Brien, Knox & Petersen, 1997). In a study conducted by Giovazolias and Davis

(2001), for example, 77,9% of respondents reported that they had at some point in their professional lives been attracted to a client. Despite the evidence of a high incidence of sexual attraction between therapist and client, as Bernsen, Tabachnik and Pope (1994) point out, very little research has been conducted on the topic. They attribute the lack of research to what they call a "vicious circle" namely discomfort with the topic has contributed to the lack of research; in turn a lack of research helps maintain discomfort with the topic (Pope, 1994 cited in Bernsen *et al.*, 1994). Commenting on the lack of research Schamess, (1999) says that since sexuality has been identified by classic psychoanalysis as playing a major role in normal development as well as in the development of psychopathology, the lack of research is an indication of a positivist view of the therapist's role i.e. therapists, regardless of theoretical orientation or training, have similar approaches to the subject of sexual contact between therapist and client. The lack of research may also be a reflection of a reluctance to investigate any phenomenon that might not be interpreted as scientific or professional (Schamess, 1999).

The research that has been done has yielded varied results. In a study conducted by Ladany *et al.* (1997), for example, the majority of respondents reported that their feelings in response to their sexual attraction to a client were mostly negative (e.g the therapist felt scared or guilty). These results were contradicted, however, in a study conducted by Giovazolias & Davis (2001), in which only 6,3% of respondents reported negative feelings.

There have, however, been studies that yielded similar results. A study conducted by Bernsen *et al.* (1994), for instance, and another conducted by Ladany *et al.* (1997) yielded similar results on the topic of characteristics that attracted a therapist to a client. In both studies, most respondents reported that physical attractiveness of a client played an important role in whether or not the therapist became sexually attracted to the client. Other characteristics rated highly in both studies were a) if the client seemed needy or vulnerable b) if the client was flirtatious or very sexual and c) if the client has a positive personality.

Giovazolias and Davis (2001) found in their research, that there is little difference in



the incidence of sexual attraction to a client between male psychologists and female psychologists. They emphasize this point, since they feel that the frequent use of the pronoun “he” when referring to a psychologist who experiences a sexual attraction to a client, incorrectly implies that it is only male therapists who experience sexual attraction to clients. It may also contribute to the discomfort a female therapist may experience if she is attracted to a client, by placing a greater taboo on the subject (Giovazolias & Davis, 2001),

In a study conducted by Conte *et al.* (1989), no significant differences in opinion based on the sex of the therapist were found. There were, however, clear differences when respondents were categorized according to their theoretical orientation. It was found that respondents who identified their orientation as psychoanalytic were more conservative regarding sexual contact with a client. Respondents who classified their orientation as behavioural, eclectic or supportive, for instance, viewed sexual contact with a client as "moderately inappropriate", whereas the psychoanalysts viewed it as "decidedly unethical".

Another issue on which most therapists agree is the inadequacy of training programs in dealing with sexual attraction between therapist and client, In a study conducted by Bernsen *et al.* (1994), 51% of respondents reported that they had received no training on the matter. According to Paxton, Lovett and Riggs (2001), a therapist who isn't trained to deal with sexual feelings toward a client, will suppress these feelings until they become unbearable. The therapist could then also become anxious or guilty and start believing that there is something wrong with him or her. If the therapist withdraws, the client may start feeling that his or her sexuality is threatening (Paxton et al., 2001).

Paxton et al. (2001) suggest that when planning training programs for therapists the following findings should be considered, since respondents to their study rated their training regarding sexual feelings in the therapeutic relationship higher than others who did not provide the following experiences: 1) Supervisors who agree that sexual feelings are a natural, expected part of any human relationship and must be anticipated and planned for by therapists to ensure a responsible and ethical response

on their part. 2) A content-specific ethics course that includes an opportunity to explore ways in which the therapist might respond to feelings of sexual attraction to a client. 3) An opportunity to explore personal attitudes and beliefs as a sexual person.

Thorn, Rubin, Holderby and Shealy (1996) found in their study that most therapists feel it would be detrimental to their profession to educate clients on sexual relations within the therapeutic relationship. The study asked therapists to give their opinions on brochures providing information on sexual relationships between therapists and clients e.g. “Actions you can take if you feel your therapist has acted inappropriately. Therapists involved in the study felt that presenting clients with this kind of information would lead to an increase of distrust in therapists and an increase in the number of false complaints filed against therapists. Thorn et al. (1996), found in their study, however, that the therapists' fears are unfounded.

### **3.2 Effects of sexual contact on the client**

Even though sexual contact with clients is viewed as unethical behaviour, and is usually assumed to be harmful to clients, there have been therapists who disagree and claim that sexual contact may be therapeutically valuable (Pope & Bouhoutsos, 1986). McCartney (1966, cited in Pope & Bouhoutsos, 1986), for instance, uses a quote by Boss to justify sexual contact with his clients:

the female analysand begins to love the male analyst as soon as she becomes aware that she has found for the first time in her life someone who really understands her and who accepts her even though she is neurotic. She loves him all the more because the analyst permits her to fully unfold her real emotions within the safe relationship of the transference (p.57).

McCartney (1966, cited in Pope & Bouhoutsos, 1986), continues by saying that in his writing, Boss does not put any limitations on the extent to which a client may express his or her needs. McCartney (1966) also points out that clients want to experience their newly discovered ways of expressing emotions, and may this may include sexual feelings. These statements are, however, contrary to what Russell (1993) finds, as he identifies nine possible psychological effects that sexual contact within the therapeutic relationship could have on the client:

1. Feeling special: The client begins to believe that s/he is in some way special to the therapist.
2. Dependency: Dependency is strongly tied in with feelings of love, and needs to be seen as part of the exploitative process. Any dependency involves a sense of disempowerment for the client.
3. Trust: The client very often experiences a sense of betrayal of trust when sexual contact occurs.
4. Guilt: The client experiences guilt as though it is his or her fault that the sexual contact has occurred. The client also feels guilty when telling others of the experience because they feel they are betraying the therapist. Both senses of guilt depress the client, and enforce or reinforce a poor or distorted self-concept.
5. Anger: A client very often experiences a deep sense of rage.
6. Frustration and helplessness: Not being able to warn others about the therapist very often leaves the client feeling frustrated and helpless.
7. Ambivalence: The client often has mixed feelings, regarding both the therapist and the therapy received.
8. Poor or distorted self-concept: Feelings of worthlessness are a common consequence of any exploitative experience. A client may also start to see his or her sexual nature as dangerous. They could also start reasoning that "this has happened to me, therefore I made it happen, therefore, there is something wrong with me".
9. Isolation: A client could feel isolated for some time after the experience, as a result of feeling too ashamed to share the experience with anyone (p.21).

Most clients who have been sexually involved with a therapist report negative effects. Pope and Bouhoutsos (1986) found that whether the client reported negative or positive effects, was related to who initiated the sexual contact. Negative effects are reported when it is the therapist who initiates the sexual relationship. Positive effects are reported when it is the client who initiates the sexual relationship. Pope and Bouhoutsos (1986) also point out that even when positive effects are reported, they very often become negative after a period of time.

### **3.3 The effects of sexual contact on the therapeutic process**

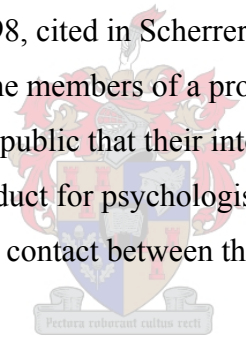
According to Smolar and Akhtar (2002), the nature of sexual contact necessitates the termination of therapy, once sexual contact has occurred. They identify three aspects of sexual relations that make it impossible for therapy to continue.

Firstly, when people become physically intimate with one another, their psychic functioning is dominated by regressive thinking and fantasy. This makes it impossible for the therapist to fulfill his or her role. Secondly, sexual contact gratifies the needs of both therapist and client. The therapist, who has agreed to attend only to the client's needs in exchange for payment, is therefore, violating the agreement with the client. Thirdly, for therapy to have a successful outcome, the therapist needs to be seen as having some kind of authority. If sexual contact occurs the therapist will no longer be in a position of authority (Smolar & Akhatr, 2002).

#### **4. PROFESSIONAL CODES OF CONDUCT AND TRAINING PROGRAMS**

The theoretical perspectives covered in a previous section provide a basis with which to compare the amount of theoretical knowledge available, and the extent to which this knowledge is put to practical use in the codes of conduct.

According to Louw and Edwards (1998, cited in Scherrer *et al.*, 2002), professional codes of conduct exist in order to ensure that the members of a profession have at least minimum level of expertise. This, in turn, assures the public that their interests will be protected. This section will look at professional codes of conduct for psychologists in South Africa, focusing on the guidelines they offer regarding sexual contact between therapists and their clients.



##### **4.1 Codes of Conduct in South Africa**

According to Louw (1997a) one way in which a profession is defined is through the existence of a code of ethics. The South African Psychological Association (SAPA), established in 1948, recognized this and published a "Digest of Ethical Standards" in 1962. Since then other organisations such as the Institute for Clinical Psychology (SAICP) as well as the Psychological Association of South Africa (PASA), have published codes of ethics (Wassenaar, 1998),

Since February 1999 the ethical conduct of psychologists has been under the control of the Health Professions Council of South Africa (HPCSA), formerly known as the Interim National Medical and Dental Council. All the different professional boards are still represented in the HPCSA (Scherrer *et al.*, 2002).

Wassenaar (1998) has found that there is still confusion among South African psychologists about the difference between the ethics committees of the Psychological Society of South Africa (PsySSA) and the Professional Board for Psychology.

The main difference between the two is that while the Professional Board is a statutory organisation with which registration is compulsory, PsySSA is a voluntary organisation that cannot take legal steps against a psychologist (Wassenaar, 1998).

The aims and functions of the ethics committees of these two organisations are also very different. While PsySSA's ethics committee aims to promote psychology, as well as to support and represent psychologists, the Professional Board's ethics committee aims to regulate the practice of psychology and to discipline psychologists found guilty of unethical behaviour and malpractice (Louw, 1997b).

#### **4.2 PsySSA's Code of Professional Conduct**

PsySSA's Code of Professional Conduct, when addressing the issue of sexual relations between therapist and client, makes a distinction between sexual harassment and sexual relations. This distinction acknowledges that at times clients experience sexual advances made by a therapist as harassment, and at times they willingly enter into sexual relationships with their therapists. Nevertheless, the Code clearly states that, "The psychologist shall not enter into a sexual or other dual relationship with a client or former client" (PsySSA, p.19).

Due to gaps in the Code created by vague definitions, there is still enough room for an unscrupulous psychologist to exploit his or her clients. Even though the Code states, for instance, that sexual relations with former clients are prohibited, provision is made for sexual relations that occur under, what the code terms, "the most unusual

circumstances"(PsySSA, p. 19). Since the Code does not provide a definition or even guidelines for what would constitute a "most unusual circumstance", an offending psychologist is left with the space to present almost any circumstance as a "most unusual circumstance".

However, the therapist has to be able to prove that, in the light of the following factors, no exploitation has taken place:

1. the amount of time that passed since the professional relationship ended,
2. the nature and duration of the professional relationship,
3. circumstances of termination,
4. the client's personal history,
5. the client's current mental status,
6. the likelihood of adverse impact on the client and others, and

7. any statements or actions made by the therapist during the course of the professional relationship suggesting or inviting the possibility of a post termination sexual or romantic relationship with the client.

Apart from the last guideline, all the others are too vague to protect the rights of the client. For instance, what criteria are used to establish an appropriate length of time that passed since the professional relationship ended isn't made clear.

### **4.3 The Professional Board for Psychology: Ethical Code of Professional Conduct**

The Professional Board's Code of Conduct takes a very similar approach to PsySSA's Code of Conduct on the topic of sexual contact between therapist and client. The Professional Board also refers to sexual harassment and sexual relationships that are entered into willingly by therapist and client. Both Codes of Conduct, however, fail to mention or offer any guidelines as to the course of action that should be taken by a therapist if a client makes sexual advances towards the therapist (Professional Board for Psychology, 2002). It could be speculated, therefore, that it has been assumed that if a client does make sexual advances towards his or her therapist, that the therapist would be equipped to manage and resolve it successfully.



Both Codes hold similar views on the topic of sexual contact with former clients. The guidelines offered by the Professional Board's Code of Conduct, for instance, are almost identical to those offered by PsySSA. The similarity between the two Codes of Conduct means that they are lacking in the same areas. The most important being a lack of an explanation of what would constitute sexual contact.

### **4.4 Possible amendments to codes of ethics**

In order to provide clients with the best possible psychological services and doing so in a responsible manner, amendments need to be made to current codes of ethics. Russel (1993) points out four possible amendments that could be made: 1) a more detailed description of what would constitute sexual contact needs to be provided; 2) reporting colleagues who are suspected of exploitation should be made an ethical requirement; 3) a minimum period of time between the termination of a therapeutic

relationship and the commencement of a sexual relationship needs to be indicated; 4) a minimum period of time between the termination of a training relationship and the commencement of a sexual relationship needs to be indicated.

It is important to note that ethical codes alone are not enough to regulate professional behaviour. Psychologists have to be responsible and display sound judgment by consulting with colleagues and be familiar with the latest developments through reading. It should also be kept in mind that since no two therapeutic situations are alike, drawing up ethical guidelines for every ethical difficulty that may arise is impossible (Scherrer *et al.*, 2002).

## **5. TRAINING PROGRAMS**

The following section identifies issues related to training programs and their position on erotic transference.

The importance of training to manage the erotic transference is pointed out by Paxton, Lovett and Riggs (2000) when they state that, "the lack of training is related to the incidence of mismanagement of sexual feelings in the therapeutic relationship" (p. 177). They state further that it has been acknowledged by various authors that even though a course in ethics is included in most training programs, students are not trained to understand and work with sexual feelings in the therapeutic relationship. In recognition of the inadequacy of training in this regard, guidelines for working with sexual feelings in the therapeutic relationship were developed by various authors. According to Pope (2000, cited in Paxton *et al.*, 2001), however, research indicated that in the year 2000, training programs were still not making use of the guidelines provided in the literature.

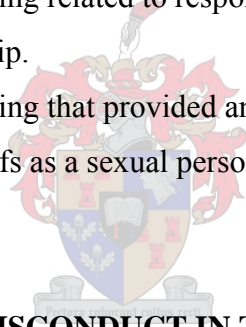
Following their study of 293 university-based therapists, Paxton *et al.* (2001) identified the following training experiences and opportunities as leaving therapists better prepared to deal with sexual feelings in the therapeutic relationship:

1. The availability of supervisors who were perceived by the respondents to agree that "sexual feelings are a natural, expected part of any human relationship and must be anticipated and planned for by therapists to



insure [sic] a responsible and ethical response on their part"

2. A content-specific ethics course that had included an opportunity to explore ways in which the respondent might respond to feelings of sexual attraction to a client; notably, the biggest impact of a content-specific ethics course appears to be between those who felt moderately and very well prepared.
3. The availability of "other courses" in which they were given an opportunity to explore ways in which they might respond to sexual feelings in the therapy relationship; the greatest impact of this specific training appears in the transition between moderately and very well prepared.
4. An opportunity to explore personal attitudes and beliefs as a sexual person.
5. Postgraduate training related to responding to sexual feelings in the therapy relationship.
6. Postgraduate training that provided an opportunity to explore personal attitudes and beliefs as a sexual person.



## **6. PREVENTING SEXUAL MISCONDUCT IN THERAPY**

As mentioned previously, ethical codes of conduct are not enough to prevent sexual misconduct from happening. This section, therefore, looks at other ways in which the prevention of sexual misconduct can be promoted.

### **6.1 Boundary violations and boundary crossings**

Norris, Gutheil and Strasburger (2003) define a boundary as "an edge of appropriate professional behaviour, a structure influenced by therapeutic ideology, contract, consent, and, most of all, context" (p. 518). Following this definition, they also make a distinction between boundary violations and boundary crossings. Boundary crossings are minor deviations from traditional practice that aren't harmful to the client, such as giving a client a lift when no other transport is available. Boundary violations, however, are harmful and involve exploiting the needs of the client (Norris *et al.*, 2003).



Gabbard (1996) holds that establishing clear boundaries plays a central role in preventing sexual misconduct in therapy, since the therapist is provided with an opportunity to assess his or her countertransference. If a therapist observes a pattern of crossing boundaries, then s/he should carefully examine the process, in order to determine if this problem is based on clinical reasoning or on countertransference (Gabbard, 1996).

Establishing clear boundaries would also help prevent therapists from starting off on what Strasburger, Jorgensen and Sutherland (1992) call the "slippery slope of boundary violations". According to Strasburger *et al.* (1992), if a therapist starts performing relatively small boundary violations, such as extending a session with a client, s/he is more likely to become sexually involved with a client. Even small violations have the effect of blurring the boundaries in therapy. When this happens, it becomes easier to commit other boundary violations. Simon (1999) adds that even if boundary violations do not lead to sexual contact, they can still cause harm to the client, as the therapist becomes distracted from the treatment process.

Gutheil and Gabbard (1998) note that, even though it is important to have clear boundaries, it is important to judge a behaviour by the context in which it occurs. According to Gutheil and Gabbard (1998) the context may be constituted by "the treater's professional ideology, the presence or nature of informed consent by the patient, the point in therapy at which the behaviour occurs, the respective cultures of the dyad, and such environmental factors as whether therapy occurs in a small town or in an urban centre" (p. 411).

## **6.2 Risk factors for therapists**

Thomas-Peter and Garrett (2000), when offering guidelines for mental health professionals working in hospital settings, suggest that it is important to conduct research on the psychological profiles of therapists and clients who are at risk of become sexually involved within the therapeutic relationship.

They observe that previous studies have indicated that therapists who do become sexually involved with their clients are more likely to repeat this behaviour with other

clients. They also tend to hold slightly different views from other therapists, such as the belief that physical contact that is not sexual is acceptable. Two groups of offenders are identified. The first is described as young therapists who take advantage of the situation, as they would in any other situation in life. The second group is made up of middle-aged therapists, who feel isolated and are experiencing difficulties in their personal lives. In this group the male therapists tend to be disillusioned, while the female therapists are looking to fulfill a fantasy of rescuing a client by restoring mental health through love. It has also been suggested that sexual orientation, sexual contact as a student with an educator, and the length of time as a practicing therapist may also be indicators of sexual contact with clients. Therapists who have not been qualified for very long are more likely than therapists who have been practicing for a longer time to become sexually involved with their clients. Therapists who describe their sexual orientation as homosexual are more likely to report sexual contact with a client, as well as therapists who were sexually involved with an educator while they were in training (Thomas-Peter & Garrett, 2000).

Norris *et al.* (2003) feel that when discussing therapist risk factors it is important to keep in mind three warnings. Firstly, personal problems do not excuse a therapist from failing to set and maintain boundaries. Secondly, any therapist, not only those viewed by the rest of the profession as "bad apples", can experience difficulties with boundary problems. Thirdly, the treatment relationship should be re-assessed to determine whether or not it would be wise to continue with the therapy (Norris *et al.*, 2003).

Norris *et al.* (2003) identify the following risk factors for developing boundary problems:

- 1) Life crises: Midlife and late-life crises can precipitate boundary violations.
- 2) Transitions: Changes in a therapist's life, even positive ones, may make him or her more susceptible to boundary problems.
- 3) Illness of the therapist: During illness, a therapist may turn to a client for comfort.
- 4) Loneliness and the impulse to confide: The need to be listened to may lead to a role reversal in which the client begins to take care of the therapist.

- 5) Idealization and the "special patient": Beauty, youth, intellect or status may cause the therapist to view a client as special.
- 6) Pride, shame, and envy: Experienced therapists are in danger of neglecting to seek supervision, since they feel that due to their experience, they are not at risk of committing boundary violations.
- 7) Problems with limit setting: some therapist have problems with setting limits for clients who continually challenge boundaries, since they may feel intimidated by the client.
- 8) "Small town" issues: In a small town it is almost inevitable that therapists and clients will encounter each other outside the analytic setting. In these situations therapists need to be more careful about maintaining boundaries.
- 9) Denial: Denying that there are boundary difficulties can lead to these difficulties developing into major boundary problems.

### **6.3 Risk factors for clients**

Morris *et al.* (2003) identify the following risk factors that could lead to a client acting out sexually:

- 1) Enmeshment: Rather than seeking autonomy, some clients become dependent on the therapist.
- 2) Changing roles: Some clients, instead of challenging the therapist, take on a role which allows them to remain dependent on the therapist.
- 3) Retraumatization: Clients who have experienced trauma, especially childhood trauma, may revert back to the role of victim when boundary violations occur in the therapeutic relationship.
- 4) Shame and self-blame: Clients often blame themselves for being abused.
- 5) "True love": If a client has had few other significant relationships in his or her life, the therapist may be seen as the last chance for "true love".
- 6) Dependency: Clients have difficulty distinguishing between help and overinvolvement.

The development of erotic transference is likely to precede any sexual contact. Blum (1973, cited in Stirzaker, 2000) identifies four factors which would make a client

more likely to develop erotic transference: 1)sexual education while in the Oedipal stage; 2)instinctual over-stimulation coupled with inadequate parental protection and support; 3)intense masturbatory conflicts; 4)family tolerance of incestuous/homosexual behaviour. Since the therapeutic relationship is in some ways a re-enactment of the parent/child relationship, it can be assumed that the therapeutic relationship could evoke Oedipal desires in the client (Stirzaker, 2000). Thomas-Peter and Garrett (2000) add that clients who become sexually involved with their therapists may display a variety of psychological vulnerabilities, such as being the victim of child abuse or having a diagnosis of a personality disorder.

Chiesa (1999), however, argues that the emergence of the erotic transference is multi-determined, and explains that experiences that have been identified as having the effect of predisposing clients to develop erotic transference, is not specifically confined to these patients. Rather than trying to find a universal explanation, each client should be assessed according to his or her individual experiences (Chiesa, 1999).



#### **6.4 Suggestions for the prevention of sexual misconduct**

Strasburger *et al.* (1992) offer the following suggestions for the prevention of sexual misconduct in therapy:

- 1) Educating therapist-trainees: Increasing the awareness of sexual exploitation by therapists should begin during their educational and training programs. Supervision for trainees should enable them to experience, tolerate and make use of countertransference feelings as they arise in the course of therapy. Trainees should be taught to anticipate times when the intensity of the therapeutic relationship calls for supervision or consultation, and possibly their withdrawal from the therapy.
- 2) Education of currently practicing psychotherapists: Most practicing therapists have not been educated about the nature and scope of sexual exploitation of patients. Like trainees, they need to know of the prohibitions against sexual exploitation and the damages it causes clients as well as the costs to the therapist.
- 3) Educating consumers and the public at large: It is important that potential consumers of therapists' services be informed of what to expect in therapy.

4) Education of professions other than therapists: Lawyers, judges and administrators need to be educated about the nature and extent of sexual exploitation by therapists, as well as the damages it causes.

5) Employers, institutions and hospitals: Employers would be well advised to investigate therapists thoroughly, since they could be held liable for the therapist's misconduct. Employers should have a clearly written policy stating that sexual exploitation of clients is unethical, is never appropriate, and constitutes grounds for immediate dismissal. A protocol for assessing and processing complaints and appeals should be developed.

6) Punitive legal and administrative processes: It is widely assumed, though not yet empirically demonstrated, that the existence of criminal sanctions would lower the incidence of sexual contact with clients, serving a preventative function for the injuries resulting from such contact.

## **7. CONCLUSION**

Apart from confusing terminology, the emphasis that most codes of ethics place on physical contact, creates the impression that this is the only way that the client could be harmed and is an indication of the underlying assumptions on which professional codes of ethics are based. These assumptions are reflected in the relevant literature, through the focus on physical boundaries, and the harm that violations of physical boundaries can cause. Borys (1994), however, touches on the importance of non-physical boundaries, when exploring the meaning of boundaries to clients, and mentions actions such as excessive self-disclosure, which could lead to a client feeling special, and in this way the opportunity to resolve doubts about worth and the dependence on the approval of others is lost.

Borys (1994) point of view is similar to that of Sheets (1999), who offers the following definition of professional boundaries, with specific reference to the nursing profession, "Professional boundaries establish the limits of the professional relationships that allow for a safe therapeutic connection between the nurse and the client." Dr Simon (cited in Sheets, 1999), a forensic psychiatrist, expands on this definition by offering the following guidelines when establishing boundaries:

“1. The rule of abstinence - a professional must abstain from personal

gratification at the client's expense.

2. Not to interfere in a client's personal relationships.
3. The promotion of client autonomy and self-determination.
4. The professional must act in the best interest of the client.
5. Respect for human dignity - which underlies all of the above. ( p.658)”

These guidelines acknowledge that clients may be harmed through actions that do not necessarily violate physical boundaries, but that violate a client's right to, for instance, autonomy, self-determination and dignity. As mentioned in the theoretical perspective, psychological growth, which includes being autonomous and self-determined, may be achieved through addressing and managing the erotic transference as it arises in the therapeutic setting, and following the above-mentioned guidelines, not doing so could then be seen as a boundary violations. This point of view, however, is not incorporated into current professional codes of ethics, and would, therefore, not be presented in this way in current training programs. From the above review, it may be concluded that ethical guidelines on sexual contact in therapy is not based on any theoretical framework, and therefore, training provided will also not incorporate a theoretical perspective.

Thus, therapists are not able to rely on ethical codes or their clinical training to provide them with guidelines on the management of the erotic, since current ethical codes seem to advocate the repression of the erotic transference, rather than the management thereof.

Advocating the repression of the erotic transference is a reflection of its absence in past and current discourses in mainstream psychology. The risk associated with this absence is that it may be a form of denial as to the presence and existence of erotic transference in the analytic setting. Incorporating the erotic transference into our every day experience of the analytic setting will ameliorate the dangers inherent in its absence from our current approaches to therapy.

In conclusion, possible areas for future research include research that will enable the authors of ethical codes to define terminology associated with sexual feelings in the therapeutic setting. The concept of the erotic transference as used in this review

represents a particular discourse, thus further research may explore how South African therapists, particularly non-dynamic therapists, construct sexual attraction in the therapeutic setting. Research may also be conducted to establish the elements and dynamics of the discomfort around the topic of sexual feelings in therapy. Also, research may be conducted to assess what is currently being covered in training programs and programs for qualified psychologists regarding the management and interpretation of sexual feelings in the therapeutic setting. Finally, future research may address the ways in which the management of sexual feelings, and not simply the physical acting out of these feelings may be experienced as abusive by clients.



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