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School of Social Sciences

Title: 'An exploration of how therapists experience erotic feelings in therapy'

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Portfolio for Professional Doctorate in Counselling Psychology

DPsych Top-up

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Original submission September 2015

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THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR DATA PROTECTION/CONFIDENTIALITY REASONS:

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City University Declaration

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SECTION A: Preface

Overview

The preface is the first component of the portfolio. The aim of the preface is to introduce readers to the next three components. The portfolio consists of: (1) a doctoral research, (2) a professional practice case study, and (3) a critical literature review of a professional dilemma. Following a description of each section (which includes the reasons I chose to study these specific subjects and their relevance to Counselling Psychology), the preface will conclude with a reflection on the thematic connection across the components of the portfolio.

Research

The second component of the portfolio is a doctoral research. The study is concerned with therapists' experience of erotic feelings in therapy. It is an original piece of research that aims to (1) explore how therapists experience erotic feelings in the context of therapy, (2) examine how their experience is constructed, and (3) identify how their accounts construct the social world. The objectives of the study are to (1) make meaning of therapists' experience, (2) theorise the basic social processes, contexts and structural conditions that impact the construction of therapists' experience, and (3) suggest practical applications (Braun & Clarke, 2006, 2013, 2014). The study is conducted using Thematic Analysis as a methodology and specifically the Constructionist model of Thematic Analysis (Braun & Clarke, 2006, 2013). Constructionist Thematic Analysis is intended to study individuals' subjective experience(s), explore how their experience is constructed, and understand how their accounts construct the social world (Braun & Clarke, 2006, 2013).

Data were collected by conducting semi-structured interviews with thirteen therapists who had more than five years of post-qualification experience. Interviews were audio recorded, transcribed and analysed. Data were analysed following the six steps described by Braun and Clarke (2006, 2013). Research findings and the implications for practice are discussed. There is an evaluation of the study, and suggestions for further research are provided.

The research, which is the largest piece of work in the portfolio, explores a very important but under-researched area of practice. In this sense, the reader has the opportunity to engage with original research findings concerning therapists' experience from their own point of view. Moreover, the reader has the opportunity to hear about practical applications and implications for practice. The research findings will be published in order to (1) inform therapists' practice, (2) guide action, and (3) potentially lead to social change. This last aspiration is based on the understanding that the construction of meaning is a two-way procedure that takes place between individuals and society shaping identities, experiences, understandings and behaviours (Blumer, 1986; Charon, 2010).

The reasons I chose to study the erotic are numerous, and are presented in detail in Chapter 1 (Introduction). The fact that the subject is under-researched, my struggle with the erotic both in life and in therapy, and the benefits of the study for my own and others' practice were among the main reasons that I was motivated to study it. The subject is in line with the values of Counselling Psychology, as it pays attention to the therapist–client relationship, subjective experience of one another, and the collaborative construction of meaning through their interaction and the mutual understanding of the material they work on (Martin, 2009 in Woolfe, Strawbridge & Douglas, 2009).

Professional practice

The third component of the portfolio is a reflection on my work with a client from my private practice. The aim of this case study is to show my ability to work collaboratively with clients, ensuring that their needs are met. The objective of the essay is to show my capacity to make use of my experience, in addition to my personal and professional awareness that informs my work.

My client was diagnosed with moderate, recurrent depression. Work-related stresses, alcohol abuse, low self-esteem, impaired sense of self, loss and long-standing family difficulties seemed to link directly to the presenting problem. I worked with her using Schema Therapy, which is an integrative approach developed by Young and his colleagues designed to treat chronic and/or recurrent depression and anxiety, chronic emotional difficulties, long-standing relationship difficulties, personality disorders, eating disorders and other mental health problems (Young, Klosko & Weishaar, 2003).

The aim of the work was to enable my client to identify, challenge and modify both early maladaptive schemas and maladaptive coping styles, replacing them with more adaptive ones. The features of Schema Therapy are described. An account of the therapeutic work, process and outcomes is also given. An evaluation of my personal and professional learning experience and the role of the supervision received complete the case study. The reasons I chose to present the specific case were in order to reflect on a case that enabled me to grow both as a person and a therapist, and to demonstrate how I 'used' myself to help my client.

It is hoped that the case study can also demonstrate my position on the nature and character of therapy. In my view, therapy has an inter-subjective character, as the therapeutic encounter involves the interaction of two subjectivities: the therapist's and the client's. This specific type of understanding and way of practising therapy is in line with the core values of Counselling Psychology, which pay attention to the therapist–client relationship, their experience of each other and the co-construction of meaning (Martin, 2009 in Woolfe et al., 2009). The case study offers the

reader an opportunity to follow my learning experience, and perhaps learn with me through a reflection on my work.

Critical literature review

The last component of the portfolio is a critical literature review on how therapists approach the dilemma of nonsexual dual relationships with current and former clients. The aim of this review is to analyse and evaluate therapists' approach. The objectives of the review are to examine therapists' beliefs and conduct on the subject, as well as to discuss the implications for practice. Although numerous forms of dual relationships are discussed in the literature, this review concentrates on how therapists approach nonsexual dual relationships with clients. The reasons I chose to review this specific topic were: to understand the nature of the phenomenon, to equip myself with knowledge to further inform my practice, because it complemented the main research subject, and because two clients asked me to become their friends (which I declined).

This topic is in agreement with the core values of Counselling Psychology, as counselling psychologists are particularly interested in making meaning of the psychological phenomena they encounter in therapy (i.e. clients' requests for entering into a nonsexual dual relationship with their therapists), in exploring the impact of these phenomena on the therapeutic relationship and in evaluating implications for practice (Smith & Fitzpatrick, 1995; Zelen, 1985). The review offers the reader an opportunity to familiarise themselves with studies on the subject and perhaps reflect on their own position with regard to the particular professional dilemma. Implications for practice are discussed.

Thematic connection across the components of the portfolio

The unifying theme across the components of the portfolio is that, in all cases, I was an 'insider' (Padgett, 2008). In terms of the main research, I was part of the group I studied (i.e. a practitioner who interviewed practitioners). In addition, I had experienced the erotic in my practice as well. With regard to the case study presented, my client and I shared, to an extent, similar feelings and life experiences. For example, I had 'lost' my mother, which left me feeling confused, scared and abandoned; this is what my client also felt when she lost her mother. My experience resulted in the development of an Abandonment/Instability schema, which was one of the schemas that my client had also developed. Lastly, with regard to the subject I am critically reviewing, two clients requested to form a friendship with me, which classifies as a nonsexual dual relationship.

According to Padgett (2008), being an 'insider' has three advantages: (1) you gain easy entry, (2) you have some knowledge about the research subject/work, and (3) you have the ability to understand nuanced reactions on the part of the participants/client(s). In relation to the research project my position as 'one of them' had three benefits. The first benefit was that a number of therapists expressed an interest in participating in my study. The second benefit was that participants felt able to connect with me very quickly. Lastly, the thirds benefit was that participants were willing to open up to me as they perceived both my training and my experience of the erotic as signs of my ability to understand and, hence, represent their experiences as closely as possible to the way they experienced them.

My position as an 'insider' also meant that I approached all subjects/cases (the main research subject, the case study and the subject I critically reviewed) with not only a sense of curiosity, but also with some knowledge. For example, when the participants and/or my client(s) shared their feelings of confusion, stress or loneliness with me, I knew (to some extent) what they were talking about. At the same time, I was continuously alert and kept

thoroughly reflecting on how my presence and experience shaped my interaction with the research participants and/or my client(s), as well as how it shaped the co-construction of meaning. Furthermore, at all times, I kept in mind that, although we did share an experience, each person felt, processed and responded to the shared experience in their own unique way.

Lastly, my 'insider' position equipped me with certain insights, the ability to understand implied content, and extra sensitivity to certain dimensions of the data and/or my client experiences. For example, in terms of the research project, I was familiar with participants' language, appropriate interviewing techniques, and 'reading' the meaning 'behind the words'. Nevertheless, I kept checking with participants, as I wanted to ensure that we did understand the same thing.

Apart from benefits, the 'insider's' position carries risks as well: (1) the risk of blurring the boundaries, (2) the risk of imposing my own experiences, values or beliefs on the participants and/or my client(s), and (3) the risk of projecting biases (Drake, 2010). The participants' presumption, for example, that researchers who are also colleagues are familiar with their realities carries a risk: participants may retain information they believe to be obvious. On the other hand, researchers may assume some similarities and fail to notice certain aspects of the participants' experience (Drake, 2010). To handle this risk, I made an intentional effort to separate my own experience from the participants' experience, examining myself and recording my reactions. It was vital that I made sure I allowed the participants to tell me their story (rather than 'push' them into certain directions), heard what they said, checked how my experience filtered what I heard, and abstained from insinuation (Padgett, 2008). Another risk, related to the 'blurring of the boundaries', was the risk of the participants' interviews turning into therapeutic sessions. To manage this risk, I was constantly aware of the purpose of our meeting and the roles we held.

The second risk that the ‘insider’s’ position carries is the risk of researchers getting over-involved in their study to a degree that participants’ voices are not heard (Cloke, Cooke, Cursons, Milbourne & Widdowfield, 2000). I handled this risk by using my experience to deepen my understanding of the participants’ experience from their point of view (as opposed to mine). Lastly, aiming to manage the risk of projecting my own biases on the participants, I decided not to disclose my own experience of the erotic to them. Soon, I realised that my decision related to my training as a therapist, but also to my desire to distance myself from the challenges of the erotic. My realisation enabled me to become both more sensitive and responsive to participants’ enquiries about my experience. At the same time, I disclosed information only at the end of the interviews and I was very careful not to judge any experience (theirs or mine). My behaviour reassured the participants that I respected and appreciated both their time and their experiences, and it reduced potential feelings of a power imbalance between us.

In similar ways to the aforementioned, I handled the same three risks in my work with my client and in my response to the two clients who asked to become friends with me. My approach was open, explorative and respectful. In addition, with regard to the professional dilemma encountered, I reviewed it in a critical manner and from all possible angles, aiming to have an all-round picture of how therapists approach nonsexual dual relationships with their clients in order to inform my own and other therapists’ practice. In conclusion, I was fully and constantly aware of both the advantages and the disadvantages of my ‘insider’s’ position on all three cases, and I handled the latter in the best possible way.

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An exploration of how therapists experience erotic feelings in therapy

Abstract

Aims and objectives

This study has three aims. The first aim is to explore how therapists experience erotic feelings in therapy. The second aim is to examine how therapists' experience of the erotic is constructed, and the third aim is to identify how therapists' accounts construct the social world. The objectives of the study are to (1) make meaning of therapists' experience, (2) theorise the basic social processes, contexts and structural conditions that influence the construction of their experience, and (3) suggest practical applications (Braun & Clarke, 2006, 2013, 2014).

Methodology

The Constructionist model of Thematic Analysis (Braun & Clarke, 2006, 2013) is used to analyse the collected qualitative data.

Method

Data were collected by conducting semi-structured interviews with thirteen therapists. The participants were six male and seven female who had more than five years of post-qualification experience. Interviews were audio recorded, transcribed and analysed.

Results

The findings suggest that the majority of participants are not prepared for their encounter with the erotic. Most of them perceive it as a mysterious phenomenon, view it as a professional taboo, and argue that it has personal and sensitive meaning for both themselves and their clients. The majority of participants appear to encounter a series of challenges, which they process internally while they handle the erotic explicitly, implicitly or not at all. Participants' understanding of the erotic is mostly influenced by their clinical experience and the quality of supervision they receive. Their experience of the erotic is constructed through their interaction with society, training institutions, the profession and the regulation of clinical practice. At the same time, due to the inter-relationship between social systems and therapeutic practice, participants' accounts construct the social world. Participants understand the erotic as a product of therapy and highlight that it can be either constructive or destructive. At last, they advocate that a practical approach to learning, open conversations on the subject and strategies to overcome the restrictions set by society, culture and regulation are required to enable their work with the erotic.

Discussion

Research findings and implications for practice are discussed. The methodology used to conduct the study is evaluated. Suggestions for further research are provided.

SECTION B: Research

An exploration of how therapists experience erotic feelings in therapy

Chapter 1: Introduction

1.1 Introduction

The purpose of the introductory chapter is to first present the story of Eros and define erotic feelings. The study of the erotic, the conceptualisation of the meaning of the erotic, and its constructive and destructive nature follow. The factors that influence how therapists understand the erotic, as well as the basic social processes and systems that shape therapists' experience of the erotic are portrayed. A reflexive statement on the researcher's background, and the journey of researching the erotic and the particular research question is presented as well. The importance of studying the specific subject, its contribution to the field, its original contribution to existing knowledge, and its relevance to Counselling Psychology are also discussed. The aims and objectives of the study and a brief description of how the topic was studied complete this chapter.

1.2 The story of Eros

The word 'eros' is the root of the word 'erotic'. In Greek mythology, Eros ('desire') was the god of sexual desire and love (Mann, 1997). In some myths, Eros was the disobedient but loyal son that Aphrodite had with Ares or with Hermes. In other earlier myths, Eros was considered to be a primitive god, a child of Chaos, who blessed the union of Gaia with Uranus and, in this sense, he was involved in the creation of the universe (Greek Mythology, 1997; Haule, 1996). In early Greek poetry and art, Eros was represented as a young, handsome male, whereas in the latter satirical poetry, he was represented as a blindfolded child who, armed with his bow and arrows, targeted humans in order to make them fall in love with the first person they encountered (Greek Mythology, 1997; Haule, 1996; Mann, 1997).

One of the best-known myths in ancient Greece was that of Eros and Psyche ('soul') who struggled with love and trust (Greek Mythology, 1997). According to the myth, Aphrodite was jealous of the beauty of a mortal princess called Psyche. Aphrodite's feelings of jealousy led her to ask her son Eros to make Psyche fall in love with the ugliest creature on Earth. However, when Eros saw Psyche, he fell in love with her and married her. Psyche's jealous sisters were not happy about Psyche's union with Eros and prompted her to betray his trust. Psyche followed her sisters' ill advice and, eventually, Eros left his wife. Psyche regretted her actions and wandered the Earth looking for Eros. Eventually, she approached Aphrodite and asked for her help. Aphrodite promised to help Psyche on the condition that she completed a series of difficult tasks that she would set for her. Psyche passed these tasks successfully, which led Aphrodite to not only consent to the union of Psyche and Eros, but also to make Psyche immortal. Eros and Psyche had a daughter called Hedone ('bliss') (Greek Mythology, 1997).

1.3 Defining erotic feelings

Eros is considered to be a type of love where the meaning varies depending on the context used. Greek, which is considered to be a very old and rich language, has different words to describe love and to distinguish between the different types of love. Based on the literature review, it appears that there is a lack of consensus on how many types of love exist. Legg (2009) supports the notion that there are five types of love: mania, eros, philos, storgy and agapeo. Krznaric (2013), however, suggests that there are six types of love. These are: eros or sexual passion, philia or deep friendship, ludus or playful love, agape or the love for everyone, pragma or long-standing love, and philautia or love of the self. Apart from eros, philia and agape seem to be the types of love most commonly found in this research. Therefore, it makes sense that they are briefly mentioned here before the focus moves on to eros.

1.3.1 Philia and agape

Philia is the kind of deep love and loyalty felt between two people who are fond of each other, share common interests, and confide in and support each other (Krznaric, 2013). According to Legg (2009), philia is a feeling that grows steadily, being influenced by the circumstances and the commitment that two friends have towards each other. Agape is considered the purest form of love, as it requires nothing in return (Krznaric, 2013; Legg, 2009). It is the type of love that is offered freely and that focuses on the object's very best interests, no matter the circumstances or the other feelings that may exist. This type of love is frequently mentioned in the Bible (Legg, 2009).

1.3.2 Eros/erotic feelings

The literature review suggests that there is confusion regarding the definition of 'eros'. Traditionally, the term has been used to describe sexual desire and bodily pleasure (Krznaric, 2013; Rycroft, 1995). However, eros does not only describe sexual love. Asheri (2004), for example, agrees that eros may involve sexual desire, but it is more than mere physical gratification. Mann (1997) suggests that the experience of erotic feelings is primarily psychological and not physical, even though it is usually considered in terms of sexual arousal. He continues stressing that the erotic implies the experience of both love and sex, as well as the experience of other feelings (such as hostility, disgust, fascination etc). He highlights that love and sex are not the same thing, although, in adult relationships, they seem to be often inextricably linked. Haule (1996) seems to hold a similar view to Mann's (1997), as he also believes eros is a psychological experience.

Mann (1997, 1999) and Krznaric (2013) suggest that eros has two sides: a positive side and a negative side. Krznaric (2013) stresses that, in its negative side, eros can be fiery, irrational and possessive, ruining the lives of those involved. On the other hand, on its positive side, eros seems to have the power to transform people's lives (Mann, 1997, 1999).

Haule (1996), Baur (1997) and Mann (1997) suggest that the confusion regarding the definition of 'eros' is reflected in the way in which the term is used in everyday language. They add that a differentiation between love and sex is essential to avoid misunderstandings in life and in therapy (Baur, 1997; Haule, 1996; Mann, 1997). Lastly, Mann (1997) suggests that the confusion between the physical and the psychological erotic seems to be what turns the experience of erotic feelings in therapy into a taboo. Introduced below is the common but neglected phenomenon of erotic and sexual feelings experienced in the context of therapy.

1.4 A common but neglected therapeutic phenomenon

The phenomenon of *clients developing and expressing erotic and sexual feelings for their therapists* occurs frequently. This means that most therapists, if not all, will encounter it at some point in their work (Bridges, 1994; deMayo, 1997; Dujovne, 1983; Hartl, Marino, Regev, Zeiss, R., Zeiss, A. & Leontis, 2007; Orbach, 1999; Phillips & Schneider, 1993; Pope, Sonne & Holroyd, 2000; Shepard, 1971). Although it appears that it is more common for female clients to experience erotic feelings for their male therapists (Cummings & Sobel, 1985; Garrett & Davis, 1994; Holroyd & Brodsky, 1977; Wincze, Richards, Parsons & Bailey, 1996), it is not uncommon for male clients to also develop erotic feelings towards their female therapists (Orbach, 1999; Russ, 1993; Shepard, 1971).

deMayo (1997) found that a total of 53.4% of the 750 female psychologists who responded to his survey experienced at least one incident of a client expressing sexual feelings for them in an inappropriate way. Most of these incidents were considered mild. For example, clients disclosed sexual dreams and fantasies about their therapists or gave inappropriate romantic or sexual gifts to them. Phillips and Schneider (1993) found that 77% of the female physicians who responded to their survey dealt with one or more incidents of patients acting in a sexually inappropriate manner. Furthermore, many writers such as Shepard (1971) and Orbach (1999) have reported

numerous case studies where clients felt and expressed feelings of erotic and sexual attraction to their therapists.

The phenomenon of *therapists experiencing erotic and sexual feelings for their clients* is also a common therapeutic phenomenon (Pope, 1987; Pope, Keith-Spiegel & Tabachnick, 1986; Pope & Tabachnick, 1993; Rodolfa, Hall, Holms, Davena, Komatz, Antunez, & Hall, 1994). Therapists are more likely to gain an awareness of their feelings through the fantasies and dreams they have about a particular client (Orbach, 1999). In their survey, Pope et al. (1986) found that, from among the 575 respondents, 95% of male therapists and 76% of female therapists had been sexually attracted to a client of theirs on one or more occasions. Some of them (specifically, 9.4% of male and 2.5% of female therapists) acted on their attraction. Sixty-three per cent of the respondents experienced guilt and anxiety or confusion about the feelings they felt for their clients.

Seven years after the survey conducted by Pope et al. (1986), Pope and Tabachnick (1993) conducted another survey, where they found that almost half of the respondents had felt sexually aroused during a session. One third of them believed that there were times their clients had also felt sexually aroused by them. A few years later, Rodolfa et al. (1994) found that 88% of psychologists (94% men and 81.3% women) from the 386 psychologists who responded to their survey had felt sexually attracted to at least one client during their career. The percentage of male psychologists reporting attraction to their clients was similar to the percentage found in the survey conducted by Pope et al. (1986), whereas the percentage of female psychologists increased.

While many studies have been completed on the development of erotic feelings in therapy, little research has been done on how therapists experience erotic feelings in therapy. Based on the literature review, it seems that research on this subject has largely focused on the prevalence of therapists acting on sexual attraction and becoming sexually involved with clients (Borys & Pope, 1989; Holroyd & Bouhoutsos, 1985; Holroyd & Brodsky, 1977; Pope et al., 1986; Rodolfa et al., 1994), the profile of

therapists who are at risk of engaging in sexual relations with clients (Butler & Zelen, 1977; Celenza, 1998; Folman, 1991; Hamilton & Spruill, 1999), the role of training in recognising and handling the erotic in therapy (deMayo, 1997; Folman, 1991; Hartl et al., 2007; Pope, 1988; Pope et al., 1986; Rodolfa et al., 1994), the attitude of the profession towards the erotic (Butler & Zelen, 1977; Pope, 1990; Pope et al., 1986; Taylor & Wagner, 1976), the conceptualisation of the erotic (Bridges, 1994; Dujovne, 1983; Freud, 1915/1963 as cited in Pope et al., 2000; Kumin, 1985; Mann, 1997, 1999; McDougall, 1995; Natterson, 2003; Orbach, 1999; Rappaport, 1956; Wrye & Welles, 1994), discussions on whether sexual intimacy between the therapist and the client is beneficial or harmful to the latter (Bouhoutsos, Holroyd, Lerman, Forer & Greenberg, 1983; Butler & Zelen, 1977; Holroyd & Brodsky, 1977; Kardener, Fuller & Mensh, 1973; McCartney, 1966; Pope, 1988; Shepard, 1971; Taylor & Wagner, 1976; Wincze et al., 1996), the characteristics of clients who may attempt to seduce their therapists (Stone, 1976), the prevalence of clients who direct sexually inappropriate behaviours towards care professionals (deMayo, 1997; Schneider & Phillips, 1997) and the professional and legal consequences that therapists are likely to face over alleged sexual misconduct (Bouhoutsos & Brodsky, 1985; Holroyd & Bouhoutsos, 1985; Koocher & Keith-Spiegel, 1998).

According to the literature review, the understanding of the erotic is largely based upon (1) single case studies, (2) data reported by secondary sources (e.g. therapists or supervisors of therapists who were attracted to, or became sexually involved with, their clients), and (3) surveys. An important limitation of single case studies is that analysis is influenced by the subjectivity of therapists and the limits of confidentiality. In addition, it is influenced by the historical, social and cultural context in which therapists live and work (Blumer, 1986; Charon, 2010). Last but not least, it is also influenced by the effect of time on memory (Rohde, Geller & Farber, 1992), as, in most studies, the cases were recalled retrospectively. Data collected from secondary sources are at risk of being skewed by sources' subjectivity, values, beliefs and understanding of the phenomenon in question. To conclude, the surveys completed on the topic primarily focus on, and are

thus restricted by, the frequency and impact of the erotic on either therapists or clients. It is noted that randomised control trial studies are not available on the subject due to the ethical implications involved.

The literature review indicates that little qualitative research has been done on the subject from the therapist's point of view. Eight qualitative research studies, conducted between 2006 and 2016, were identified as relevant to this study. These studies are presented below.

McClounan (2012) conducted a study with two sets of eight psychotherapists registered with the United Kingdom Council for Psychotherapy. The project involved two small-scale studies. The aim of the first study was to explore psychotherapists' experiences of engaging, or not engaging, with erotic phenomena presenting in therapy. The aim of the second study was to identify the impact of training and development on assisting or hampering therapists' ability to tolerate the erotic in their work. Data were collected through semi-structured interviews and analysed using Interpretative Phenomenological Analysis. The findings indicate that there is confusion between 'the sexual' and 'the erotic', resulting in the sexual dominating and obscuring the erotic. This, generates the fear of shame and suggests the need for a differentiation between the two. More specifically, the findings from the first study indicate that the erotic can evoke feelings of fear and discomfort, which are multi-faceted, leading therapists to look for ways to feel protected and safe. Five super-ordinate themes and sub-themes were identified (McClounan, 2012, pp. 88–89):

1. **Fear of the unknown**
    - Erotic as unnerving
    - No map, guidance or instructions
    - Taboo or not taboo?
2. **Fear of self**
    - Fear of own erotic desire
    - Fear of the power and potential to abuse
    - The voyeur within

3. **Fear of the other**
    - Dangerous desire
    - The risk of harming the other
    - Potential to short-change clients
4. **The need to protect and feel safe**
    - Boundaries to contain
    - Timing is everything
    - A life fulfilled
    - Age as an excuse
    - Seeking refuge in the mother–child relationship
5. **Factors facilitating the work**
    - Supervision to confess and contain
    - Training as helping or hindering
    - Experience increasing comfort
    - The influence of personal biography

In the second study, McClounan (2012) further explored the findings from his first study via the themes of (1) power and authority in training and development to date, (2) approaches to learning that could be deemed avoidant and dead as opposed to engaging and alive, and (3) the impact on the work. McClounan (2012) suggests that more training on the management of the erotic is required to support therapists in engaging the erotic in their work.

Rodgers (2011) completed a study with six therapists who were the researcher's ex-fellow students and work colleagues. The aim of the study was to explore therapists' understanding and experiences of erotic transference within therapy. Data were collected through semi-structured interviews and analysed using Interpretative Phenomenological Analysis. The findings showed that all participants felt what they perceived to be erotic transference and/or sexual and loving feelings in therapy. There was little distinction between the two phenomena, and the two terms were frequently used interchangeably. The participants held conflicting views as to whether

using the phenomena would be beneficial to the work, but they were willing to learn more about it. The participants who encountered sexual attraction in their work experienced feelings of shame and embarrassment, as well as feelings of fear and a sense of being inadequately prepared to work with the erotic. Six emergent themes were grouped by Rodgers (2011, p. 269) in two clusters:

1. **Comprehension and utilisation of erotic transference within therapy**
    - Comprehension of phenomena
    - Feelings about using phenomena in therapy
    - Therapists' feelings when sexual awareness becomes part of the therapeutic relationship
2. **Support for therapists**
    - Experience of training around erotic transference
    - Experience of supervision around erotic transference
    - Feelings about ethics and boundaries

The findings highlighted that the participants lack clarity in their understanding of erotic transference, and the link between erotic transference and sexual attraction in therapy. Rodgers (2011) suggests that therapists need to have more training on the subjects of erotic transference and sexual responsibility in therapy.

Pliakou (2009) carried out a study on the male therapist–female client dyad. The study was compromised of two smaller studies. The aim of the first study was to explore female clients' feelings towards their male therapists. The participants were six female clients who had been in therapy with a male therapist for a minimum of three months. Data were collected through semi-structured interviews and analysed using Interpretative Phenomenological Analysis. The findings indicate the significance of the masculine for participants, as embodied by their male therapists, the correlation of the masculine to participants' feelings for their father, and participants' difficulties in expressing certain feelings in therapy (such as romantic feelings).

Pliakou (2009, pp. 133–150) identified four super-ordinate themes and sub-themes:

1. **Men are from Mars, women are from Venus**
    - Preoccupation with the masculine
    - The Feminine and Masculine – Gender perceptions
2. **Longing for the male therapist**
    - Needing the male therapist
    - Idealisation of the male therapist
    - The romantic
3. **The therapist and the father**
    - Father and therapist as a safe haven
    - The therapist as a reparative experience of father
    - The therapist as a compensatory experience of father
4. **To come out in the open or stay inside?**
    - Spoken material – Verbally processed
    - Unspoken material – Not processed
    - Unspoken material – Alternatively processed

The aims of the second study were to explore male therapists' feelings towards their female clients, and how these feelings unfolded in therapy. Participants were seven male therapists registered with a professional organisation. Data were collected through semi-structured interviews and analysed using Grounded Theory (Charmaz's Constructivist model of Grounded Theory). The findings suggest that the erotic is prevalent in therapy as a result of genuine and/or counter-transferiential feelings. Participants spoke both of a 'shared' and a 'feared' erotic, whereas the erotic taboo was further explored in light of their reflective and analytic use of self. Lastly, participants spoke of the erotic as a mutually transformational experience.

Five theoretical categories and sub-categories were identified (Pliakou, 2009, p. 212):

1. **Emotional possibilities**
    - Genuine
    - Projective
    - The father
2. **Eroticisation of the relationship**
    - Erotic manifestations
    - The shared erotic
    - The feared erotic
3. **Facing the taboo**
    - Key aids in dealing with the erotic
    - Use of self
    - Explicitly addressing the erotic with clients
    - Implicitly addressing the erotic with clients
    - Effects of therapeutic modalities
4. **Gender in the therapeutic relationship**
    - Awareness of gender
    - Deconstructing masculinity
    - Sociocultural associations
5. **The transformational erotic**

Pliakou (2009) argues that more training on the experience of erotic feelings in therapy is required to facilitate therapists' work with these feelings.

Elliott, Loewenthal and Greenwood (2007) reflected on an historic case where the first author experienced feelings of erotic counter-transference for a young, male client she worked with for twelve weeks. The aims of the study were to examine the author's experience of erotic counter-transference and to determine if erotic counter-transference is largely a defence against intimacy in therapy or an opportunity for transformation. Sessions' transcripts, clinical notes, records of the therapist's thoughts, feelings and reflections (written immediately after each session), and further comments

resulting from reflection in personal therapy and in supervision served as data. Data were analysed retrospectively using the Free Association Narrative methodology. Triangulation was achieved through research supervision, the first author's personal therapy and clinical supervision, and the professional literature existing on the subject. The findings served as a form of 'practice-based evidence' aimed at showing a possible understanding of the therapeutic encounter, the feelings experienced in the room, and the strategies used to manage them. Elliott et al. (2007) reached the conclusion that erotic transference and counter-transference can be problematic for clients and therapists, but they can also be an opportunity for growth for the two of them.

A few years ago, the author of the present study conducted a study with ten therapists on the management of the erotic (Kotaki, 2010). The aim of the study was to explore how therapists manage their clients' erotic feelings towards them. Data were collected through semi-structured interviews and analysed using Grounded Theory (Charmaz's Constructivist model of Grounded Theory). Six conceptual categories and sub-categories were identified (Kotaki, 2010, pp. 31–48):

1. **Gaining awareness of clients' erotic feelings**
    - Indirectly
    - Directly
    - Using feelings of counter-transference
    - Using supervision
2. **Understanding clients' erotic feelings**
    - Erotic transference
    - Re-enactment of relational patterns
    - Projection
    - Genuine
3. **What makes the therapeutic relationship erotic?**
    - The nature of the relationship
    - A number of therapeutic factors
    - Clients' history/background

4. **Managing clients' erotic feelings**
    - Conceptualising the meaning of the erotic
    - Dealing with the feelings evoked by the realisation of the erotic
    - Being cautious of their interventions/responses
    - Taking into account a range of therapeutic factors to inform their response
    - Addressing their own erotic feelings towards their clients
5. **Evaluating the implications for practice**
    - A sense of tension in the consulting room
    - Feelings as fading when they are worked through
    - The work with the erotic affecting the therapeutic process and outcome (mostly positively)
    - The work with the erotic strengthening the therapeutic relationship (in the majority of cases)
    - Feeling vulnerable towards clients who became obsessed with them
6. **Getting support to work with the erotic**
    - Supervision
    - Personal therapy
    - Self-education
    - Reflecting on the factors that impact their ability to manage the erotic

The findings indicate that most participants find it difficult to understand and manage the erotic effectively. This is primarily due to feeling unprepared for their encounter with it. Kotaki (2010) suggests that ongoing training and supportive supervision are fundamental for therapists to manage the erotic in an ethical and professional manner.

Spilly (2008) conducted research with thirteen practitioners. The aims of the study were to examine therapists' subjective experience of erotic transference and to ascertain what therapeutic skills and techniques are useful for managing the phenomenon in practice. Data were collected through interviews and analysed using Qualitative Data Analysis as a methodology. The findings suggest that therapists' experience of erotic counter-transference and their responses to their clients depend on the intensity of their clients' erotic transference. Most practitioners turned to supervision to get support in order to manage the erotic dynamics developed in the room, as the majority of them had received no formal training on the subject. Supervision and consultation were deemed extremely helpful to their work with the erotic. Practitioners who worked in managed care settings practised within a time-limited model, which did not allow exploration of the erotic. In cases where erotic feelings were mutual, practitioners were particularly reluctant to seek consultation and experienced intense feelings of anxiety and discomfort. Spilly (2008) supports the idea that therapists need training on the management of erotic transference and counter-transference in order to be able to work with these phenomena.

Martin, Godfrey, Meekums and Madill (2011) completed research with thirteen therapists from the field of counselling and/or psychotherapy. The aims of the study were to explore therapists' views on sexual boundaries and the strategies they use to manage them in therapy. Data were collected through interviews and analysed using Grounded Theory informed by the principles of Free Association Narrative as a methodology. The findings suggest that (1) minor non-sexual boundary crossings are perceived both as possible precursors of more serious violations and as opportunities for understanding the clients' problems, and (2) there is consensus regarding boundaries concerning the therapist–client sexual relationship, but variance about fantasy, flirtation and touch. In addition, Martin et al. (2011) found that the participants who managed sexual attraction successfully had gone through four stages. These stages are the following: (1) noting the feelings evoked by sexual attraction, (2) facing up to sexual attraction by acknowledging that there is a problematic situation, (3) reflecting on their

experience, as well as processing and managing reactions, and (4) formulating sexual attraction such that it works to the clients' therapeutic benefit. Furthermore, Martin et al. (2011) identified four problematic responses by therapists to boundary pressures. These are (1) self-protective/defensive reactions manifested through the reinforcement of boundaries, (2) moralising or omnipotence stances expressed in terms of expertise or morality, (3) behaviours of neediness/over-identification with the client's emotions and difficulties, and (4) responses affected by over-protective anxiety. Lastly, the participants viewed their ability to maintain the ethical stance of 'participant–observer' as essential in their efforts to manage threats to boundaries. Martin et al. (2011) suggest that (more) training and ongoing supervision are required to sensitise practitioners to sexual attraction and enable them to manage it effectively.

McNulty, Ogden and Warren (2013) conducted a study with three therapists who were disciplined for violating the boundaries and forming sexual relationships with current and former clients. The aim of the study was to examine therapists' accounts of sexual boundary violations in order to identify their decision-making process. Data were collected through semi-structured interviews and analysed using Interpretative Phenomenological Analysis. The findings disclosed two basic themes related to participants' decision-making process. The first related to participants' endeavours to neutralise the power imbalance that existed between themselves and their clients in order to feel no guilt for engaging in a sexual relationship with them. Participants did this by: (1) playing down their clients' mental health problems, (2) emphasising the conventionality of the relationship, and (3) avoiding testing the appropriateness of the relationship by revealing it to their supervisor. The second theme related to the therapist's alteration of identity from hero to victim and then to perpetrator, as the sexual relationship moved from success to failure, boundaries were re-established and participants disciplined. McNulty et al. (2013) suggest that training using case vignettes for discussion in class and supervision are required to support therapists in avoiding sexual boundary violations.

Some of the main limitations of these studies are their small sample size (six to thirteen participants), the diversity of the sample studied, and the influence of the researchers' subjectivity on the collection, analysis and interpretation of data. The impact of time on participants' memory (Rohde et al., 1992) - as most cases were recalled retrospectively - the effect of the limits of confidentiality, and the impact of volunteers' motives in terms of participating in a study are further limitations. The methods selected to study the subject are deemed appropriate, with Interpretative Phenomenological Analysis and the Grounded Theory being used more frequently.

Despite the appropriateness of the methodologies used in the presented studies, it must be noted that they have limitations as well (as is the case with every methodology). Interpretative Phenomenological Analysis, for example, has been criticised for attempting to take up both a modern and a post modern position (Smith, Flowers & Larkin, 2009). Similarly, Grounded Theory has been criticised for being overly subjective, feeding the participants with the interviewee's views and understandings on the subject studied, and composing a story as opposed to letting the story emerge (Glaser, 2002). Following the presentation and discussion of the research conducted on the subject, some of the best-known theories on the conceptualisation of the meaning of the erotic are presented below.

1.5 Conceptualisation of the meaning of the erotic in therapy

1.5.1 Erotic transference and erotic counter-transference

The widely held view regarding the presence of the erotic in therapy is that the erotic is a result of transference. Freud was the first to study the erotic in the analytic situation. In 1915, he published the paper *Observations on Transference-Love*, where he explained patients' erotic feelings for their analysts as erotic transference. In transference, patients transfer old patterns and repetitions to their analysts. More specifically, transference takes place when perceptions, responses and feelings that patients have experienced in their interaction with their primary caregivers are transferred to their analysts.

Originally, Freud (1915/1963 as cited in Pope et al., 2000) believed that transference was helpful only if the feelings transferred to the analysts were positive. If the feelings were negative, they were considered an obstacle to the analytic process. The only time that positive transference was considered to be unhelpful was when the feelings were erotic. In this occasion, transference was seen as interrupting or destroying the analysis. Furthermore, initially, Freud (1915/1963 as cited in Pope et al., 2000) believed that transference was not the 'real work' of psychoanalysis and, therefore, it should be interpreted only when it got in the way of the 'real work'. The 'real work' consisted of reconstructing the unconscious story of the patient's life and, therefore, making the unconscious conscious. The rationale behind this is that, when the unconscious material is both worked through and psychologically utilised by the patient, it loses its power and thus no longer has control over the patient's life. Eventually, Freud re-evaluated his original ideas about transference and formed the view that transference is fundamental to the analytic process. Thus, he supported that analysts should understand and use feelings of transference in order to move the analytic process forward (Freud, 1915/1963 as cited in Pope et al., 2000). Kernberg (1994) suggests that Freud's ambivalence about the meaning and use of erotic transference in psychoanalysis could be partly explained by the

historical and social context of the time, as Viennese society was scandalised by the number of female patients who fell in love with their male analysts.

In the same paper, Freud (1915/1963 as cited in Pope et al., 2000) explained analysts' reciprocation of their patients' erotic feelings for them as erotic counter-transference. Originally, Freud saw counter-transference feelings as an obstacle to the work, and urged analysts to deal with their feelings promptly. However, later, he realised that counter-transference enabled analysts to access and understand their patients' problems in a way that they would not be able to access differently. As a result, he reconsidered the therapeutic value of counter-transference and advocated that analysts should make use of their counter-transference feelings to enrich the analytic work and process.

Kahn, Atkinson, Lindzey and Thompson (1997) argue that transference has no gender. Although male therapists are likely to draw paternal transference and female therapists are likely to draw maternal transference, all significant relationships will eventually get transferred to the therapists regardless of their gender. Kahn et al. (1997) add that transference applies to neither clients nor the therapeutic relationship exclusively. Instead, it applies to all humans and in all relationships, as humans tend to replay some aspects of their early life experiences, every day and everywhere they go. To finish, Kahn et al. (1997) argue that the acknowledgement of counter-transference feelings is one of the conceptual roots of the inter-subjective theory, as not one but two dramas are being played out in therapy.

Freud's conceptualisation of the central role of the erotic in therapy has dominated the field of psychoanalysis for many decades. Since then, numerous theories have formed about the meaning and use of erotic feelings in the context of therapy. The meaning of the erotic seems to have been defined, redefined and modified through authors' interpretations of what happens in specific situations, influenced by the historical, social and cultural contexts they lived and worked in (Blumer, 1986; Charon, 2010).

1.5.2 A metaphor for the communication of nonsexual issues

Dujovne (1983) supports the notion that clients' erotic feelings for their therapists serve as metaphors for the communication of nonsexual issues. She suggests that the most common nonsexual issues that can be conveyed through sexual metaphors are clients' needs for acceptance, desires to test their power over their therapists, fears of relating in ways other than sexual, feelings of anxiety elicited by the work, desires to getting their dependency needs fulfilled, and therapists' rejection.

Other nonsexual issues, also communicated through sexual metaphors, may relate to clients' resistance to the therapeutic process and progress, re-enactment of previous pathological relationships and experiences or an attempt to be close to an idealised parental figure who was unavailable or harsh in reality. Clients' masochistic tendencies, feelings of envy and a wish to degrade and make the therapist worthless can also be expressed through erotic and sexual metaphors. Lastly, feelings of hostility, an inability to tolerate and handle separation, attempts to control the therapist and the work, and attempts to test the integrity of the therapist can also be conveyed through the expression of erotic and sexual feelings and fantasies (Dujovne, 1983).

Dujovne (1983) argues that the notion that clients fall in love with their therapists due to their personal charisma is a grandiose assumption, which therapists ought to explore in depth. She stresses that clients' feelings and attempts to seduce their therapist are an attempt to break boundaries, change their therapist's role and alter the nature of the relationship. Therefore, she warns therapists to place no trust in their clients' erotic and sexual feelings, fantasies and desires for them. Instead, she advises them to keep the boundaries as intact as possible, explore the meaning of their clients' feelings, requests and behaviours, and make therapeutic use of them. Lastly, Dujovne (1983) supports that therapists' own erotic and sexual feelings for their clients also serve as metaphors for the expression of nonsexual issues. The most common of these issues are therapists' feelings of inadequacy and ignorance, an unconscious desire to end a difficult

therapeutic situation, the need to sustain positive fantasies about themselves, and poor skills of self-control.

Bridges (1994) suggests that the experience of erotic feelings in the room can offer important information about clients, therapists and the two of them as a therapeutic couple. She supports that the erotic can have multiple and varied meanings for both clients and therapists. Further to this, she highlights that, for therapy to be effective, both clients and therapists must feel free and safe enough to experience and explore the feelings developed in the room. At the same time, she stresses that this is not the same as acting out (Bridges, 1994).

Bridges (1994) adds that feelings of erotic transference and counter-transference may be particularly challenging to acknowledge, accept and tolerate, especially if the experience of these feelings deviates from clients' and therapists' accepted views of themselves, values and standards. She emphasises the role of counter-transference as an invaluable source of information about the therapeutic couple and process, and suggests that therapists must monitor and process their feelings to gain an understanding of their meaning for their clients, themselves and their work. In addition, she acknowledges that therapists' greatest challenge is to contain their feelings and sexual tendencies while working towards a psychodynamic formulation of their clients' cases (Bridges, 1994).

According to Bridges (1994), the erotic can disguise a variety of issues. More specifically, it can often mask clients' needs for admiration and nurturing, avoidance of intimacy, feelings of grief or hostility, re-enactment of traumatic object relations, fears, inner conflicts and vulnerabilities. In the same line, therapists' erotic feelings for their clients may disguise the need for love, admiration or distraction, feelings of anger, disappointment or hate, fear of intimacy, resistance to taking therapy to the next step, and a treatment impasse.

1.5.3 An opportunity for transformation

Orbach (1999) argues that therapy is a highly intimate encounter, where issues such as trust, disappointment, love, hate, sexuality, betrayal and so on are dramatised. Therapists work on these issues in two ways: the first way is to examine what themes present in their clients' lives and how these themes affect their lives, whereas the second way is to explore how these themes present into and shape the therapeutic relationship. Orbach (1999) suggests that the erotic can be an invaluable opportunity for the transformation of clients and therapists as long as therapists can handle it effectively. In her view, for mutual growth and transformation to occur, therapists must acknowledge the erotic, examine, tolerate and contain the feelings it elicits, explore and analyse its meaning and use their understanding to enrich the process (Orbach, 1999). This seems to imply that therapists could facilitate work with the erotic if they were willing and able to tolerate the feelings evoked.

Wrye and Welles (1994) also view the erotic as an opportunity for growth and transformation. They locate the origins of love and desire in the mother–infant relationship, which is a human's first love relationship and forms the basis for the erotic in therapy and in life. According to Wrye and Wells (1994), feelings of love and desire are replayed in therapy and emerge through transference and counter-transference. The therapist's role is to recognise, tolerate, understand and work through these transferences. In addition, Wrye and Wells (1994) stress the need for therapists and clients to co-create the therapeutic frame within which they strive to understand what happens in and out of the room. It seems that, through this process, clients and therapists have the opportunity to heal their wounds, be reborn, transform their lives, and, perhaps most importantly, become the co-authors of a new story.

McDougall argues that ‘Human sexuality is inherently traumatic’ (1995, p. ix). She suggests that the quest for love is associated with the psychic conflicts generated by the clash between instinctual drives and restrictions inflicted by the external world. The first psychic conflict that humans experience is associated with the mother–infant relationship and, specifically, with the infant’s realisation that the mother is a separate object from him or her. The feelings of tension, frustration and anger triggered by this loss influence, inhibit, interfere and play out in life. Love and hate become indistinguishable, causing tension and leading humans to an eternal quest for resolution (McDougall, 1995). In this sense, the erotic seems to be an essential part of therapeutic work in terms of the process of self-exploration, self-knowledge and love.

Natterson (2003) supports that love and the self are interdependent, as love plays an important role in self-motivation and self-actualisation. Furthermore, love is culturally and inter-subjectively engendered, which means that the nature, experience and expression of love changes as the culture, values and morals change. According to Natterson (2003), the therapeutic relationship is a mutually loving relationship that coexists and interacts with the broader cultural context of love. Therapists express their love for their clients through listening, understanding, supporting and using themselves to help them. Clients can feel their therapists’ love for them and reciprocate the love. The experience of loving and being loved is an invaluable, inter-subjective experience that is mutually beneficial to clients’ and therapists’ work regarding the issues of love, recognition and self. In this sense, love seems to be part of the therapeutic process and an agent for clients’ and therapists’ change and personal growth.

Mann (1997) argues that the experience of erotic feelings in therapy is commonly and incorrectly confused with the experience of sexual desire. In his view, the erotic is primarily a psychological experience, whereas sex is a physical experience (Mann, 1997). He locates the origins of humans’ erotic experience in the mother–infant relationship. He explains that this early experience is reproduced in adulthood with sexual partners and re-enacted

in therapy through transference. Although he understands the erotic in terms of transference and counter-transference, he disagrees with the view that the erotic is simply created by the therapeutic situation. He proposes that transference love is as real as love in any other relationship (Mann, 1997, 1999).

More specifically, Mann (1997) views the erotic as a mixture of past traumatic experiences and hopes for the future. He proposes that human beings' ultimate desire is to heal or transform their traumas into something new, enhanced and developed. In this sense, the erotic is an active process that is at the heart of therapeutic work. The analytic couple comes together in a symbolic intercourse, hoping to 'give birth' to the client's psychological growth (Mann, 1997).

In addition, Mann (1997) speaks of the erotic as having two faces: a positive face and a negative face. His position is that the erotic is largely an opportunity for self-understanding, self-healing and self-transformation for both therapists and clients. He supports his position by explaining that the erotic not only allows access to the core of human psyche, but also subverts both the client's and the therapist's stability, which opens up the path for personal growth. At the same time, Mann (1997) acknowledges that the erotic is not always an opportunity for transformation, as it can also be a form of resistance or avoidance.

1.5.4 A form of negative transference

1.5.4.1 Rappaport's resistance

Rappaport (1956) views clients' erotic feelings for their therapists as a form of negative transference and, in particular, as a form of resistance. He argues that clients' desires to eroticise the therapeutic relationship are an attempt to manipulate their therapists and make therapy a less painful experience for themselves. He suggests that therapists must acknowledge their clients' erotic feelings for them, confront and interpret their feelings and behaviours, and maintain their authority. With respect to therapists' own

erotic feelings for their clients, he argues that therapists must acknowledge and contain their feelings and not act upon them (Rappaport, 1956).

1.5.4.2 Kumin's erotic horror

Kumin (1985) argues that erotic transference is a form of negative transference. It can relate to pre-oedipal and oedipal phases of development, refer to actual or fantasised seductions by one or both parents, and involve both sexual and aggressive drives. According to Kumin (1985), when clients realise their own erotic feelings for their therapists, they tend to experience feelings of intense discomfort, which he calls 'erotic horror'. It is the awareness of their feelings that triggers their defences and, in this sense, the erotic is seen as a form of resistance. Kumin (1985) suggests that therapists can feel 'erotic horror' as well, as therapy is an intimate relationship where both clients and therapists will, at some point, experience feelings of intense discomfort and frustration associated with their desires.

Although Kumin (1985) acknowledges erotic transference as key to clients' understanding and therapeutic process, he views erotic counter-transference as a dangerous therapeutic experience that therapists must resolve without delay to free themselves from their desires. Russ (1993) argues that Kumin's (1985) position towards erotic transference and counter-transference implies double standards, and explains that both experiences are key to clients' and therapists' understanding and subjective identity. Consequently, according to Russ (1993), for therapy to be effective, both erotic transference and counter-transference must be accepted, understood and used in a therapeutic manner.

1.6 The constructive and destructive nature of the erotic

The two faces of the erotic have been a subject of interest for a large number of writers. The majority of them agree that the erotic can be either constructive or destructive, depending on the meaning assigned to it. According to Blumer (1986) and Mead (1934), we co-construct knowledge and meaning through our interaction with the 'others', symbolic communication and mutual interpretation of the story we share. In addition, according to Blumer (1986) and Charon (2010), we form relations with the 'others' and respond to them based on the meaning we assign to these relationships. The meaning(s) we assign to relationships, situations and events are influenced by social interaction and the context in which they present (Blumer, 1986; Charon, 2010).

Based on the literature review, the erotic can be constructive for clients when therapists are able to (1) acknowledge, accept, understand and normalise their clients' erotic feelings for them, (2) explore their motives, fears and hopes, (3) keep the boundaries, (4) psycho-educate clients on the phenomenon, (5) contain their desires and feelings, (6) teach clients new ways of relating to others, and (7) assist clients in finding gratification in real life (Bridges, 1994; Dujovne, 1983; Freud, 1915/1963 as cited in Pope et al., 2000; Mann, 1997, 1999; McDougall, 1995; Natterson, 2003; Orbach, 1999; Rappaport, 1956; Wrye & Welles, 1994). The erotic can be constructive for therapists when they are able to (1) acknowledge, accept, normalise, contain and examine their feelings, (2) process the dynamics developed in the therapeutic relationship, (3) recognise and handle sexual challenges, dilemmas and conflicts, and (4) gain a deeper understanding of both their needs and themselves (Bridges, 1994; Dujovne, 1983; Mann, 1997, 1999; Orbach, 1999). The basic principle is that all feelings and fantasies are to be explored and understood rather than acted upon (Bridges, 1994; Dujovne, 1983; Freud, 1915/1963 as cited in Pope et al., 2000; Mann, 1997, 1999; McDougall, 1995; Natterson, 2003; Orbach, 1999; Rappaport, 1956; Wrye & Welles, 1994).

On the other hand, the erotic can be destructive for both clients and therapists when it remains unrecognised and is misunderstood, ignored, denied, uncontrollable or treated in secrecy. Under these conditions, the risk of handling the erotic in a non-therapeutic or unethical manner increases. In this sense, the erotic can have detrimental effects on therapists, clients and the profession, as numerous past and recent studies have documented (Bouhoutsos et al., 1983; Butler & Zelen, 1977; Holroyd & Bouhoutsos, 1985; Pope, 1990; Pope et al., 2000; Taylor & Wagner, 1976; Wincze et al., 1996). The factors that appear to influence how therapists understand the erotic are described below.

1.7 Factors that influence therapists' understanding of the erotic

What are the factors that influence therapists' understanding of the erotic? Based on the literature review, it seems that there is a wide range of factors that influence how therapists understand and process the erotic in the context of therapy. These factors seem to be broadly classified into three categories. These categories are:

1. Therapeutic and contextual factors.
2. Academic and professional factors.
3. Personal, social and cultural factors.

1.7.1 Therapeutic and contextual factors

The therapeutic and contextual factors include aspects such as the context and frequency of the erotic feelings' expression (Hartl et al., 2007; Pope et al., 2000; Zelen, 1985) and the intention and motivation behind clients' feelings and behaviours (Hartl et al., 2007; Zelen, 1985). Factors also include the perceived level of personal and professional threat involved for therapists (deMayo, 1997), clients' presenting problems and mental health diagnosis (deMayo, 1997; Pope et al., 2000) and the incestuous nature of the erotic (Folman, 1991; Searles, 1959; Stone, 1976).

1.7.1.1 The context and frequency of the erotic

Therapists' understanding and response towards their clients' erotic feelings and behaviours are influenced by the context and frequency of the erotic feelings' expression (Hartl et al., 2007; Zelen, 1985). For example, erotic feelings and/or behaviours that are expressed repeatedly are highly likely to evoke feelings of discomfort and anxiety (Hartl et al., 2007; Zelen, 1985). Such feelings may lead therapists to behave in a way that could shame their clients, withdraw or even terminate therapy (Pope et al., 2000).

1.7.1.2 The intention and motivation behind the erotic

Therapists' perception of the intention and motivation behind their clients' erotic feelings and behaviours appear to play a fundamental role in how therapists process and respond to these behaviours (Hartl et al., 2007; Zelen, 1985). According to Hartl et al. (2007), clients' erotic behaviours are broadly classified as unintentional or intentional and aimed at achieving closeness or disrupting the work. Therapists' views of their clients' intention and motivation affect their feelings and, hence, their responses. For example, erotic behaviours perceived as intentional and aimed at causing problems in therapy are likely to evoke intense feelings of anxiety or unease, leading to therapists adopting defensive attitudes. This is less likely to occur if clients' behaviours are perceived as unintentional and aimed at achieving closeness.

1.7.1.3 The perceived level of personal and professional threat involved

Therapists' subjective experience of their clients' erotic feelings and/or behaviours as a threat or danger to either their personal or professional safety seem to play a major role in their responses. More specifically, therapists' perception of threat is likely to determine whether these feelings and behaviours will be treated as part of the work or as sexual harassment (deMayo, 1997). As every case is unique, therapists are called to evaluate the perceived level of threat to them on an individual basis.

1.7.1.4 The clients' presenting problems and mental health diagnosis

Clients' presenting problems and mental health diagnosis appear to play a particularly significant role in how therapists process and respond to their clients' erotic feelings and/or behaviours towards them. For example, erotic feelings and/or behaviours expressed by psychotic or cognitively impaired clients are mostly perceived as a manifestation of psychopathology or an inability for reality testing (deMayo, 1997; Pope et al., 2000). On the other hand, erotic feelings and/or behaviours expressed by other groups of clients are mostly treated as part of clients' case conceptualisation and treatment plan.

1.7.1.5 The incestuous nature of the erotic

The incestuous character of the erotic appears to contribute to therapists' feelings of anxiety, guilt and shame about the erotic feelings developed in the room. This seems to be due to the parallel between the mother–infant and the therapist–client relationship in terms of roles, dynamics, power imbalance and characteristics of the dyad. According to Folman (1991), Searles (1959) and Stone (1976), the resemblance has the power to ensure erotic feelings are symbolically perceived as incestuous and thus experienced as abusive.

The vast majority of studies state that the therapist–client relationship equates to the mother–infant relationship in terms of power imbalance. However, Wright (1985) and Serban (1981) support the notion that there is no issue of power inequality in the therapeutic relationship. More specifically, they argue that therapists are as vulnerable to clients as clients are to therapists in terms of power, control, seduction and abuse. Lastly, Serban (1981) highlights that some clients do not hesitate to make false allegations of abuse against their therapists, possibly led by feelings of frustration, motives of revenge or hopes for financial gain.

1.7.2 Academic and professional factors

Academic and professional factors include aspects such as therapists' training on the erotic (Bridges, 1994; deMayo, 1997; Folman, 1991; Hamilton & Spruill, 1999; Hartl et al., 2007; Pope, 1988; Pope et al., 1986; Rodolfa et al., 1994), theoretical orientation (Bridges, 1994; Hamilton & Spruill, 1999; Hartl et al., 2007; Pope et al., 2000) and clinical experience of working with erotic material (Bridges, 1994; Church, 1993). They also include aspects such as the role of supervision and consultation (Celenza, 1998; Folman, 1991; Hartl et al., 2007; Ladany, Hill, Corbett & Nutt, 1996; Pope et al., 1986; Rodolfa et al., 1994; Stake & Oliver, 1991; Yourman & Farber, 1996) and the role of the profession and regulation in clinical practice (Butler & Zelen, 1977; Gottlieb, Sell & Schoenfeld, 1988; Pope, 1987, 1990; Pope et al., 1986; Sell, Gottlieb & Schoenfeld, 1986; Taylor & Wagner, 1976).

1.7.2.1 Training on the erotic

Based on the literature review, it appears that most training institutions have failed to prepare therapists for the intimate nature of the therapeutic relationship and process, as well as the intense erotic feelings that both clients and therapists may experience. Moreover, they seem to have failed to prepare them for the discomfort, anxieties, fears and risks related to the phenomenon, and the ways in which they could understand and work with it in their practice (Bridges, 1994; deMayo, 1997; Folman, 1991; Hartl et al., 2007; Pope, 1988; Pope et al., 1986; Rodolfa et al., 1994). Pope et al. (1986) found that 55% of the 575 respondents in their survey felt that they were given no training on how to manage their own erotic feelings of attraction for their clients.

The consequences of inadequate training seem to be numerous. For example, therapists may view the erotic as a professional taboo and therefore avoid talking about it with their supervisors and colleagues. This results in them losing their usual sources of support. In addition, therapists may fail to recognise and handle ethical conflicts in their practice. Lastly, therapists may ignore, avoid, withdraw and repress their feelings or shame their clients (Bridges, 1994; deMayo, 1997; Folman, 1991; Hamilton & Spruill, 1999; Hartl et al., 2007; Pope et al., 1986; Rodolfa et al., 1994). The ultimate result is that therapists are at risk of handling the erotic in a non-therapeutic, if not unethical, manner, placing their clients and themselves at risk for harm. However, theory does not seem to be enough. According to Folman (1991) and Hamilton and Spruill (1999), therapy training courses need to teach therapists the social skills and strategies required to contain and handle the erotic ethically and effectively in their practice.

1.7.2.2 Theoretical orientation

The psychodynamic, humanistic and cognitive behavioural approaches appear to understand the erotic, and hence approach it in a different way. The psychodynamic approach is the theoretical approach that has explored the meaning and use of erotic feelings in therapy more extensively than any other approach. It understands erotic feelings as products of erotic transference and counter-transference, and it normalises and accepts them as part of the therapeutic process. Therapists do not share their own feelings of attraction for their clients, but use their feelings to understand what happens in their clients, themselves and the work (Bridges, 1994; Dujovne, 1983; Freud, 1915/1963 as cited in Pope et al., 2000; Mann, 1997, 1999; McDougall, 1995; Natterson, 2003; Orbach, 1999). In this sense, psychodynamically trained therapists seem to be more familiar with the erotic than other therapists, and have a better understanding of its presence, meaning and use.

The humanistic approach understands the development and experience of all feelings in the context of therapy as products of the interaction between therapists and clients in the here-and-now (Rogers, 1961). It prompts clients and therapists to share their feelings and examine the genesis and meaning of these feelings in their work. This does not mean that humanistically trained therapists share all their feelings for their clients with their clients at all times. *What*, *how much*, to *whom* and *when* they disclose is a decision made based on therapeutic criteria, such as the purpose the disclosure serves in that particular case and moment. Yet, humanistic therapists have neither a theory regarding the experience of the erotic nor a 'language' to use to raise and address it. In this light, humanistic therapists seem to be less equipped than psychodynamic therapists to understand and manage the erotic in their practice.

The cognitive behavioural therapy approach tends to neither discuss nor address the erotic in therapy. According to Gutheil (1989), clear case formulations and treatment plans, in combination with short-term therapy interventions, reduce the likelihood for erotic feelings to develop. As a result, cognitive behavioural therapists may struggle to process and handle erotic and sexual feelings in their work. In this light, cognitive behavioural therapists appear to be the least equipped therapists of all with respect to recognising, processing and managing the erotic in a therapeutic and professional manner.

1.7.2.3 Clinical experience of working with the erotic

A therapist's ability to understand the complex dynamics of the erotic, as well as to contain and handle the intense feelings it elicits, seems to be central in maintaining a therapeutic attitude when working with these feelings. These abilities tend to develop through clinical practice and supervision (Bridges, 1994; Church, 1993). Consequently, novice therapists may find it particularly challenging to understand what happens to their clients, themselves and therapy. This means that novice therapists are more likely to ignore or repress the erotic to avoid the discomfort associated with it or respond in

ways that could shame their clients (Bridges, 1994). This, on the other hand, does not automatically mean that experienced therapists do not feel discomfort, shame and embarrassment or do not withdraw from their clients in an attempt to manage the erotic (Bridges, 1994).

1.7.2.4 The role of supervision and consultation

Having professional supervision is an essential requirement for practice and a fundamental component of good practice. In their survey, Pope et al. (1986) found that 57% of their sample of 575 respondents sought supervision or consultation to discuss their feelings of attraction for their clients. Younger therapists were more likely to seek supervision than older therapists, while no significant difference was noted between male and female therapists. Stake and Oliver (1991) found that approximately 50% of their respondents resorted to supervision or consultation for advice. They also found that 19% of them discussed their feelings within the safe environment of personal therapy. Rodolfa et al. (1994) found that approximately 60% of their sample of 386 respondents sought supervision or consultation to examine and discuss their feelings for their clients, whereas 27% did not seek any professional advice or support. The remaining 13% failed to answer the question. Male psychologists were more likely to discuss feelings of attraction in supervision than female psychologists, but no age differences were noted between the respondents. Those who turned to supervision or consultation aimed to safeguard their clients' welfare, re-establish their objectivity, and understand their feelings of attraction. Most of those who had not sought supervision or consultation said that they believed their feelings did not interfere with their work. Some said that they feared a negative reaction, whereas others admitted that feelings of anxiety or shame prevented them from seeking supervision. These surveys indicate that only one in two psychologists who are attracted to their clients use supervision to discuss the erotic (Pope et al., 1986; Rodolfa et al., 1994; Stake & Oliver, 1991).

The most common barriers in seeking supervision seem to be supervisees' perception of the subject as an issue unworthy of discussion in supervision, desire to impress their supervisors, or fear that their supervisors could harm their career (Hartl et al., 2007; Ladany et al., 1996). Other barriers seem to be supervisees' feelings of anxiety and shame, as well as their belief in a negative response by their supervisor (Celenza, 1998; Rodolfa et al., 1994; Yourman & Farber, 1996). The last barriers on this list of potential barriers seem to be supervisees' discomfort to discuss sexual issues and an assumption that their supervisors would feel uncomfortable as well (Hartl et al., 2007).

Ladany et al. (1996) and Hartl et al. (2007) advise supervisees who feel too uncomfortable to discuss erotic and sexual feelings with their supervisors to either change their supervisor or seek consultation with their peers and colleagues. They argue that group support may help therapists to contain their feelings more effectively, think about them in a professional manner and feel supported. At the same time, although group supervision and/or consultation seem to be more supportive to supervisees than individual supervision, this is not a guarantee. Folman (1991), for example, describes an incident where a psychologist raised the erotic with her group of colleagues. Her colleagues responded with discomfort, bias and anger. More specifically, they told her that she was seductive, provocative and too immature to do the job. The psychologist got the message that the erotic is not a subject to be examined and felt both embarrassed and isolated by her colleagues.

1.7.2.5 The role of the profession and regulation in clinical practice

The experience of erotic feelings in the consulting room is a common therapeutic phenomenon that the profession/professional community appears to have addressed only partially (Folman, 1991; Pope, 1987; Pope et al., 1986). This, according to a plethora of authors (Bouhoutsos et al., 1983; Butler & Zelen, 1977; Holroyd & Bouhoutsos, 1985; Pope, 1987, 1990; Pope et al., 1986; Taylor & Wagner, 1976; Wincze et al., 1996), seems to

have a negative impact on clients, therapists and the reputation of the profession. More specifically, although the profession has thought about the erotic and attempted to manage the problem of psychologists' acting on feelings of sexual attraction (Gottlieb, 1990), it seems that it has failed to successfully address the issue of sexual misconduct. Many believe that this is due to the profession's initial response towards the erotic and sexual misconduct which, to some extent, consisted of avoidance and denial (Pope & Bouhoutsos, 1986; Taylor & Wagner, 1976; Zelen, 1985).

The fact that the profession has addressed the erotic only to some degree is supported by a number of cases of sexual misconduct recorded in the reports of ethics committees (American Psychological Association Ethics Committee, 2012, 2013, 2014). It is also supported by surveys in which practitioners admit that they have been sexually involved with current or formers clients (Borys & Pope, 1989; Holroyd & Bouhoutsos, 1985; Holroyd & Brodsky, 1977; Lamb, Woodburn, Lewis, Strand, Buchko, & Kang, 1994; Pope et al., 1986; Rodolfa et al., 1994). At the same time, the numbers are only indicative, as not all cases of sexual misconduct become known due to (1) practitioners' fear of punishment, (2) colleagues' reluctance to report cases of sexual misconduct that they are aware of (Folman, 1991), and (3) difficulties relating to the process of clients' reporting incidents of sexual misconduct (Gottlieb et al., 1988).

Sexual misconduct seems to be an ethical violation for which psychologists are frequently disciplined (American Psychological Association Ethics Committee, 2012, 2013, 2014). Sell et al. (1986) and Gottlieb et al. (1988) draw attention to regulatory boards having established no sets of guidelines to evaluate the severity of the misconduct or decide how therapists should be disciplined. The absence of guidelines seems to make the decision-making process inconsistent, leading many psychologists to mistrust the disciplinary procedures and to fear that allegations may be handled unjustly. The anxiety and fear of this prospect seems to reinforce the idea that the erotic should be handled in secrecy.

1.7.3 Personal, social and cultural factors

The personal, social and cultural factors include therapists' and clients' background and life experiences (Baur, 1997; Gabriel, 2005; Mann, 1997, 1999; Orbach, 1999), therapists' comfort with their own and others' sexuality (Bridges, 1994) and the attitude of society and culture towards the erotic in therapy (Hare-Mustin, 1974).

1.7.3.1 Therapists' and clients' background and life experiences

Baur (1997), Gabriel (2005), Mann (1997, 1999) and Orbach (1999), draw attention to the therapeutic couple and the sub-conscious communication between therapists and clients, arguing that both of them bring their own primitive experiences, thoughts and feelings to their encounter. This means that their social and cultural background, history and experiences are likely to significantly influence their interaction and relationship, as well as their understanding of the erotic and response to it. It also means that, when a subject as personal and sensitive as the erotic is involved, the beliefs that both of them hold about themselves, others, sex and sexuality are likely to be triggered. This has the potential to evoke a wide range of intense feelings and reactions and, ultimately, test the strength of the relationship.

According to Blumer (1986) and Mead (1934), we co-construct knowledge and understanding(s) through our interaction with the 'others', symbolic communication and mutual interpretation of the story we share. Our interpretation is influenced by our life experiences and the historical, social and cultural contexts we live in. This implies that therapists' work would benefit from therapists having (1) an awareness of the values and beliefs they hold towards the erotic, (2) an appreciation of how factors such as their own background, experiences, values and beliefs can influence the therapeutic relationship and work, and (3) an understanding of their clients' background, attitudes and beliefs on the subject (as in any other subject) (Baur, 1997; Gabriel, 2005; Mann, 1997, 1999; Orbach, 1999).

1.7.3.2 Therapists' levels of comfort with their own and others' sexuality

According to Bridges (1994) and Hartl et al. (2007), the erotic has the power to interfere with the therapeutic process, generate stress and affect both the therapeutic relationship and therapists' performance. Therapists' levels of comfort with their own and others' sexuality seems to be vital to their ability to manage the erotic effectively. Bridges (1994) points out that, if therapists experience discomfort towards sex and sexuality, they are likely to ignore, avoid, repress or withdraw to protect themselves from experiencing feelings of anxiety, guilt and shame. On the other hand, if therapists feel comfortable with their own erotic and sexual material, they are likely to be more prepared to think about it, tolerate the feelings evoked, contain sexual urges, seek advice and work with it in a therapeutic fashion.

In agreement with this rationale, Bridges (1994) suggests that personal therapy may be required for therapists who struggle with or feel overwhelmed by sex and sexuality due to their own personal history and experiences. Therapy could assist these therapists in examining, understanding and containing their thoughts and feelings both as individuals and as professionals (Bridges, 1994). In this case, the benefits of personal therapy seem to be multiple, as therapists are supported to grow as individuals, protect their practice and promote their clients' wellbeing.

1.7.3.3 The attitude of society and culture towards the erotic in therapy

Hare-Mustin (1974) stresses that psychologists would benefit from being aware and respectful of the values, social codes and moral expectations of the community they work in, as society can considerably influence how they practice. This is due to the inter-relationship between therapists and society, in the process of constructing meaning. According to Blumer (1986) and Charon (2010), our interaction with society shapes our identity and the meaning(s) we assign to our experiences. In turn, the way we perceive our identity and experience a phenomenon influence society's understanding and attitudes towards this phenomenon (e.g. the experience of erotic feelings in therapy).

In addition, according to Hare-Mustin (1974), psychologists would also benefit from understanding and accepting that the moral codes of the community for personal sexual contacts and for professional sexual contacts may differ. In this case, Hare-Mustin (1974) highlights that what matters is not what is acceptable in therapists' private lives, but what the community finds acceptable as a widely known and announced practice in psychotherapy. Hillman and Stricker (2001) argue that social prohibitions, incest and social stereotypes can have a significant impact on how therapists work. For this reason, they advise that psychologists have knowledge and understanding of them. Their position is in agreement with Schwartz's (1993) and Butler and Zelen's (1977) position, which states that practitioners ought to be aware of the effect that the structure and character of the community they work in can have on their practice. Given in the next section are the basic social processes and systems that influence how therapists experience the erotic, how their experience is constructed, and how they work with it.

1.8 The experience of the erotic

The term 'basic social processes' describes the most common and repetitive ways of social interaction between individuals and groups, and between different groups. Social interactions are dynamic reciprocal relationships that not only impact the individuals and/or the groups that interact with each other, but also the quality of the relationship established between them. The essential conditions for social interaction to occur are social contact and communication (Georgas, 1995).

Parker (2009) argues that social and cultural systems shape not only how humans experience their own and others' erotic and sexual feelings and behaviours, but also how they interpret, understand and respond to that experience. In this case, the social systems that hold these roles are training institutions, the profession, the regulation of clinical practice, and society through existing social norms, stereotypes and associations that people make (Bridges, 1994; Butler & Zelen, 1977; deMayo, 1997; Folman, 1991; Gottlieb et al., 1988; Hamilton & Spruill, 1999; Hare-Mustin, 1974; Hartl et al., 2007; Pope, 1987, 1988, 1990; Pope et al., 1986; Rodolfa et al., 1994; Sell et al., 1986; Taylor & Wagner, 1976). Due to the interdependence between the aforementioned social systems and therapy the attitudes that these systems hold towards the erotic shape therapists' experience of the erotic and work with it.

1.8.1 Training institutions

Most training institutions seem to promote a cognitive understanding of the erotic, neglecting its emotional understanding and thus failing to prepare psychologists for the intimate character of the therapeutic relationship and the intense erotic and sexual feelings that both clients and therapists may experience (deMayo, 1997; Folman, 1991; Hamilton & Spruill, 1999; Pope et al., 1986; Rodolfa et al., 1994). In their survey, Pope et al. (1986) found that 55% of their 575 respondents received no training on the erotic. A few years later, Rodolfa et al. (1994) found that 40% of the 386 respondents in their

survey received no training on the subject during graduate school, whereas 51% received no training during their internship as well. The researchers noted that there were no significant differences between older and younger psychologists in this area of enquiry, which indicates that the attitude of the majority of training institutions towards the experience and process of erotic feelings in therapy has remained unchanged for some time.

As a result, the majority of therapists who become aware of their clients' erotic and sexual feelings for them tend to experience feelings of distress, suffer a sense of personal threat and encounter challenges they are not prepared to deal with (Dujovne, 1983). Consequently, most of them are inclined to avoid or withdraw from their clients (Bridges, 1994; deMayo, 1997; Folman, 1991; Hamilton & Spruill, 1999; Hartl et al., 2007; Pope et al., 1986; Rodolfa et al., 1994). However, it seems that not all therapists' emotional responses to their clients' erotic and sexual feelings for them are negative. Russ (1993) reports that some therapists may feel a sense of flattery due to feelings of vanity. In addition, Natterson (2003) supports that some therapists may feel excitement due to their perception of the erotic as a sign of therapeutic progress.

Apart from how therapists experience their clients' erotic feelings for them, most training institutions seem to have also failed to address how therapists experience their own feelings of attraction for their clients (Bridges, 1994; deMayo, 1997; Folman, 1991; Hamilton & Spruill, 1999; Pope et al., 1986; Rodolfa et al., 1994). The literature review suggests that the majority of therapists who are attracted to their clients seem to experience negative emotions about it. Rodolfa et al. (1994) report that 55% of the 386 respondents in their survey disclosed that they felt discomfort, guilt or anxiety for having erotic feelings for their clients, whereas neither gender nor age differences were noted between the respondents. Pope et al. (2000) note that most therapists who are attracted to their clients react with surprise, guilt, anxiety, fear, frustration and confusion about their feelings, role and tasks. Bridges (1994) reports that most therapists, including those who have a lot of experience, can feel shame and embarrassment about their feelings

and this may lead them to withdraw emotionally from their clients. In this regard, it appears that the ultimate result of the approach that many training institutions hold towards the erotic is that erotic feelings are marginalised.

1.8.2 The profession

Although the profession's initial response of avoidance of the erotic and denial of therapists' sexual misconduct has changed, it appears to still feel a sense of anxiety towards the erotic (Folman, 1991; Pope & Bouhoutsos, 1986). This seems to lead a large number of therapists to feel anxiety too towards the presence of the erotic and the prospect of talking about it with colleagues and supervisors (Folman, 1991). The likelihood of being judged as unprofessional leads these therapists to isolate and alienate themselves from their usual sources of support and, consequently, feel lonely and lost (Bridges, 1994; Folman, 1991; Pope et al., 1986; Rodolfa et al., 1994). As a result, many therapists are likely to handle the erotic as a 'dark secret' (Folman, 1991). In this sense, the attitude that the profession seems to have towards the experience of erotic feelings in therapy turns the erotic to a mysterious phenomenon that most therapists have no way of understanding.

1.8.3 Regulation

The regulators of clinical practice seem to share the feelings of anxiety that the professional community experiences towards the erotic. In addition, the realisation that they cannot address sexual misconduct effectively (American Psychological Association Ethics Committee, 2012, 2013, 2014) seems to have resulted in them overreacting towards allegations of sexual misconduct. The regulators' feelings of anxiety towards the erotic alongside therapists' observations - that the regulators lack a set of guidelines to assess the severity of the misconduct and determine how therapists should be disciplined - seem to have a negative impact on therapists' trust of regulation procedures (Gottlieb et al., 1988; Sell et al., 1986). Moreover, the power and authority that regulators utilise to control clinical practice, in combination with

the enforcement of a series of prohibitions and the fear of punishment, seem to reinforce most therapists' thinking that the erotic should be handled in secret. In this sense, the attitude of regulators seems to somewhat undermine therapists' work.

1.8.4 Society

An individual's experience of (any) phenomena is socially and culturally constructed (Charon, 2010; Crotty, 1998; Guba & Lincoln, 1989; Kant, 1787/1933). Blumer (1986) and Charon (2010) explain that the construction of meaning is a two-way procedure that takes place between individuals and society. Our interaction with existing social norms and the 'others' and the associations we tend to make shape our identity, our experiences and the meanings we assign to our experiences. In turn, the way we perceive our identity and experience a phenomenon influences society's understanding and attitudes towards this phenomenon (Blumer, 1986; Charon, 2010). Guba and Lincoln (1989) add that the influence of social and cultural factors in the construction of reality leads to the construction of shared realities. The construction of shared realities is promoted through the mutual interpretation of what happens in a particular situation.

The subject of the erotic seems to be mostly avoided by most Western societies. Although sex and sexuality are used to sell, manipulate and control in our society, it seems that erotic and sexual feelings are largely experienced with a sense of discomfort and treated with silence. Due to the inter-relationship between individuals (in this case, therapists) and society (Blumer, 1986; Charon, 2010), therapists' experience of the erotic, the construction of their experience and their work with the erotic are significantly influenced by existing social norms, values, traditions, stereotypes and associations that the therapists make.

Hare-Mustin (1974), attempts to explain society's attitude towards the experience of erotic feelings in therapy, suggesting that a more conservative attitude is often held towards those who work in teaching and healing professions. In her understanding, this is because these people are seen as the maintainers of society's harmony, order and standards (Hare-Mustin, 1974). Schwartz (1993) approaches the subject of the influence of society in clinical practice from a different perspective, and suggests that the violation of boundaries might relate to the increasingly fragmented and individualistic character of modern societies. More specifically, he suggests that more and more people appear to feel lonely and unloved. This means that both therapists and clients are likely to enter therapy being 'hungry' for love and attention. Therapy, on the other hand, is a warm, loving and intimate relationship that aims to meet people's emotional needs. In this light, it is not a surprise that therapists and clients may develop erotic and sexual feelings for each other and act upon them.

Butler and Zelen (1977) also connect the character of modern societies with the risk of sexual misconduct, but they make a different link. They support the idea that, in modern societies, sexual expression is rather open, which can have an impact on how therapists process the erotic and interact with and relate to their clients. They suggest that, nowadays, therapists tend to be more approachable, talk more about their thoughts and feelings, and share more about their lives with their clients. In their view, this type and level of sharing can erode the boundaries and potentially lead to sexual engagements between therapists and clients.

Following the presentation of the literature review conducted on the research topic, a reflexive statement on my (the researcher's) background and journey of researching the erotic and the particular research question is presented. The importance of studying the specific subject, its contribution to the field and its original contribution to existing knowledge are highlighted. Lastly, its relevance to Counselling Psychology is also described.

1.9 Reflexive statement – The researcher's background and journey of researching the erotic and the particular research question

The present study uses a qualitative research methodology. Adhering to the notion that qualitative research is subjective (Patton, 1990; Smith, 2008), it seems essential to let the readers of the study know about my personal, educational, professional and research background, as well as about my journey of researching the erotic and the particular research question. This way, readers will have the opportunity to understand who I am and how my experiences have shaped the project and its results. Braun and Clark (2013) recommend that researchers write reflexive comments and statements using the first-person pronoun, which is what I have done in this thesis.

Ever since I can remember, I have been highly interested in listening to and understanding people and their life stories. My family is connected to healthcare professions and my mother, my role model, taught me to care, love and respect others. My values, in combination with the emphasis that my mother placed on academic achievement and women's financial independence, led me to study social work, psychology, counselling and, later, counselling psychology. While working on this project, I worked as a part-time social worker while maintaining a private practice as a chartered psychologist.

My career in social work has taught me that, although it is rare for service users to experience erotic feelings for their social workers, it is still possible. Similarly to therapists, social workers are required to reflect on how they experience their service users' (erotic) feelings for them, make sense of their experience and evaluate the impact of their experience on themselves and the work. I found the experience of the erotic easy to process and to handle, and I, automatically, assumed that this would be the case for me in every professional field.

Although working as a social worker was a rewarding experience, psychology was, is, and will always be my greatest love. Therefore, while still in employment as a social worker, I studied for my bachelor's degree in Psychology (Aristotle University of Thessaloniki, Greece) and I practised in a psychiatric unit with in-patients who were treated for severe and enduring mental health problems. Practising was an exciting experience for me, but the amount of work I could do with the patients was limited. This was because most of them were acute psychiatric patients who, most of the time, were unable to make use of therapy. This experience, in combination with the fascination I felt for the human psyche, made me realise that what I wanted to do with my career was to work therapeutically with clients, making use of myself, knowledge, skills and the therapeutic relationship to help them.

Feeling the need to expand my horizons, I made the decision to leave behind everyone and everything I knew and loved and move to the United Kingdom to do a master's degree in Counselling Skills (University of Hull). Although I did learn a lot from the course, I still felt that I did not have the experience and skills required to work with clients. Feeling a sense of responsibility towards the people who would trust me with their problems, I decided to do my second master's, this time in Counselling Psychology (Roehampton University).

When I started practising as a trainee counselling psychologist, initially in a primary care and later in a secondary care placement, I was surprised to see that I struggled to work with clients who found me attractive, let alone with clients I felt attracted to. Noticing the difference between my experiences as a social worker and as a trainee psychologist, I could not help wonder about the reason for this. Situating my experiences in context, I quickly came to realise that the challenges I encountered related to the nature of the therapeutic relationship, which is much more intimate and intense than the relationship established between social workers and service users. I also attributed the challenges I came across to having received inadequate training on the experience and management of erotic feelings in therapy. My

realisation led me to turn to self-education and to have a number of informal conversations with my colleagues about the subject. Very quickly, I figured out the importance of keeping a close eye on my thoughts and feelings, reflecting on my practice, and using supervision to talk about what happens in the room.

However, it was not until I started having personal therapy that I became more and more aware of the effect that my parents' personal relationship had upon my views on love and sex, the ways I related romantically to the opposite sex, and the difficulties I experienced in my work with the erotic. Over time, I made a series of some life-changing realisations. The first realisation was that I was scared of love. I had seen that love, based on my experience of my parents' relationship, could not only hurt but also lead to extreme behaviours, such as manipulating and blackmailing your partner. Understanding this, it made sense that I avoided love and the potential madness it could bring into my life. However, then, I also realised something else. I realised that love could be good as well. I had witnessed its positive impact on some of my friends' lives. It was at that time that I decided I did not want to live the rest of my life feeling scared of love. The third realisation I made was that avoiding love in my personal life linked to the struggles I experienced with love in my practice. This was the moment I decided I wanted to feel comfortable with love so I could love my clients. In addition, I wanted my clients to feel comfortable to love me as well, if this is what they felt for me as their therapist.

My realisations, my sense of responsibility - this time, towards both myself and my clients - and my need to understand and equip myself to manage the erotic in my practice (all while I worked towards the award of my MSc in Counselling Psychology) led me to conduct qualitative research on the erotic. Qualitative methodology is particularly attractive to me, as I am interested in exploring and understanding the richness of others' experiences (Patton, 1990; Smith, 2008). The study I conducted aimed to explore how therapists manage their clients' erotic feelings for them. To address the research question, I interviewed ten therapists and analysed the collected data using

Charmaz's (2006) Constructivist model of Grounded Theory. The core category, which encapsulated and reflected the meaning of all conceptual categories, suggested that 'The way therapists gain awareness, understand and manage their clients' erotic feelings for them is the result of an ongoing interaction and process between their experience in the room, reflection on their clients' and their own feelings, various therapeutic factors and supervision' (Kotaki, 2010, p. 48). In short, therapists' understanding and management of the erotic are neither easy nor a straightforward process.

Although I did learn a lot from the project, I did not feel satisfied. Somehow, the exploration of the management of the erotic was not enough any longer. It was at that time that I figured out I was ready to look into therapists' subjective experience of the erotic and the construction of their experience (as opposed to only its management). The challenge of working on a subject where little research has been done (with the aim of making an original contribution to existing literature) played a role too. Lastly, the benefits of the study on my own and others' work motivated me tremendously. As a result, I decided to do a professional doctorate at City University.

My aims were to explore (1) how therapists experience the erotic in their work, (2) how their experience is constructed, and (3) how their accounts construct the social world. Although I was a novice researcher, I had a strong motivation to learn and grow. My curiosity and my drive enabled me to commit myself to the long process of conducting research at a doctoral level. In addition, the gradual shift in my research interests helped me understand that research participants might be at a different level of readiness to mine in terms of exploring, reflecting and talking openly about their experiences. This understanding enabled me to be more sensitive to the participants' experiences and feelings, respectful of their level of readiness and willing to follow their own pace in the interviews. Lastly, being aware of my personal beliefs and biases on the subject, I consciously strived to reduce the impact of my subjectivity on the project by keeping a reflexive attitude towards myself and the research process all the way through.

1.10 The importance of studying the specific subject

The attitude of intellectualisation that most training institutions appear to hold towards the erotic result in the erotic being marginalised. In addition, the feelings of anxiety that the profession seems to experience towards the subject seem to evoke anxiety in therapists too. The use of power and the fear of punishment that the regulators tend to employ to control clinical practice, appear to (to some extent) contribute towards the cultivation of a climate of apprehension and secret management of the erotic which can increase therapists' chances to mishandle it. Moreover, the attitudes of avoidance, silence and control that seem to be held in most Western societies towards the experience of erotic and sexual feelings appear to contribute to therapists (1) having a limited understanding of the erotic and (2) perceiving the erotic as a mysterious and dangerous phenomenon with which they should not engage. These factors, in combination with the limited qualitative research conducted on the experience of erotic feelings in therapy from the therapist's point of view, increase therapists' risk of malpractice.

Thus, if therapists have no or only a limited understanding of the erotic, they are at risk of:

1. Failing to recognise and work with erotic transference, counter-transference and other therapeutic issues conveyed through the experience and expression of erotic and sexual feelings in the context of therapy.
2. Failing to recognise and address ethical conflicts and dilemmas in their work.
3. Acting upon the erotic and getting sexually involved with their clients.

All three risks can have a significant negative impact on clients, therapists and the profession, as many studies have documented (Bouhoutsos et al., 1983; Butler & Zelen, 1977; Holroyd & Bouhoutsos, 1985; Pope, 1990; Pope et al., 2000; Taylor & Wagner, 1976; Wincze et al., 1996). Thus, in my view, it seems important that therapists have the opportunity to examine how they experience erotic feelings in therapy, how their experience is constructed,

and how their stories construct the social world. The findings of the study will be published and become available to the therapeutic community to inform clinical practice and guide action.

1.11 Contribution of the study to the field

While many studies have been completed on the development of erotic feelings in therapy, the vast majority of studies are quantitative and conducted from clients' perspective. In contrast, only a small number of qualitative research studies have been done on how therapists experience erotic feelings in therapy from practitioners' perspective (Elliott et al., 2007; Kotaki, 2010; Martin et al., 2011; McClounan, 2012; McNulty et al., 2013; Pliakou, 2009; Rodgers, 2011; Spilly, 2008). Hence, an in-depth account of how therapists experience erotic feelings in therapy from their own point of view, along with an exploration of how their experience is constructed and construct the social world, will be important contributions to psychotherapeutic literature.

1.12 Original contribution of the study to existing knowledge

As already mentioned, while many studies have been completed on the development of erotic feelings in therapy, little qualitative research has been done on how therapists experience erotic feelings in therapy from their own perspective (Elliott et al., 2007; Kotaki, 2010; Martin et al., 2011; McClounan, 2012; McNulty et al., 2013; Pliakou, 2009; Rodgers, 2011; Spilly, 2008). This study is anticipated to produce an original contribution to existing knowledge and the professional area by:

- Exploring both an under-researched and important area of practice for therapists.
- Suggesting practical applications and guiding action.
- Discussing the implications for practice.

I endeavour to share the acquired knowledge with the therapeutic community by publishing the findings of the study in scientific journals and contributing to conferences and workshops on the subject. One of my main aspirations is to encourage practitioners to talk about the phenomenon, understand it, process it, reflect on their practice and learn how to work with it effectively. In addition, I hope that the findings of the research will guide action and, potentially, lead to social change and the development of policies useful to therapists' work with the erotic. This is because social interaction shapes how therapists experience erotic feelings, make meaning of their experience and work with these feelings in therapy. In turn, the way that therapists experience erotic feelings, make meaning of their experience and work with these feelings, influence and shape the attitude of society, training institutions, the profession and the regulation towards the presence of erotic feelings in therapy.

1.13 Relevance of the topic to Counselling Psychology

The topic is particularly interesting and relevant to the work of counselling psychologists, psychotherapists, counsellors and other practitioners. This is because erotic feelings can develop in any therapist's practice. This means that most practitioners, if not all, will encounter these feelings at some point in their career (Bridges, 1994; Cummings & Sobel, 1985; deMayo, 1997; Dujovne, 1983; Garrett & Davis, 1994; Hartl et al., 2007; Holroyd & Brodsky, 1977; Orbach, 1999; Pope et al., 2000; Phillips & Schneider, 1993; Russ, 1993; Shepard, 1971; Wincze et al., 1996). A therapist's ability, or inability, to understand, contain and handle the erotic in a therapeutic manner can have a significant impact on their clients, themselves and their work.

In line with the core values of Counselling Psychology in particular, counselling psychologists are predominantly interested in therapist–client interaction, the subjective experience of each other and the co-construction of meaning through their interaction and mutual interpretation of the story they share (Martin, 2009 in Woolfe, Strawbridge & Douglas, 2009). This means that counselling psychologists are interested in understanding the

psychological phenomena that may develop in therapy, how they experience and process these phenomena, the impact of the phenomena on the therapeutic relationship and the implications for clinical practice (Pope et al., 2000; Smith & Fitzpatrick, 1995; Zelen, 1985).

The study has constructionist and interpretative leanings, fitting in with the values of Counselling Psychology. More specifically, it assumes that (1) there are many subjective realities, (2) understandings are co-created, and (3) researchers and participants co-construct understandings through their interaction and the mutual interpretation of the story they share and explore. The assumptions of the study mirror both the therapeutic process and the interaction between therapists and society. Stated in the next paragraphs are the aims and objectives of the study and a brief description of how the topic was studied.

1.14 Aims and objectives of the study

This study is concerned with how therapists experience erotic feelings in therapy. The aims of the study are to:

1. Explore how therapists experience erotic feelings in therapy.
2. Examine how therapists' experience of the erotic is constructed.
3. Identify how therapists' accounts construct the social world.

The objectives of the study are to (1) make meaning of therapists' experience of the erotic, (2) theorise the basic social processes, contexts and structural conditions that influence the construction of therapists' experience, and (3) suggest practical applications (Braun & Clarke, 2006, 2013, 2014).

1.15 How the topic was studied

I studied the subject using a qualitative research methodology. I interviewed thirteen therapists (six male and seven female) who had more than five years of post-qualification experience. Interviews were semi-structured, audio recorded and transcribed. Transcripts were anonymised. Being aware of the limitations of the studies already completed on the experience of erotic feelings in therapy and looking for a methodology that would represent my ontological, epistemological and philosophical positions (and that would also address the research question), I chose to use Thematic Analysis as a methodology and specifically the Constructionist model of Thematic Analysis. Constructionist Thematic Analysis is designed to explore individuals' subjective experience(s), identify how their experience is constructed and understand how individuals' accounts construct the social world (Braun & Clarke, 2006, 2013). The next chapter describes in detail the methodology used in the study.

Chapter 2: Methodology

2.1 Introduction

The organisation of this chapter is as follows. In the first part of the chapter, the research question and aims of the study, the relationship between ontology, epistemology, philosophy and methodology, the researcher's ontological, epistemological and philosophical stance and the influence of her standpoints on the study are presented first. The rationale for choosing to use the constructionist research paradigm follows. The rationale for deciding to use a qualitative research methodology and the different qualitative research methodologies considered for the project are presented next. The description and the rationale for opting to use Thematic Analysis as a methodology are portrayed. The description of the Constructionist model of Thematic Analysis, the reasons for deciding to use the specific model and the advantages and disadvantages of (Constructionist) Thematic Analysis complete the first part of the chapter.

In the second part of the chapter, the project's ethics approval and an overview of the research design are presented. The study's data sampling method and the criteria for selecting the research sample and estimating its size are also described. An overview of the research participants follows. A description of the recruitment procedure, method used to collect the data and preparation of the interview schedule is also portrayed. The self-reflexive interview the researcher had on the subject, the pilot interview conducted on the subject and the procedures of conducting, audio recording and transcribing the interviews are also presented. The chapter completes with a reflexive statement on the researcher's influence on interviewing and a description of how the data were analysed. The research question and the aims of the study are presented below.

2.2 Research question and aims of the study

The research question that served as a starting point to the research process was *How do therapists experience their clients' erotic feelings for them?* However, very early in the course of the research, it became apparent that participants wanted to talk not only about how they experience their clients' erotic feelings for them, but also how they experience their own erotic feelings for their clients. Realising that the subject was more complex than I had initially thought, I followed the directions the study began to take (McLeod, 2001). Consequently, this study is concerned with *How do therapists experience erotic feelings in therapy?*

The aims of the study were to explore the following questions:

1. How do therapists experience the erotic in the context of therapy?
2. How is therapists' experience constructed?
3. How do therapists' accounts construct the social world?

The objectives of the study were to (1) make meaning of therapists' experience, (2) theorise the basic social processes, contexts and structural conditions that influence the construction of therapists' experience of the erotic, and (3) suggest practical applications (Braun & Clarke, 2006, 2013, 2014). The findings of the study will be published and become available to the therapeutic community to inform clinical practice and guide action.

According to Denzin and Lincoln (2005) and Guba and Lincoln (1989), there is a strong link between a researcher's ontological, epistemological and philosophical assumptions and the methodological decisions made for a study. For this reason, (1) the relationship between ontology, epistemology, philosophy and methodology, (2) my ontological, epistemological and philosophical stance, and (3) the influence of my standpoints on the study are described below.

2.3 Relationship between ontology, epistemology, philosophy and methodology

A researcher's stance on reality (ontological stance), knowledge (epistemological stance) and underlying assumptions about the world and inquiry (philosophical stance), along with the research question, inform a series of methodological decisions that must be made in a study. The decisions concern fundamental aspects of the study, such as the choice of methodology to address the research question and the choice of methods to collect and analyse the data (Denzin & Lincoln, 2005; Guba & Lincoln, 1989). Furthermore, the decisions concern the role of the researcher in terms of relating to the research participants and influencing the research process and findings (Denzin & Lincoln, 2005).

2.3.1 The researcher's ontological stance

Ontology is 'concerned with "what is", with the nature of existence, with the structure of reality' (Crotty, 1998, p. 10). In my view, reality is subjective, socially constructed, interpretative, historically situated and subject to constant change. It is based on our own perception and understanding of the self, the 'others' and the world. It is socially constructed through our interaction with the 'others' and their world (Kant, 1787/1933), our own past and present experiences, and from being part of social groups such as our family, school, community and workplace (Charon, 2010).

The way we view our world is influenced by the way we interpret our encounters and experiences. The known world has no meaning except for what is attributed to it by us (Guba & Lincoln, 1989; Kant, 1787/1933). The way we interpret our encounters and experiences is influenced by our gender, class, ethnicity, previous learning, where we are in life, and the historical, social and cultural contexts we live in (Blumer, 1986; Charon, 2010). As we and the social world changes, our own subjective reality changes (Charon, 2010).

2.3.2 The researcher's epistemological stance

Epistemology is concerned with the nature of knowledge itself, as well as with the relationship between researchers and the topic being researched. It attempts to answer what knowledge is, what we know, how knowledge is acquired and how we know what we know (Bechtel, 1988a, 1988b; Crotty, 1998; Guba & Lincoln, 1989; Willig, 2001). In my opinion, knowledge is partial, subjective, socially constructed, provisional and constantly evolving. It is partial because our skills of perception, observation and description are selective (Willig, 2001). In addition, it is subjective because our perception of a situation influences our understanding of that situation.

We co-construct knowledge and understanding(s) through our interaction with the 'others', symbolic communication and mutual interpretation of the story we share (Blumer, 1986; Mead, 1934). Our interpretation is influenced by our life experiences and the historical, social and cultural contexts we live in. We are particularly interested in understanding things that are relevant and useful to us (Mead, 1934). We tend to learn throughout our lives, and this is the reason why knowledge is provisional and ever-evolving. When expanding our knowledge or acquiring new knowledge, we use previously gained knowledge to build upon it. Lastly, we know what we know about a subject by critically questioning our understanding of it.

2.3.3 The researcher's philosophical stance

In my view, we define ourselves through our interaction with the 'others', their responses to us and our interpretation of these responses. We form relations with the 'others' and respond to them based on the meaning we assign to these relationships. The meaning(s) we assign to relationships, situations and events are influenced by social interaction and the context in which they present (Blumer, 1986; Charon, 2010). These meanings are redefined and modified through our interpretation of what happens in a specific situation or event (Blumer, 1986; Charon, 2010). The way we know the world is based on the same process we use to define ourselves and relate to 'others'.

2.4 Influence of the researcher's ontological, epistemological and philosophical stance on the study

Researchers must be clear about their ontological, epistemological and philosophical assumptions, as well as about the aims and objectives of their study. This is because both their worldview and understanding of their project inform the entire research process, from conceptualisation to findings (Silverman, 2005; Willig, 2001). In this project, my ontological stance informed the study in terms of conceptualising *what it is that I wanted to know about how therapists experience erotic feelings in therapy*. My epistemological stance informed the work by identifying *how I could find out about how therapists experience erotic feelings in their work*. To conclude, my philosophical assumptions informed the work by determining *how I should approach the study to answer the research question*.

The present study aimed to explore how therapists experience erotic feelings in therapy, how their experience is constructed, and how their accounts construct the social world. The objectives of the study were to (1) make meaning of therapists' subjective experience, (2) theorise the basic social processes, contexts and structural conditions that influence the construction of therapists' experience, and (3) suggest practical applications (Braun & Clarke, 2006, 2013, 2014). The applications would not only inform therapists' practice but also guide action, potentially leading to social change and the development of appropriate policies. This is because the construction of meaning is a two-way procedure that takes place between us and society (Blumer, 1986; Charon, 2010). Our interaction with the 'others' (social interaction) shapes our identity and the meanings we assign to our experiences. In turn, the way we perceive our identity and experience a phenomenon influence society's understanding and attitudes towards this phenomenon (Blumer, 1986; Charon, 2010). This means that, with regard to the present study, social interaction shapes how therapists experience erotic feelings in therapy, the construction of their experience and the ways in which they work with the erotic in their practice. In turn, the way that therapists experience the erotic and work with it influences and shapes

society's understanding and attitudes towards the experience of erotic feelings in therapy.

In order to explore how therapists make meaning of the erotic in therapy, I planned to meet and conduct face-to-face interviews with the research participants. Understanding would derive from our interaction and mutual interpretation of the story we would share. To facilitate this, I endeavoured to establish rapport and actively listen to them. At the same time, I planned to keep an eye on my own subjectivity and how it could influence my relationship and interaction with the participants, the research process and the interpretation of their experiences.

The research paradigm that integrated my ontological, epistemological and philosophical assumptions and that enabled me to address the research question was the constructionist paradigm. This is because a constructionist research paradigm assumes a relativist ontology (there are many subjective realities), a subjectivist–interactive epistemology (understandings are co-created) and a constructivist–interpretative philosophical perspective of the world (researchers and participants co-construct understandings influenced by their interaction and mutual interpretation of the story they share) (Guba & Lincoln, 1989). The constructionist research paradigm and the rationale for choosing it for the study are described below.

2.5 Research paradigms

Research paradigms are fundamental sets of beliefs that steer action and influence a series of methodological decisions to be made in a study, as the two of them inter-relate (Guba & Lincoln, 1989; Hayes, 2000). Guba and Lincoln (2005) describe five major research paradigms: the positivist, the post positivist, the constructionist/constructivist, the critical and the participatory paradigms. As the scope of this study does not extend to describing the major research paradigms in detail, only the paradigm that represents the approach taken will be described here.

2.5.1 Constructionist research paradigm – Rationale for its choice

The constructionist paradigm argues that there is no single objective reality 'out there' but there are many subjective realities. People co-construct meaning and knowledge through their interaction with the 'others'' subjective worlds and the mutual interpretation of the story they share (Guba & Lincoln, 1989). In this sense, meaning is a mutual construction transmitted within a social context (Guba & Lincoln, 1989).

Constructionism emphasises the inter-relationship between humans and society in terms of constructing meaning. Our social interaction shapes our identity and the meaning(s) we assign to our experiences. In turn, the way we perceive our identity and experience a phenomenon influence society's understanding and attitudes towards this phenomenon (Blumer, 1986; Charon, 2010). At this point, it must be noted that constructionism is not the only form of knowing. Logic, experiments and free association are also some of the various ways of gaining knowledge.

Crotty (1998) and Guba and Lincoln (1989) argue that we construct meaning(s) and social realities actively. The construction of our realities is influenced by the social and cultural contexts we live in. This is because our culture shapes *if* and *how* we experience things and situations, as well as *how* we respond to them. In addition, the construction of our realities is

influenced by the historical context we live in, the use of symbols (such as language), and our values, beliefs and prior experiences (Blumer, 1986; Mead, 1934).

According to Guba and Lincoln (1989), the influence of social and cultural factors in the construction of reality leads to the construction of shared realities. The construction of shared realities is promoted through collaboration, interaction and the mutual interpretation of the story we share. In conclusion, research from a social constructionist perspective is concerned with exploring how social reality is constructed and the implications for the subjective experiences of people and social practice (Willig, 2001). The present study is a constructionist study, as it aims to explore how therapists experience erotic feelings in therapy, how their experience is constructed and how their accounts construct the social world.

As mentioned earlier, the choice of a paradigm informs a series of methodological decisions that are required in a study (Guba & Lincoln, 1989; Hayes, 2000). Deciding on the constructionist research paradigm influenced the choice of the methodology I used in the study; this was the methodology of Thematic Analysis and specifically the Constructionist model of Thematic Analysis. The choice of the Constructionist model of Thematic Analysis influenced the choice of the method I used to collect the data; this was through interviews. It also influenced the choice of (1) the techniques I used to analyse the data, and (2) the way in which these techniques were applied; these were the data analytic procedures described by Braun and Clarke (2006, 2013). Lastly, the choice of the Constructionist model of Thematic Analysis influenced the extent to which I, as the researcher, related to and interacted with the participants, and influenced the research process and outcome (Braun & Clarke, 2006, 2013). In the following sections, the beginning of this journey and the methodological decisions taken are described from scratch. The rationale for choosing to use a qualitative research methodology and the different qualitative research methodologies considered for the study are presented first.

2.6 Methodological considerations

2.6.1 Rationale for choosing to use a qualitative research methodology

To meet the aims of the study, I needed to develop a close and interactive relationship with the participants. Understanding would derive from our interaction and the mutual interpretation of the story we would share. Based on the requirements of the study, it was evident that a qualitative design was the best choice for this project. This is because qualitative designs allow the study of human experiences in their natural settings (Lincoln & Guba, 1985; Patton, 1990; Smith, 2008), allow their in-depth exploration (Smith, 2008; Smith, Harre & van Langenhove, 1995; Willig, 2001; Yardley, 2008) and give a rich account of them from participants' points of view (Patton, 1990).

Moreover, qualitative designs perceive behaviours as a whole (Patton, 1990), are interested in understanding the influence of the social environment on individuals' behaviours (Patton, 1990) and are concerned with implications for practice. Lastly, they use flexible data collection and analysis procedures (Denzin & Lincoln, 2005; Silverman, 2005; Smith, 2008; Willig, 2001), enable the development of a close and direct interaction between researchers and participants, and acknowledge the influence of researchers' subjectivity and interpretations throughout the research process and analysis (Smith, 2008; Smith et al., 1995; Willig, 2001; Yardley, 2008). Presented in the next section are the different qualitative research methodologies considered for the study.

2.7 Different qualitative research methodologies considered

According to Braun and Clarke (2006), the methodologies that seek to identify patterns across data are numerous. The methodologies considered for the study were the methodologies of Phenomenology, Grounded Theory and Thematic Analysis. Consequently, it makes sense to give a brief description of Phenomenology and Grounded Theory, as well as the reasons they were rejected; this analysis is presented first. An account of Thematic Analysis and the rationale for its selection are presented next. A description of the Constructionist model of Thematic Analysis, the reasons for choosing the specific model for the study and the advantages and disadvantages of (Constructionist) Thematic Analysis are also portrayed.

2.7.1 Phenomenology

Phenomenology is a qualitative inductive approach that is based on the paradigm of philosophy (Creswell, 1994, 1998; Patton, 1990). It studies the essence of individuals' lived experience of everyday phenomena and describes this experience from the individuals' point of view and within the context of their lives (Christensen, 2001; Creswell, 1994, 1998; Giorgi & Giorgi, 2008; Patton, 1990; Smith et al., 2009). Phenomenology can be divided into Descriptive Phenomenology and Hermeneutic or Interpretative Phenomenology (Smith et al., 2009).

2.7.1.1 Descriptive Phenomenology

Descriptive Phenomenology takes no account of the researcher's role, assumptions and understandings of the phenomenon in question, which is called 'bracketing'. According to Husserl (1927), bracketing enables researchers to set aside their consciousness of the studied phenomenon (intentionality). Consequently, they can concentrate on their perception of the phenomenon without being influenced by their subjectivity, and gain an unbiased understanding of the phenomenon itself.

2.7.1.2 Hermeneutic or Interpretative Phenomenology

Hermeneutic Phenomenology takes the opposite stance to Descriptive Phenomenology. According to Heidegger (1967) (who was Husserl's student), the analysis and interpretation of a phenomenon is inevitably influenced by numerous subjective factors. Some of the most important factors are the context within which the phenomenon is presented, the researcher's reflexive awareness of the phenomenon and the researcher's inter-subjective relationship with participants in their mutual effort to explicate the essence of the studied phenomenon (Heidegger, 1967).

In my opinion, both Descriptive Phenomenology and Hermeneutic Phenomenology would have provided a rich description of how therapists experience erotic feelings in therapy. However, Descriptive Phenomenology would neither explore nor capture the role of the researcher's subjectivity in the work, the role of social interaction and the influence of context on how therapists process erotic feelings. On the other hand, Hermeneutic Phenomenology would take into account all these factors, but would not be able to produce practical guidance that addresses therapists' concerns associated with the phenomenon and that informs their practice. For these reasons, I decided that neither Descriptive Phenomenology nor Hermeneutic Phenomenology were the appropriate research methodologies for the study.

2.7.2 Grounded Theory

Grounded Theory was originally conceived and described by Glaser and Strauss in 1967. Grounded Theory is an inductive research methodology designed to study individual subjective experiences, social processes and the inter-relationship between individuals and society (Charmaz, 1995, 2006, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1998). The aim of Grounded Theory is to generate a theory through the systematic collection and analysis of empirical data in order to explain the studied phenomenon and suggest practical applications (Birks & Mills, 2011; Charmaz, 1995, 2006, 2008; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1998). The emerging analysis drives subsequent data collection to elaborate on,

refine and develop the emerging theory (Charmaz, 1995, 2006, 2008; Glaser, 1978, 1992; Glaser & Strauss, 1967; Strauss & Corbin, 1998). Data are collected until theoretical saturation is reached (Charmaz, 1995, 2006, 2008; Glaser, 1978, 1992; Glaser & Strauss, 1967; Strauss & Corbin, 1998). The emerging theory is both time-specific and context-specific and subject to interpretation. In addition, it is flexible but durable over time, and can be refined and extended by other researchers (Charmaz, 1995, 2008).

Researchers approach the studied phenomenon with as few preconceived ideas as possible, which allows the construction and modification of the inductive theory. Moreover, they avoid conducting an early comprehensive literature review on the subject in order to handle the risk of ‘forcing’ data into categories (Charmaz, 1995, 2006, 2008; Glaser, 1978, 1992; Glaser & Strauss, 1967; Strauss & Corbin, 1998). The methodology provides researchers with explicit but flexible step-by-step guidelines to collect and analyse the data, which enables them to manage the project (Charmaz, 1995, 2003, 2008). In addition, the methodology is rigorous, as it provides researchers with not only a set of guidelines to work with, but also a set of criteria to evaluate the outcome of their work (Charmaz, 2006; Glaser, 1978).

Since 1967, Grounded Theory has evolved both philosophically and methodologically. Nowadays, there are three major approaches in Grounded Theory, influenced by their authors’ underlying ontological and epistemological beliefs and theoretical paradigms of inquiry. The first approach is the Glaserian approach, the second is the Straussian approach and the third one is the Constructivist approach. The ontological, epistemological and philosophical stances of these three approaches, as well as the reasons they were rejected, are described briefly below.

The Glaserian approach is based on the original work and subsequent writings of Glaser. Glaser holds a realist ontological, an objectivist epistemological and a positivist philosophical perspective of the world. The approach was rejected because I disagreed with its objectivist and positivist foundations.

The Straussian approach is based on the refinements that Strauss and his associate Corbin made to the original approach (Charmaz, 2006). Strauss and Corbin hold a relativist ontological, a subjectivist epistemological and a post positivist–interpretive philosophical perspective of the world. This approach was rejected because I disagreed with some of its fundamental assumptions; for example, the role of researchers in the research process. In addition, I did not feel comfortable with the rigid way in which the approach's analytic procedures are implemented, which increases the likelihood of data being 'forced' into preconceived categories.

The Constructivist approach was developed by Charmaz (1995, 2003, 2005, 2006, 2008). Charmaz (2003) holds a relativist ontological, a subjectivist–interactive epistemological and a constructivist–interpretative philosophical perspective of the world. The approach was compatible with my ontological, epistemological and philosophical positions, and it was also able to address the research question. For these reasons, Charmaz's Constructivist model of Grounded Theory (2006) was initially selected as the most suitable methodology for the study. However, later, and following a careful re-examination of what I endeavoured to do, it was rejected. This was because I decided that I was not interested in producing a fully worked-up Grounded Theory analysis.

2.7.3 Thematic Analysis

Thematic Analysis has a less coherent developmental history than Phenomenology and Grounded Theory. It appeared as a method in the 1970s, but it was often variably and inconsistently used. A good description of and guidelines for Thematic Analysis were presented by Boyatzis in a book published in 1998 (Boyatzis, 1998). At the same time, Boyatzis (1998) advocated that Thematic Analysis is not a methodology in its own right, but a tool that researchers can use across qualitative methodologies. Likewise, Ryan and Bernard (2000) viewed Thematic Analysis as a process used within 'major' analytic traditions, such as Grounded Theory and Phenomenology, rather than as a specific methodology.

Thematic Analysis became a named and claimed methodology in 2006, when Braun and Clarke published a paper titled *Using Thematic Analysis in Psychology* (Braun & Clarke, 2006). Since then, Thematic Analysis has been defined as an independent and reliable qualitative methodology that researchers use to identify, analyse and report patterns (themes) across data (Braun & Clarke, 2006, 2013). At the very least, Thematic Analysis organises and describes the data set in rich detail, but it frequently goes beyond this to analyse and interpret various aspects of the research subject (Braun & Clarke, 2006). The aims of Thematic Analysis are to (1) make sense of the data, and (2) tell an accurate story of what the data mean (Braun & Clarke, 2006).

Thematic Analysis is widely used in psychology, healthcare research, social research and other disciplines (Braun & Clarke, 2006, 2013; McLeod, 2001). It is designed to study individuals' subjective experience(s) of a phenomenon, understandings and perceptions, accounts of practice, influencing factors, representation and the construction of individuals' experience(s) (Braun & Clarke, 2013). It can suggest practical applications and influence the development of policies related to the subject in question (Braun & Clarke, 2013, 2014).

Thematic Analysis can be conducted both within the positivist and the constructionist research paradigms, although the focus and outcome of the research will be different for each (Braun & Clarke, 2006, 2014). It can give a rich thematic description of the entire data set or a detailed account of one or two particular themes within the data (Braun & Clarke, 2006). It can be inductive (data-driven analysis) or deductive (theory-driven analysis) (Braun & Clarke, 2006). Themes can be analysed at a semantic level or a latent level; the first is explicit, whereas the second is interpretative (Braun & Clarke, 2006).

Before taking a closer look at Thematic Analysis, the following five terms should be defined. The term 'data corpus' refers to 'all data collected for a particular research project' (Braun & Clarke, 2006, p. 79), whereas the term 'data set' refers to 'all the data from the corpus that are being used for a particular analysis' (Braun & Clarke, 2006, p. 79). Moreover, the term 'data item' is used to refer to 'each individual piece of data collected, which together make up the data set or corpus' (Braun & Clarke, 2006, p. 79). In addition, 'codes' 'identify a feature of the data (semantic content or latent) that appears interesting to the analyst' (Braun & Clarke, 2006, p. 88). More specifically, the term 'code' refers to 'the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon' (Boyatzis, 1998, p. 63). Lastly, a 'theme' 'captures something important about the data in relation to the research question, and represents some level of *patterned* response or meaning within the data set' (Braun & Clarke, 2006, p. 82).

In Thematic Analysis, the most frequent ways of collecting data are interviews, focus groups, qualitative surveys and vignettes (Braun & Clarke, 2013). Sampling size is not predefined, but decisions are made as the research proceeds. The analysis of data starts as soon as the collected material is transcribed and ends when the final report is produced (Braun & Clarke, 2006). Data collection and analysis tend to occur concurrently (Braun & Clarke, 2013). Analysis involves a constant moving back and forward between the entire data set, the coded extracts of the data analysed and the

analysis of the data produced (Braun & Clarke, 2006). In addition, analysis is a process that develops over time; hence, it should not be forced (Ely, Vinz, Downing & Anzul, 1997). Analysis consists of six phases. To avoid repetition, they will not be presented here; instead, these phases are described in Section 2.9. Researchers play an active role during the collection and analysis of the data (Braun & Clarke, 2006); hence, they must be reflexive towards their biases, role and the research process (Braun & Clarke, 2006). In addition, researchers write memos throughout the whole process, which enables them to make sense of the data (Braun & Clarke, 2006). Lastly, although there is not a specific rule about this, most researchers - especially those who aim to conduct inductive research - avoid completing a comprehensive literature review on the subject prior to data analysis in order to reduce the risk of 'forcing' the data into categories (Braun & Clarke, 2006). Instead, they do an initial literature review aimed at preparing the research proposal and developing their sensitivity to the subtle features of the data (Tuckett, 2005).

2.8 Rationale for choosing the methodology of Thematic Analysis

The reasons that Thematic Analysis was chosen for the study are presented below:

- It is a widely used methodology in the field of psychology (Braun & Clarke, 2006).
- It is designed to identify, analyse and report patterns (themes) through the systematic collection and analysis of data (Braun & Clarke, 2006).
- It is flexible, straightforward and provides researchers with a set of guidelines to work with (Braun & Clarke, 2006).
- Results are readily accessible to those who are not part of the academic community (Braun & Clarke, 2014).

2.9 Constructionist model of Thematic Analysis

Constructionist Thematic Analysis focuses on how events, realities, meanings and experiences are constructed and how individuals' accounts construct the world (Braun & Clarke, 2013). It is inductive in nature, as the identified themes are strongly linked to the data (Braun & Clarke, 2006). Themes are analysed at a latent, interpretative level (Braun & Clarke, 2006). Interpretation is influenced by social and cultural contexts, the historical period, researchers' and participants' interaction and researcher's subjectivity (Braun & Clarke, 2006). Analysis aims at a rich thematic description of the entire data set; hence, Constructionist Thematic Analysis is suitable for the study of under-researched subjects (Braun & Clarke, 2006).

Data are primarily collected through interviews, which are transcribed verbatim. Sampling is usually purposive, which is the case in most qualitative methodologies (Patton, 2002). The sampling size is not predetermined, but decisions are made as the research progresses. The collection, coding and analysis of data occur concurrently (Braun & Clarke, 2006). Analysis is not a linear process but a recursive one (Braun & Clarke, 2006) and involves six phases. These are (1) familiarising oneself with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report (Braun & Clarke, 2006, 2013). Researchers pursue those themes that seem to be important and make the most analytic sense; they also keep memos throughout the entire research process (Braun & Clarke, 2006). Understandings are co-constructed through the dynamic interaction between researchers and participants (Braun & Clarke, 2006).

Researchers approach the subject with as few preconceived ideas as possible (Braun & Clarke, 2006). The role of the researchers is active during the entire process; thus, reflexivity towards themselves and the research process is essential (Braun & Clarke, 2006). For this purpose, researchers are advised to keep reflexive journals throughout the process (Braun & Clarke, 2006). The literature review is part of the researchers' theoretical sensitivity (Tuckett, 2005). Researchers avoid conducting a comprehensive literature review prior to the completion of the analysis to avoid 'forcing' the data into predetermined categories (Braun & Clarke, 2006). Results are presented in terms of a story line, map or model related to the research question (Braun & Clarke, 2006). Member checking is considered to be the most significant means of establishing the credibility of the analysis (Braun & Clarke, 2006). The way in which the data were analysed is described in Section 2.26.

2.10 Reasons for selecting the Constructionist model of Thematic Analysis

The main reasons why the Constructionist model of Thematic Analysis was identified as the most suitable methodology for the research project are:

- It fits my ontological, epistemological and philosophical stances.
- It is an exploratory methodology designed to study subjects where little research has been done (Braun & Clarke, 2006).
- It can address the research question, as it is suitable for studying individuals' subjective experience(s) of a phenomenon, identifying how their experience is constructed, and understanding how their accounts construct the social world (Braun & Clarke, 2006, 2013).
- It can suggest practical applications and contribute to the development of appropriate policies related to the subject under examination (Braun & Clarke, 2006, 2013).

2.11 Advantages and disadvantages of (Constructionist) Thematic Analysis

According to Braun and Clarke (2006, 2013), some of the main advantages of (Constructionist) Thematic Analysis are the following:

- Thematic Analysis is a flexible methodology that can be used by researchers from various methodological backgrounds.
- It is fairly straightforward, and easy to learn and to conduct.
- It can be used to study large data sets, highlight similarities and differences across data sets and generate unexpected insights.
- In Constructionist Thematic Analysis, researchers and participants construct understandings and meanings actively and collaboratively.
- Data can be interpreted from a psychological and a social perspective.
- Results are readily accessible to an educated general public.
- Thematic Analysis can be used to produce qualitative analysis suited to inform policy development.

Most of the disadvantages of Thematic Analysis relate to the way in which the methodology is used rather than the methodology itself. Braun and Clarke (2006, 2013) report that some of the main disadvantages of (Constructionist) Thematic Analysis are:

- The flexibility of the methodology might make it hard for researchers to decide on what aspects of the data they should focus on.
- Researchers may find it difficult to maintain both a sense of continuity and contradiction in individual accounts.
- The 'voices' of individual participants may get lost, especially if they are part of a large data set.
- Interpretations are subjective; hence, there is some concern regarding the reliability of the results.
- Researchers cannot make claims about the effect of language use.

2.12 Ethics approval

This project was approved by the Research and Ethics Committee of the Department of Psychology at City University, London. The project's approval number is PSYETH 11/12 011. The approval was granted on 15th December 2011.

2.13 Overview of research design

As already seen, the qualitative research methodology of Thematic Analysis, and in particular the Constructionist model of Thematic Analysis, was selected to meet the aims of the study. Data were collected by conducting semi-structured interviews with thirteen participants. Interviews were audio recorded, anonymised and transcribed. Data were analysed according to the six analytic phases described by Braun and Clarke (2006, 2013). The model was deemed the most appropriate for the study as it fit my ontological, epistemological and philosophical stances and was able to address the research question. Described in the next section are the data sampling methods used in the study, and the criteria for selecting the research sample and for estimating its size. An overview of the research participants will follow.

2.14 Data sampling method

2.14.1 Sampling

Sampling is the process of selecting research participants for the purpose of studying a subject (Hayes, 2000). In qualitative research designs, sampling emphasises the quality and depth rather than the quantity and statistical representativeness. In addition, the typical approach to sampling is purposive, especially when the aim of the study is to gain an in-depth understanding of the subject in question (Patton, 2002).

2.14.2 Purposive sampling

Purposive sampling refers to the selection of a sample in which the features or processes being studied are illustrated or are most likely to be illustrated (Denzin & Lincoln, 2005; Padgett, 2008; Patton, 1990, 2002; Silverman, 2005). This type of sampling is particularly informative and enables researchers to start gathering rich data on the studied phenomenon (Patton, 1990, 2002; Silverman, 2005). A popular method of identifying purposive sampling is the snowball or chain sampling method, which is ideal for locating information-rich participants (Biernacki & Waldorf, 1981; Patton, 1990, 2002). According to this method, subjects who have already participated in a study (and have offered rich information) identify and nominate other subjects who are also likely to offer rich information (Biernacki & Waldorf, 1981; Patton, 1990, 2002). The main limitation of this method is that the sample can be biased and/or over-represented (Johnston & Sabin, 2010). In the present study, this risk has been managed by using a wide variety of recruitment methods.

2.15 Identifying the research sample

To meet the aims of the study, I needed to sample therapists who were the most likely to provide me with rich information and who also practised within ethical boundaries. To find the required sample, I had to set standards with respect to therapists' eligibility to participate in the study (Padgett, 2008). To do this, I needed to identify inclusion and exclusion criteria for potential participants. These criteria are described below.

2.15.1 Inclusion criteria

The first criterion I set was that participants should have a minimum of five years of post-qualification experience. This is because the study would benefit from collecting and analysing rich, detailed, full and contextualised data about therapists' experiences (Patton, 1990, 2002; Silverman, 2005). This type of data allows researchers to gain a thorough knowledge of the

experience they are studying. The second criterion I assigned was that participants should be registered with professional bodies that support and regulate their practice. The logic behind this was to have a point of reference with regard to boundaries for ethical and safe practice. Lastly, participants could have come from any discipline, work with any model and practise either privately or in an organisation (voluntary or statutory). The aim behind this was to recruit a wide range of participants to add variation, depth and breadth to the data.

2.15.2 Exclusion criteria

Therapists who had less than five years of post-qualification experience were excluded from sampling. This is because the likelihood of novice therapists offering rich data was deemed small. No participants were excluded on the basis of age, gender, ethnicity, race, disability, sexuality, religion or any other discriminatory factor.

2.16 Sample size

In qualitative research studies, there are no concrete guidelines on sample size (Patton, 2002). Qualitative researchers are required to make a decision that takes into account the research question, the methodology used and the resources available (Padgett, 2008; Patton, 1990, 2002; Silverman, 2005). A widely used technique that is able to address the question of how much data are needed for a qualitative study is the technique of saturation (Braun & Clarke, 2006). This technique was developed by Glaser and Strauss in 1967 (Glaser & Strauss, 1967). Saturation typically refers to the point when collecting additional data does not generate any new information (Morse, 1995; Sandelowski, 1995).

In a Thematic Analysis study, the final sample size of the study is not known to the researchers at the time the study commences (Braun & Clarke, 2013). Braun and Clarke (2013) advocate that the size must be small enough for researchers to manage the collected data but large enough for researchers to identify patterns of meaning in the data. On average, the number of interviews required for small, medium and large Thematic Analysis studies are 6-10, 10-20 and 20+ respectively (Braun & Clarke, 2013). As I aimed to conduct a medium scale study, it was anticipated that 10-20 therapists would participate in the study.

2.17 Overview of the research participants

The research participants are described below to enable the readers of the study to visualise the context from within which the themes and sub-themes identified (Patton, 1990). Some demographic information has been changed to protect participants' anonymity. The participants were thirteen therapists (six male and seven female) who were registered either with the British Psychological Society (BPS), the British Association for Counselling and Psychotherapy (BACP) or the United Kingdom Council for Psychotherapy (UKCP). Participants had from 5 to 36 years of post-qualification experience. Nine practised only privately, two worked only in the public sector and two worked both privately and in voluntary organisations. Participants' theoretical orientations varied. The models they used to practise were psychodynamic, humanistic and cognitive behavioural, while most of them practised integratively.

Participants' ages ranged from 36 to 65 years old, with nine of them being between 40 and 49 years old. Nine of them described their sexual orientation as heterosexual, three as gay and one as bi-sexual. Six were in a relationship, five were married, one was single and one was divorced. Ten lived and practised in London, whereas the rest of them lived and practised out of London.

All participants agreed to their interviews being audio recorded and then transcribed by a transcription service. In addition, they all gave positive feedback on the use of semi-structured interviews as the most suitable instrument to explore the phenomenon in question, and they appreciated the flexible and respectful way in which their interviews were conducted. In addition, all of them read and confirmed the accuracy of their transcribed interview. Lastly, all participants asked to receive an electronic copy of the final thesis.

Two more therapists expressed an interest in participating in the study but they were not recruited for different reasons. The first therapist was not recruited because he had less than five years of post-qualification experience. The second therapist was not recruited because she was unhappy with receiving no compensation for the time she would devote to the study. Table 1 shows the participants' demographic characteristics.

Table 1. Participants' demographic characteristics

Gender	Male: 6
	Female: 7
Age	20–29: 0
	30–39: 1
	40–49: 9
	50–59: 2
	60–69: 1
Sexual orientation	Heterosexual: 9
	Gay: 3
	Bi-sexual: 1
Family situation	In a relationship: 6
	Married: 5
	Divorced:1
	Single: 1
Years of post-qualification experience	1–9: 5
	10–19: 7
	20–29: 0
	30–39: 1
Type of practice	Private: 9
	Organisation: 2
	Private and organisation: 2
Location	In London: 10
	Out of London: 3

Described in the next section are the procedure for recruiting participants, the method used to collect the data and the preparation of the interview schedule.

2.18 Recruitment procedure for participants

Participants were recruited via the following methods:

1. Using the method of snowball or chain sampling.
2. Advertising the research project in the journals *The Psychologist* (BPS) and *Therapy Today* (BACP).
3. Advertising the research project on the UKCP website (www.psychotherapy.org.uk/iqs/dbitemid.1626/sfa.view/research_notices.html).
4. Advertising the project in Glosnet (Gloucestershire Networking group for Counsellors and Psychotherapists) and Counsellors and Psychotherapists in Private Practice (CAPPP) professional networks.

Therapists who were interested in participating in the study contacted me by email. Following their expression of interest, I emailed them the Participant Information Sheet (Appendix 1) and the advertisement of the project (Appendix 2). The documents included information on the aims of the project, the collection, analysis and handling of data, the participants' rights, the limits of confidentiality, the debriefing procedure, the project's ethical clearance, and the university's complaints procedure. The information provided aimed to enable potential participants to make an informed decision about participating in the study. The participants and I mutually agreed upon the date, time and location of their interviews (Warren, 2001).

2.19 Data collection method

2.19.1 Semi-structured interviews

Data were collected through the completion of individual, semi-structured, face-to-face interviews. Semi-structured interviews are flexible and enable participants to tell their story from their own perspective. They follow the participants' lead and respect their pace, interests and experiences while remaining focused on the subject (Hayes, 2000; Smith, 1995; Willig, 2001). They require careful preparation and planning of the questions to be asked and the way they should be asked (Willig, 2001). The main disadvantage of interviews, whether semi-structured or unstructured, is that they are time-consuming to conduct and analyse.

Conducting semi-structured interviews facilitated my interaction and engagement with the participants' world and gave me an in-depth understanding of their experiences (Hayes, 2000; Silverman, 2005). Participants were interviewed once and all interviews were audio recorded. Additional data were collected through the memos I wrote and the reflexive journal I kept (Braun & Clarke, 2006).

2.20 Preparing the interview schedule

The questions included in the interview schedule (Appendix 3) were based on (1) the initial literature review I conducted to prepare the research proposal for the study, and (2) the study's initial research question (see Section 2.2). However, the initial research question evolved from the first interview, as all thirteen participants felt the need to share and reflect on how they experienced both their clients' erotic feelings for them and their own erotic feelings for their clients; as demonstrated in Chapter 3 (Results and Analysis).

Although the interview schedule changed straight away, it did not change dramatically, as what I needed to do was simply add a second set of questions similar to the first. The first set of questions would explore how the participants experienced their clients' erotic feelings for them, whereas the second set would explore how the participants experienced their own erotic feelings for their clients. All questions were open-ended, exploratory, carefully worded and process-orientated. As the research progressed, the non-fruitful questions were deleted while others were modified and re-modified to support exploration (Smith, 1995). Probes were used to clarify answers and encourage the participants to keep talking (Padgett, 2008; Warren, 2001). Closed and leading questions were avoided (Smith, 1995). The first set of questions was tested in the pilot interview I conducted on the subject and in the self-reflexive interview I had on the subject. The self-reflexive interview, the pilot interview, and the procedures of conducting, audio recording and transcribing participants' interviews are portrayed below.

2.21 Self-reflexive interview

Before conducting any interviews with research participants, I decided to have a self-reflexive interview. Thus, I asked a colleague of mine to interview me using the interview schedule I had prepared as a guide. The reasons for having the self-reflexive interview were to:

1. Experience what it feels like to be a participant interviewed on the subject.
2. Increase my awareness about my own assumptions and beliefs on the subject.

What I found was that the subject was not easy to talk about, as the experience of erotic feelings is a very personal issue to me. My experience helped me to assume a highly empathic attitude towards the research participants. In addition, the interview helped me to identify and reflect on some of my own assumptions and beliefs on the subject, and think how they could influence the research process and results. For example, an assumption I held was that heterosexual therapists would not notice the experience of erotic feelings coming from same-sex clients, which could

potentially ‘block’ therapy. This reinforced the necessity of keeping a reflexive stance throughout the process.

2.22 Conducting a pilot interview

Prior to conducting any interviews with research participants, I also conducted a pilot interview with a colleague. My aim was to have the research protocol, recording equipment and interview schedule tested (Hayes, 2000; Janesick, 1994; McLeod, 2003). I conducted the interview with a 42-year-old female heterosexual therapist. She lived and worked in London and had five years of post-qualification experience. I emailed her the Participant Information Sheet and the advertisement of the project, and we mutually agreed upon the time and place for the interview. The participant discussed two historic cases where erotic feelings were implicitly expressed by her clients.

After the interview, I asked the participant to give me feedback on the content of the interview and the way in which it was conducted. Based on her feedback, semi-structured interviews were indeed the most appropriate method to collect data for this study. The participant said that the interview allowed her to talk about her experiences from her own point of view without any restraints. Furthermore, she commented on my ability to follow her lead and pace while still keeping sight of the areas I aimed to explore. She added that she appreciated that I respected and valued her thoughts, feelings and experiences and emphasised that our interview was an invaluable opportunity for her to further reflect on her experiences and practice. From my own point of view, the pilot interview offered me the opportunity to practise my interviewing skills. It also offered me the chance to observe how I interacted with the participant, how the interview evolved, how her experiences were interpreted and how knowledge was co-constructed.

2.23 Conducting semi-structured interviews

2.23.1 Before conducting the interviews

On the day of the interview and before the interview commenced, I gave participants a brief overview of the study. In addition, I handed them an extra copy of the Participant Information Sheet (Appendix 1) and asked if they would like to reread it. My aim was to refresh their memory about the research subject and procedures, and give them the opportunity to ask questions.

Being fully aware of the importance of gaining participants' informed consent to participate in a study and understanding that participants are free to decline participation (BPS, 2009; Christensen, 2001; Christians, 2005; McLeod, 2003; Meara & Schmidt, 1991; Punch, 1994; Silverman, 2005; Warren, 2001; Willig, 2001), I handed them two identical copies of the Participant Consent Form (Appendix 4). I asked them to read this form carefully, tick the terms agreed with (if not all), and then sign and date the form if they still wished to take part in the study. I retained the first copy of the signed form for my records and they kept the second one for theirs.

2.23.2 Throughout and following the completion of the interviews

The time that passed between the participants receiving full information about the study and having their interview conducted ranged between two and five weeks, depending on how soon they were available to meet. Participants were interviewed once only. The first question I asked them was how they had come to the field of therapy, while the second question was on what their interest in the research subject was. There were two reasons I asked these two general questions. The first reason was to enable the participants to relax and to introduce the subject to them (Hayes, 2000; Smith, 1995), while the second reason was to establish a rapport with them. According to Willig (2001), establishing rapport is vital for gathering a rich account of participants' experiences.

The content of the interviews varied, as I pursued the subjects that the participants defined as important, placed the information offered within the context it was derived from and tried to make meaning of the participants' experiences, thoughts, feelings, actions and processes. I closed all interviews by asking for feedback on the content and process of the interview. Based on the feedback received, the questions asked were thought-provoking, which the participants appreciated. In addition, the way their interviews were conducted was flexible, open-minded and respectful, which they valued highly.

At the end of each interview, I gave the participants the opportunity to debrief, ask questions and further discuss their interview experience. In addition, I handed them the Debriefing Information Form (Appendix 5) to ensure that they were fully aware of the support sources available to them in case they felt distressed by their participation. How the interviews were audio recorded and transcribed is demonstrated next.

2.24 Audio recording and transcribing interviews

All participants consented for their interviews to be audio recorded. Interviews were recorded using a digital recorder. Recording enabled me to keep regular eye contact with the participants, which facilitated the establishment of rapport (Padgett, 2008; Smith, 1995; Willig, 2001). It also enabled me to concentrate on their story while having an accurate record of it (Padgett, 2008; Silverman, 2005; Smith, 1995). Recordings were transferred to computer files and erased from the recorder.

As soon as the recorded interviews were transferred to my computer, all names and other identifying information were erased to protect the participants' anonymity. The interviews were stored with the file name format of 'number of interview – date the interview was conducted – recording'. Access to the files was protected by a password that only I knew. I then sent the anonymised interviews to a transcription service to have them

transcribed verbatim. I chose to do this because interview transcripts are time-consuming and I ought to be wise with the time available.

All participants had given their consent for their interviews to be transcribed by a service. Following transcription, all of them were sent an electronic copy of their transcript to read for reasons of transparency. The transcription service I used adhered to the Data Protection Act (Department of Health, 1998). Transcribed interviews were stored on my computer with the file name format 'number of interview – date the interview was conducted – transcript' to match the recordings. A reflexive statement on the effects of my interaction with the research participants on the interviewing process is given below.

2.25 Reflexive statement – The researcher's effects on the process of interviewing

Most people who are engaged in face-to-face situations are inclined to be cooperative and avoid interpersonal conflicts, if possible (Hayes, 2000). Being aware of this inclination, as well as of the potential effects of my verbal and non-verbal communication on participants' responses, I endeavoured to enable them to speak openly and honestly as opposed to adjusting their responses to what they believed I wanted to hear. To do this, I worked on establishing a rapport (Hayes, 2000), followed their pace and lead, reflected and clarified when necessary (Hayes, 2000), made a conscious effort to neither agree nor disagree with what they said (Hayes, 2000) and kept monitoring the impact of my presence and the interview on them. In addition, prior to interviewing the research participants, I conducted a pilot interview with the aim to test the research protocol, equipment and tool (semi-structured interviews) (Hayes, 2000; Janesick, 1994; McLeod, 2003) and to observe my interaction with the participant, how her experiences were interpreted and how meaning was co-constructed.

Participants' feedback on how they experienced their interviews was of upmost importance to me, as I cared to engage with them in a meaningful way in the exploration of the erotic. All thirteen participants said that I had listened to their thoughts, feelings and stories with interest, sensitivity and respect. They added that they felt able to share their experiences with me without worrying that they would be judged in any way. Lastly, they commented on the benefits of reflecting on their practice and learning from our interaction and the time we spent together.

On my behalf, I enjoyed the interviews as well although I must admit that I felt a sense of nervousness the day the first two interviews were conducted, which I perceived as normal (Braun & Clarke, 2013). Nonetheless, the nervousness disappeared the moment the interviews started. My focus was two-fold: on (1) my interaction with the participants and (2) myself. With respect to my interaction with the participants, I focused on connecting, listening actively, following those threads that seemed to be of importance to the participants, and making meaning through our interaction and mutual interpretation of the story we shared. With respect to myself, I was aware of my thoughts, feelings and potential triggers. Overall, I experienced the participants as being open, insightful and willing to talk with honesty. At the same time, I was aware that some participants, at some moments, felt a sense of discomfort due to the sensitive nature of the subject. Empathising enabled me to respond appropriately to the moment and appreciate them for having accepted to participate in my study. A description of how the collected data were analysed complete this chapter.

2.26 Analysing the data

Thirteen interviews were completed in a period of eight months. Interviews lasted from 53' to 1h52' with most of them lasting around 1h30'. As soon as I received a transcribed interview, I printed a copy of it. I then listened to the recording having on hand both the copy and the field notes I had kept. I did this with the aim of clarifying any unclear points and to add information on non-verbal elements, such as participants expressing or emphasising ideas

through body movements or gestures (Braun & Clarke, 2006). I attempted to capture the flavour of the language used by tentatively interpreting silences, ‘ums’ and pauses (Braun & Clarke, 2006). Studying a transcript enabled me to immerse in the data, which is an essential part of the process of conducting a Thematic Analysis study (Braun & Clarke, 2006, 2013). It also enabled me to gain a retrospective insight into issues that went unnoticed during the course of the interview(s). Participants read the transcripts as well and confirmed that their interviews were accurately transcribed.

I approached the research subject with as few preconceived ideas as possible and listened to what was of importance to the participants (Braun & Clarke, 2006). I followed up those themes that appeared to be the most interesting and make the most analytical sense (Braun & Clarke, 2006). The collection, coding (familiarising oneself with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report) and analysis of the data occurred concurrently (Braun & Clarke, 2006). Analysis constantly moved back and forward between the entire data set, the coded extracts of the data analysed and the analysis of the data produced (Braun & Clarke, 2006).

I wrote memos (Appendix 7) and drew diagrams to represent the links between codes, between themes and between different levels of themes (Braun & Clarke, 2006). I conducted a comprehensive literature review after the collected data were analysed to ensure that data were not ‘forced’ into predetermined categories (Braun & Clarke, 2006). Being aware of the role of my subjectivity in the research process, I maintained a reflexive stance towards the research process and myself (Braun & Clarke, 2006), which can be seen throughout this thesis. Data reached partial saturation due to time constraints (Green & Thorogood, 2004) and recruitment coming to a standstill. Five themes and their sub-themes were identified. The next chapter presents the results of the study and their analysis.

Chapter 3: Results and Analysis

3.1 Introduction

The organisation of this chapter is as follows. A reflexive statement on the researcher's subjectivity, as well as on the challenges she encountered, is presented at the beginning of the chapter. A brief description of how data were collected and analysed is portrayed as well. The presentation and analysis of the results follow.

3.2 Reflexive statement – The impact of the researcher's subjectivity and the challenges encountered

To believe that researchers choose to study a subject without having some pre-existing ideas about it is unrealistic. To assume that their personality, values, beliefs and bias on the subject will not have an impact on the collection and analysis of the data is equally unrealistic. Researchers shape the data through the way they phrase their questions, the topics they discuss, the threads they leave out, or follow up, and the depth in which they explore those threads they choose to follow (Braun & Clarke, 2006). Moreover, researchers shape the data through their interaction with the research participants and the interpretation of the participants' accounts (Braun & Clarke, 2006).

Being aware of the impact that my subjectivity could have on the study, I employed a number of strategies to minimise this risk. Some of the strategies I used were to keep a reflexive journal, have a self-reflexive interview, stay as close to participants' experience as possible, challenge myself constantly as to what I was seeing in the data, have my work monitored by my supervisor, and employ a set of criteria to evaluate the study.

Furthermore, one of the several techniques I used to increase the credibility of the results was to send the participants a copy of a summary of the results asking them to read, reflect and comment on them (member checking) (Braun & Clarke, 2006). Their feedback was recorded, analysed and became part of the results (Braun & Clarke, 2006). A brief summary of the participants' feedback is given in Section 4.6.1.1. Nonetheless, and despite the measures taken, in this study, understandings were co-constructed actively and collaboratively through the dynamic interaction between me and the participants (Braun & Clarke, 2006). This means that the story presented here is (1) bound to the particular social, cultural and historical context within which the research has been conducted and (2) subject to interpretation and modification.

Below, I talk about a risk I thought through and I explain the measures I took to manage it. However, I must mention that I did not encounter it. Following this, I talk about two challenges I did encounter and I describe the ways I handled them.

1. **Participants disclosing ethically questionable behaviour**

   To handle the risk of participants disclosing practice that could be deemed ethically questionable, which meant that I should take action, I stated well in advance, both in writing (Participant Information Sheet - Appendix 1; Participant Consent Form - Appendix 4) and verbally (at the day of the interview, prior to the interview commencing), the limits of confidentiality. In addition, I explained the course of action I would have to take in case they made such a disclosure. I was aware that the limits of confidentiality could potentially restrict some participants' disclosure of their experience of the erotic, thus influencing the results to an extent.

2. Being a practitioner interviewing practitioners

Being a practitioner interviewing other practitioners included the risk of rushing to conclusions due to my 'insider knowledge'. One of the ways I handled this risk was to pay extra attention to data that surprised me. On reflection, I believe my role as a practitioner was in no way disadvantageous to my role as a researcher. This was confirmed by the feedback received from the participants at the end of every single interview. All of them said that I neither made any assumptions about their thoughts and feelings, nor did I feed them with my own views on the subject. On the contrary, all thirteen commented on my open, sensitive and respectful attitude towards their stories and experiences. Claire, for instance, said: *'I enjoyed how we got into it (the erotic) and it felt that there was a good sort of sparking off each other. I really appreciated that you didn't just .. I didn't have a sense .. It felt like you opened it out and that was quite permission giving and we went where the flow went and you checked in every now and again that you were covering the ground. So, that felt good in terms of having the dialogue because it felt like an exploration which felt really useful' (Int 3, ll 767-777).* Furthermore, Isabelle said: *'I think it is a great research study that you are doing. I think it is good because it isn't talked about enough [...] I think there were some really good questions in there. I felt we kind of dealt with the important things. I felt you were very respectful about my particular point of view, you were able to take me forward with that in some areas where perhaps you wanted a little bit more information, you gave me enough space for me to be able to adapt, modify, ask questions. Yes, I am very positive about it' (ll 947-960).*

3. The impact of the participants' stories on me

The interaction between the participants and me was dynamic and, in the vast majority of interviews, there was a spark between us. Our conversations were lively, interesting and meaningful. Some parts of participants' stories felt familiar to me, whereas other parts were novel.

For example, participants' need to work on themselves with the aim of feeling more comfortable with love, sex and sexuality was familiar to me. On the other hand, the impact of society on how same-sex individuals (in this occasion, the participants) perceive their sexuality was a novel subject to me, as I am heterosexual. In all cases, I paid full attention to what the participants said, aiming to make meaning of their experiences. In addition, there were times that I felt overwhelmed by some participants' stories and the impact that their experiences seemed to have on them and their work with the erotic. Lastly, there were times I felt dazzled by the length of some participants' accounts. In order to handle my feelings, following the completion of each interview, I spent a good amount of time debriefing and relaxing, which enabled me to process my thoughts and feelings at my own pace.

3.3 Brief description of data collection and analysis

Data were collected through an ongoing interaction between myself - the researcher - and the participants. Collection, coding and analysis occurred concurrently (Braun & Clarke, 2013). The analysis was a recursive process that involved six phases (Braun & Clarke, 2006, 2013). An example of generating initial codes (phase two of the analysis) can be seen in Appendix 6. Data reached partial saturation due to time restrictions (Green & Thorogood, 2004) and recruitment coming to a halt. The results suggest that the majority of participants struggle to manage erotic and sexual feelings in therapy not only due to their personal history, but also due to the impact of society, training institutions, the profession and the regulators in the consulting room and on the individuals within it. As demonstrated, a reflexive stance towards both the research process and myself was kept throughout the entire study (Braun & Clarke, 2006, 2013). Through the process of data analysis, five themes and eight sub-themes were identified. These are presented in Table 2.

Table 2. Themes and sub-themes

Theme	Sub-themes
Theme 1: The entrance of the erotic in the consulting room	Sub-theme 1: Emotional responses to the erotic Sub-theme 2: Perceptions about the erotic • The erotic is mysterious • The erotic is a taboo • The erotic has personal meaning for therapists and clients
Theme 2: Working with the erotic	Sub-theme 1: Processing challenges internally • Keeping the therapeutic 'hat' on • Recognising erotic transference and counter-transference • Validating clients' sexuality Sub-theme 2: Handling the erotic • Addressing the erotic explicitly • Addressing the erotic implicitly • Not addressing the erotic
Theme 3: Experiencing the erotic – Therapists' understanding of the erotic and construction of their experience of the erotic	Sub-theme 1: Factors • Clinical experience • Quality of supervision Sub-theme 2: Inter-relationships • The role of training institutions • The role of society • The role of the profession • The role of regulation
Theme 4: The meaning of the erotic	Sub-theme 1: A product of therapy • Transference and counter-transference • A metaphor for the communication of nonsexual issues • An opportunity for transformation • A form of negative transference Sub-theme 2: The two faces of the erotic • The constructive erotic • The destructive erotic
Theme 5: Practice implications	• Working out an interactive practical approach to learning • Breaking the silence • Overcoming restrictions set by society, culture and regulation

In the next section, the results and their analysis are presented.

3.4 Theme 1: The entrance of the erotic in the consulting room

3.4.1 Sub-theme 1: 'I felt a bit "out of my depth"' – Emotional responses to the erotic

It appears that the participants' experiences and emotional responses to the presence of erotic feelings in therapy were shaped by the meaning assigned to the feelings. Although some participants believed that they had an understanding of the erotic in therapy, most participants admitted that they were unprepared for their encounter with it. As a result, the entrance of the erotic in the consulting room left these latter participants feeling a sense of surprise and discomfort, as illustrated in the extracts from Adam and Bill. Adam: *'It really took me by surprise' (Int 1, ll 416-417). 'I didn't expect an avow of sexual attraction by this woman (client) in those circumstances (therapy)' (Int 1, ll 535-536).* Bill: *'The first one (case) was quite early in my work and so it was a long time ago. I don't have a huge amount of memory of it, but client told me she was in love with me [...] I really didn't know what to do with it at the time. I had no idea. "Huh! What's this?" [...] I didn't find her attractive [...] Basically I just kept my blinkers on, heard what she said and largely ignored it, which wasn't a great way of dealing with it. I didn't know any better' (Int 2, 106-121).* In these extracts, it can be seen that Adam almost excludes the possibility of the erotic entering the therapeutic relationship. Based on a disclosure he made earlier in his interview about his personality and history, his position could be seen as a defence mechanism utilised to offer him a sense of safety over his work. Bill is also surprised to hear that his client is 'in love' with him, which leads him to 'freeze' and ignore her disclosure. His reaction could be viewed as the result of lacking the experience to respond to the erotic in a therapeutic manner. This is because, as he told me earlier, the case he talks about occurred over a decade ago during the first days of his career.

Further to this, we might wonder if Adam's and Bill's feelings of puzzlement could also stem from the confusion between erotic feelings and sexual feelings, which appears to be the case for most participants. It is perhaps this confusion between the erotic as a psychological experience and the sexual as a physical experience that leads to the erotic being misunderstood and treated as a taboo, causing an intense psychological response in the majority of those who encounter it.

Apart from puzzlement, many participants disclosed that they experienced anxiety and fear towards the erotic as well. Claire and Eddie, for example, believed that the erotic was beyond their ability to handle. This evoked feelings of apprehension, as illustrated in the following quotes. Claire: *'A client [...] disclosed that he was very attracted to me and I felt a bit "out of my depth"' (Int 3, ll 48-50).* Eddie: *'I think it's a really dangerous thing (working with the erotic) because we go in so unprepared for it. And then any feelings - I'm going to speak for my own experience - any feelings of sexual or erotic transference or counter-transference can become quite difficult to [...] (handle)' (Int 5, ll 43-48).* From these extracts, it can be seen that Claire and Eddie are anxious about their ability to handle the erotic in a therapeutic manner, which elicits secondary feelings of nervousness and fear. Eddie's feelings appear to intensify due to his difficulty of handling his own erotic desire for his clients, which he seems to perceive as an extra challenge in his work with the erotic. In this light, it is not a surprise that many participants seem to experience the erotic as a subject to avoid.

However, not all participants felt discomfort, anxiety and fear (only) when they encountered the erotic. Some of them felt a sense of flattery, which appeared to balance out the negative feelings they also experienced from time to time. Others felt a sense of joy, as they perceived the presence of the erotic in the room as a sign that therapy 'works'. This was the case for Daniel: *'I believe it (the erotic) means it needs to happen for analysis to succeed [...] I'm usually excited and interested when it does. I think "good"' (Int 4, ll 998-1001).* For Daniel, the erotic seems to be a way of assessing the progress of the work. In this sense, the erotic does not relate to actual sexual

acts, which makes it a subject to value rather than fear and avoid. At the same time, Daniel's view of the erotic as a means of evaluating therapeutic progress could be his way of defending himself against sexual attraction and, therefore, staying out of the erotic equation.

All participants were aware of the occasions in their practice where they felt erotic desire for certain clients. Most of them were reluctant to accept their feelings and felt discomfort about them. Moreover, the idea of 'using' their clients to satisfy their own personal needs elicited feelings of guilt and shame. The experience described by Bill reflects the experience of many others: *'There's always a bit of guilt in me that I want something I shouldn't want [...] And that's not just about wanting sex. There's a sort of real emotional closeness that some of that's me getting what I want from the client. Me getting my emotional needs met by being really close to my client' (Int 2, 1284-1292).* The extract from Bill suggests that, for him, working with a client he finds attractive unsettles him. We might speculate that his feelings stem from his understanding that therapy is formed to meet clients' rather than therapists' emotional needs. Failing to acknowledge that therapy, to some degree, serves some of the therapist's needs, can lead to participants wondering if they have taken advantage of their client's trust, time and money to meet their own emotional needs. Perhaps a way to define if and when therapists take advantage of their clients is to examine if their own needs and their clients' needs are in conflict.

Some participants questioned their motives behind their interventions when working with clients they were attracted to: *'We were talking about the client's difficult relationships with men and I think [...] I felt sort of urges to want to ask her about her sexual experiences with a particular guy. And it was quite .. I was thinking "Why, why do I want to ask this question?"' (Int 5, ll 476-483).* In this, it can be seen that Eddie feels confused by his urge to know more about his client's sexual encounters with a particular man. Although he seems to be uncertain of the reason why, his reflection suggests that he is conscious that his questions do not necessarily aim to serve the

work. His awareness leads him to question his motives and judge himself as unprofessional.

All participants disclosed historical and current cases of theirs where they felt attracted to clients from the opposite sex, the same sex or both sexes. In some occasions, attraction was one-sided, whereas in other occasions, feelings were mutual. For many in the group, both their own sexual orientation and their clients' gender influenced how vulnerable they felt towards the erotic: *'If say for instance a male came in and said these things to me (having erotic fantasies about her) it wouldn't even rattle me. I think it was because of the same gender [...] because I'm a lesbian myself [...] I remember talking about it in supervision. I was saying I felt fearful [...] I felt afraid that if the client didn't get her way or I terminated she would say I was sexual with her. So I felt sometimes, "Could this client hold me at ransom?" I was afraid' (Int 12, ll 747–763).* Laura, who is attracted to women, appears to experience no threat from her male clients' erotic longings for her. Instead, she seems to feel vulnerable to female clients' yearnings for her. A way of looking at Laura's vulnerability is that her belief that allegations of sexual misconduct made by same-sex clients - as opposed to allegations made by clients from the opposite sex - are more likely to be taken seriously by the regulators due to her sexual orientation. This means that Laura is likely to feel intense discomfort every time she becomes the object of a female client's desire.

Many participants disclosed that working with clients they were attracted to meant that they were called to not only contain their desire for them, but also their frustration for being unable to fulfil their yearnings. This is what Bill says in the following extract: *'Lots of being seduced and feeling frustrated by that - because (I was) seduced but (at the same time, I was) kept away [...] It (the feeling) was [...] frustration. (What I was thinking was) "She's beautiful, she's showing me her beautiful soft belly. I'm not allowed to touch". Simple as that' (Int 2, ll 1019-1028).* In this extract, it can be seen that, for Bill, frustration is part of the desire he feels for his client.

3.4.2 Sub-theme 2: Perceptions about the erotic

3.4.2.1 'There's something deeper about it' – The erotic is mysterious

The perception of the erotic as a phenomenon that differs from the other phenomena that tend to develop in therapy appeared to heighten the discomfort that most participants felt when they encountered it. For them, although the erotic shared similarities with other therapeutic experiences, it seemed to entail qualities that the others did not: *'I still bring a level of discomfort to it [...] I still really don't want to have to talk about it if I can possibly get away with it and that is completely at odds with other aspects that I might.. with anger for example - or suicide which I feel completely comfortable talking about [...] I don't know.. it (the erotic) is more, it's more sensitive, it's more personal and its more, there's something deeper about it, I am not quite sure but yes..' (Int 11, ll 1100-1111).* Here, Katrina can be seen speaking of the erotic, carrying 'baggage' that causes her feelings of discomfort. She struggles to define what the 'baggage' is about, which leads her to making speculations. The uncertainty she feels about it seems to make her hesitant to engage with it when it is presented in her work.

3.4.2.2 'A lot of our role is about being a mother figure to clients' – The erotic is a taboo

For many participants, the different nature of the erotic related not only to its mysterious qualities but also to the perception of it as a taboo. For these participants, the therapeutic relationship resembled the maternal relationship. This automatically meant that experiencing erotic feelings for their clients was perceived as an incestuous state of affairs they should keep away from. Here is what Claire says about it: *'Well I think it (the erotic) can be disturbing and worrying [...] because of the fear of taboo [...] A lot of our role is about being a mother figure to clients [...] I think a lot of therapists can feel quite threatened about stepping over to the other position [...] moving from being potential mother to potential lover' (Int 3, ll 615-626).* Here, it can be seen that the understanding of the erotic as a taboo has the potential to cause intense discomfort, as it challenges the values and morals that the profession

holds towards the erotic. In this light, participants' understanding of the erotic is socially constructed through their interaction with the 'others' and the social context in which they live and work. This, along with the participants' reluctance to acknowledge that the maternal relationship is indeed an erotic relationship, seems to intensify their uneasiness towards the experience of erotic feelings in therapy.

3.4.2.3 '(I) felt [...] he had sexualised me and I felt anger' – The erotic has personal meaning for therapists and clients

The group argued that the erotic has the power to activate, in both parties, the image they hold of themselves as sexual beings and the beliefs they hold about sex. In this sense, the erotic has personal, sensitive and private meaning for both therapists and clients. In the following extract, Eddie reveals the meaning that the erotic holds for him and explains how it has been shaped by his own sexual experiences: *'It was the energy between us; there was "something going on" [...] I was finding it very, very confusing [...] Then, there's going to be an added thing for me - my own sexual shame as a gay male growing up. So, there's all this thing about sex being manipulation and power and all my own stuff going on' (Int 5, ll 276-289).* Here, Eddie speaks of how his personal history influences his experience of the erotic in the room. As a gay man, the erotic tends to trigger feelings of confusion and discomfort in him. He attributes these feelings to his own sexual shame and perception of sex as a means of control and manipulation. In this sense, the way that the participants experience the erotic and the meaning they assign to it seems to be considerably shaped by their gender, sexual orientation, views about sex and sexuality, and their life experiences.

The potential of the erotic triggering counter-transference feelings of anger, as well as a sense of threat, can be seen below: *'I was just "slimed" [...] he looked at my breasts, he looked at me sexually, he licked his lips [...]' (Int 12, ll 227-232). 'He was treating me like I was one of his prostitutes (He said) "I pay you; you do what I want you to do". So I said to him "Is this how you treat the women that you pay for? Am I an object to you?" (Int12, ll 270-275). '(I) felt [...] he had sexualised me and I felt anger. I went (clicks fingers) that needs to stop but for two reasons [...] one was the therapeutic element and one was my own personal feelings. So, yes, that was also going on for me at the time in the room and my distance with him [...] between him (and me). I moved completely in my chair [...] I felt slightly threatened and so angry' (Int 12, ll 343-360).* Here, Laura perceives her client's manner in the room as a direct way to dominate and subjugate her through sexual means. His sexualised aggressive behaviour seems to offend her both as a therapist and a woman. As a result, she experiences feelings of anger and a sense of threat, which alienate and frighten her. The strong counter-transference feelings she experiences seem to impair her ability to engage with him at that point in time. Her difficulty to bear his sexuality and aggression leads her to block transference and overlook a potentially good therapeutic opportunity for her client.

Lastly, for some participants, the erotic evoked feelings of guilt but for different reasons than those described earlier. In these cases, participants felt that desiring their clients equated to being unfaithful to their partners or spouses. This case is illustrated in the following extract from Eddie: *'This incident where I said about erotic transference.. probably the main confusion is.. I'm in a long term relationship and it almost felt I was being deceitful or unfaithful, there was that side of things that came into it' (Int 5, ll 709-714).* For Eddie, feeling attracted to his client is perceived as cheating on his partner. Here, the risk is that his inner conflict, if it remains unresolved, may lead him to adopt a neutral attitude towards his client to reduce the guilt. This could potentially compromise the authenticity of their relationship and influence the outcome of the work.

The findings suggest that participants' subjective experience and interpretation of the erotic is influenced by a number of factors, such as their background, attitudes towards sex and sexuality, past and present life experiences, and the social and cultural environments in which they live. In this sense, people co-construct understandings through their interaction with the 'others', symbolic communication and mutual interpretation of the story they share (Blumer, 1986; Mead, 1934). Moreover, the way that people respond to the various situations they encounter is based on the meaning they assign to these situations (Blumer, 1986; Charon, 2010).

3.5 Theme 2: Working with the erotic

3.5.1 Sub-theme 1: Processing challenges internally

3.5.1.1 'It takes away from me my capacity to be able to do my job' – Keeping the therapeutic 'hat' on

The feelings of discomfort that many participants experienced as a result of the presence of the erotic in their work seemed to be intensified by the challenges encountered. The biggest challenge that most participants dealt with was the two-fold challenge of maintaining their position as therapists. On the one hand, the participants feared that their clients' erotic feelings for them could get in the way of therapy by 'robbing' them of their ability to maintain a therapeutic attitude. This is what Katrina talks about in the following extract: *'I think it (the erotic) takes away from me my capacity to be able to do my job and help him. And that's what the worry is, that's what the fear is [...] I don't feel that it devalues it (the work), but it distracts into such a degree that I am not going to be able to do what we need to do together in order to make sure that he is alright' (Int 11, ll 609-616).* In this, Katrina speaks of how the erotic has the power to distract her, interfering with the therapeutic process and compromising her client's wellbeing. Being distracted by her client's feelings for her seems to lead her to doubt her ability to stay focused on the work and be an effective therapist to him. Katrina's fear of being sidetracked and consequently useless to her client reflects a major fear experienced by the entire group.

On the other hand, many participants felt anxious about the impact that their own erotic feelings for their clients could have on their ability to maintain their position: *'With respect to my own desire, I think my anxiety was [...] that I would be too busy, let's say with this client, looking at him and thinking, "I'd love to kiss you" or "I'd love to get naked" or whatever it might be [...] Yeah, that I would just sit there feeling horny and wouldn't be able to function [...] Yeah, not doing the job - that was my anxiety' (Int 4, ll 879-893).* Here, it appears that the sexual attraction that Daniel feels for his client triggers the anxiety of being consumed by his own erotic desire for him. This makes him feel vulnerable towards the erotic and concerned about his ability to contain his feelings and do the job effectively. Not surprisingly, his anxiety represents an anxiety felt by a large number of participants.

3.5.1.2 'I had a more naive view that it was kind of more about the relationship and me' – Recognising erotic transference and counter-transference

Another challenge that many participants encountered was the challenge of recognising erotic transference and counter-transference as opposed to personalising the meaning of the erotic in therapy, as illustrated below: *'I think in that earlier relationship with the client, I had a more naive view that it (the erotic) was kind of more about the relationship and me than I now think [...] Now I see it as less to do with me' (Int 7, ll 183-187). 'I think I was a bit enchanted with him and taken with him and there was clearly some, sort of, powerful attachment from his side (too)' (Int 7, ll 225-228).* From this, it can be seen that George loses sight of the context - namely, the therapeutic relationship - which leads him to misinterpret the true source of the erotic feelings experienced in the room. As a result, he believes that the attraction developed between his client and himself is down to his own personal attributes and to the special relationship developed between the two of them, rather than to a common therapeutic phenomenon. His misinterpretation could stem from a lack of experience in this area of work but it could also stem from his own longing to be sexually desired by his client as a man.

3.5.1.3 'I think that she's playing with being more attractive and how that's seen by me' – Validating clients' sexuality

The third challenge that many participants came across was the challenge of witnessing and validating their clients' sexuality from an adult position. Many found themselves in a situation where their clients longed for them to 'see' and validate them as sexual beings. This was perceived as clients' need to explore and experience their sexuality within the safe environment of their therapy.

Although the participants said that they had an understanding of both the rationale and the benefits of sexual validation for their clients' self-esteem, many preferred to respond to their clients' needs from a parental rather than an adult position. This is what Claire talks about in the following extract: *'It feels like there's always an erotic flavour with all clients, and with her, yes, I think that she's playing with being more attractive and how that's seen by me. So it feels more mother and daughtery kind of transference material' (Int 3, ll 87-92).* In this extract, it can be seen that approaching sexuality from an adult position may feel unsafe to some participants. This leads them to approach their clients' sexuality from a parental framework, which (in this instance) is the mother-to-daughter framework. We might speculate that the discomfort that these participants experience could lead them to deny their clients the opportunity to explore, understand and experience their sexual self as part of their therapy.

3.5.2 Sub-theme 2: Handling the erotic

3.5.2.1 'What's going on here?' – Addressing the erotic explicitly

Alongside processing challenges internally, many participants found themselves wondering *if* and *how* they should handle the erotic. Half of the group addressed the experience of erotic feelings in the room primarily in a direct way with their clients. These participants believed that talking about the 'elephant in the room' - in this case, their clients' erotic feelings for them - would help their clients contain their feelings and experience new ways of relating to others. This is what Isabelle speaks of in the following extract: *'We talked about her working through things and how maybe what was happening here (feeling attracted to her therapist) is really important because maybe to have these feelings, to be able to sit with these feelings, to still have a relationship with somebody, even when there isn't a reciprocation [...] might be part of what she needed to do to be able to have healthier, more sustainable relationships' (Int 9, ll 530-539).* The extract illustrates that Isabelle feels comfortable to discuss and normalise her client's erotic feelings for her as an expected reaction to the type of intimacy that characterises the therapeutic relationship and work. Her aim is to enable her client to contain her feelings for her, and help her to form caring and loving relationships with others without being sexual with them. In this sense, addressing the erotic explicitly seems to be a method utilised to normalise clients' feelings, help contain them and enable clients to grow through the therapeutic relationship and process.

Some participants said that, in certain occasions, some clients took the initiative to disclose their feelings of sexual attraction for them to them directly, without them (the therapists) raising the subject. As already seen, some of these participants ignored, either partially or completely, their clients' declarations of feelings in an attempt to avoid the discomfort associated with the erotic. Others aimed to acknowledge and value their clients' feelings, which it seemed to be the case for Adam: *'The way I dealt with it was to thank the person for what they've expressed [...] (I told her) that it felt like she was offering me something very precious, very, very precious and that I was*

aware of the preciousness of what she was doing and that I would honour that in myself [...] (I told her that) I was not about to respond in any other way than that, that I would make no advances myself and I expected there to be no contact between us (between sessions)' (Int 1, ll 385-396). In this extract, Adam's response appears to be a way of normalising and containing his client's feelings for him. At the same time, his response seems to be slightly impersonal. For a moment, I wondered if Adam's response was aimed to discourage his client from feeling attracted to him so he could avoid the erotic and its associated challenges and tensions. My thought was somewhat reinforced when Adam disclosed that every single time he encounters the erotic, he has to *tell himself what to do*: *'I do (what I do) with any client when we have something powerful coming towards me. I hold station (and say to myself): "Feel this. Take a breath. Be aware of what's happening. Be present. Maintain eye-contact and really feel what's going on and address this"' (Int 1, ll 538-543).*

Some participants spoke about disclosing their feelings of sexual attraction to their clients. These participants seemed to believe that being genuine was the only way to have an authentic relationship with them. This is the case for Eddie, as illustrated in this extract: *'I was flooded by the sexual energies. It wasn't just a sort of .. it was very, very powerful, very potent. In the room I became quite neutral (as a way to handle his feelings) [...] ..I was aware of what was going on for me' (Int 5, ll 144-148). 'Part of that (training) is about looking at what we call a head on collision, "What's going on here?" So, rather than dancing around it I was sort of "Look, I'm feeling quite sexualised and my energies are very sexual; what's going on for you?"' (Int 5, ll 159-164).* In this extract, it can be seen that Eddie feels overwhelmed by his attraction for his client, which leads him to initially adopt a neutral attitude in the room. His behaviour seems to aim at protecting himself from the seductive power of his feelings. Later, he reconsiders and decides to disclose his feelings to maintain the genuineness in their relationship. The inner conflicts and processes described by Eddie seem to capture the conflicts and processes that most participants who decided to disclose their feelings to their clients appeared to endure.

3.5.2.2 *'I might talk in the third person' – Addressing the erotic implicitly*

Other participants preferred to mostly raise their clients' erotic feelings for them indirectly due to their fear of shaming them. As Laura states: *'It (the way of raising her clients' erotic feelings for her) would need to be done very carefully [...] not shame (them) [...] I might talk in the third person' (Int 12, ll 123-127).* In this extract, Laura suggests bringing the subject up with caution. Her way to do this is to talk to her clients in the third person while introducing the phenomenon of clients developing erotic feelings for their therapists. Her way appears aimed at causing no harm to her clients but, based on what she said during her interview, there is a sense that it may also be aimed at protecting herself from the anxiety that a direct approach could evoke. Not surprisingly, her way is also 'the way' for several participants in the group.

Regardless of the explicit or implicit way that the group raised the topic of the erotic, the participants aimed to understand the meaning of it with the intention of using it therapeutically. At the same time, most of them avoided rushing into making any interpretations due to the sensitive and personal meaning it has for people: *'I had to think of a strategy, a plan. Because I think just to have said straight out, it would have been too much. And also was I right? [...] everything's tentative [...] just because I think and feel this, does it mean I am right? No. We have to think about how to test out the hypothesis' (Int 9, ll 473-483).* Here, Isabelle explains her rationale for testing out her hypothesis about her client's feelings for her. Her fear of overwhelming her client, in combination with her uncertainty, leads her to think of a plan before making any interpretations.

Many participants evaluated that when they worked with the erotic, either explicitly or implicitly, most clients felt valued, respected and safe. It seems that normalising the erotic and giving their clients the permission to feel their feelings for them, without experiencing any fear or embarrassment, enabled the clients to bear their feelings and explore the meaning they held for them. This is what Claire talks about in the following extract: *'I think it's mostly about allowing and letting it unfold [...] It's one of many things that we can explore. So, for me, it's like a permission to .. I guess I give non-verbal permission for clients to be attracted to me if they want to be or to dislike me or to .. Part of our job is to be available for things that are probably not very easy. Erotic charge can be that' (Int 3, ll 485-504).* The extract suggests that, for Claire, being psychologically available to be 'used' by her clients means that her clients can be true to their feelings for her. In this sense, the participants' ability to be 'used' by their clients has the potential to enable both clients and therapists to learn and grow.

3.5.2.3 'If it isn't broken, don't fix it' – Not addressing the erotic

Several participants decided not to address their clients' erotic feelings for them. Most of these participants appeared to question the meaning of raising the erotic, suggesting that there was no benefit in it: *'If it (the erotic) is useful.. [...] I wouldn't comment on it. "If it isn't broken, don't fix it". I would let it play out. I'm very unlikely to comment on a positive transference because it fuels the work and it can also be quite shaming to, kind of, name it, it can, kind of, kill something off' (Int 7, ll 244-251).* Other participants seemed to believe that, as long as the erotic did not interfere with the work, there was no reason to talk about it: *'With the (other) guy (client) that I am working with currently, it (his attraction for her) didn't turn into anything where I felt that I needed to attend to it, and it has kind of gone away, it has kind of gone away throughout the process of the work' (Int 11, ll 573-577).* In these extracts, George and Katrina justify their decision not to address the erotic, saying that 'there is no reason for this'. At the same time, based on George's and Katrina's reflections during their interviews, it seems that their actions were

also partly determined by the difficulty they felt in addressing the presence of the erotic in the room. George, for example, was charmed by the client: *'At the time, I don't' think I thought about it (addressing the erotic) enough, I don't think I was questioning of it enough. (Pause) I think I was a bit enchanted with him and taken with him' (Int 7, ll 225-226).* Katrina, regardless of her clinical experience, still found it uncomfortable to work with the erotic: *'I still bring a level of discomfort to it. I still struggle with it [...] I still really don't want to have to talk about it if I can possibly get away with it' (Int 11, ll 1100-1103).*

Lastly, some participants seemed to use theory as a means of disconnecting from the erotic. This appears to be the case for Adam, who explains sexual energy as spiritual energy: *'Realising that (that the erotic is manifested differently in men and women) and then feeling this energy and then reading about kundalini and various other spiritual understandings of se.. spiritual energy, about how kundalini comes from, is coiled around the muladhara chakra which is the base chakra, which is .. [...] all a bit technical but there are seven main chakras in the body. The muladhara is situated around the perineum. It's slightly different for men and women but these are psycho-spiritual energy centres that are located in the body and they transform prahna which is the life-force. And so when.. when you become aware of that and the way they've described it is the serpent that's coiled around the muladhara which is the base chakra and then through awakening, the serpent begins to uncoil and curl around the spine and then increases and increases until it gets to the crown chakra, the sahasrara, and then you become enlightened through there. It's all very bloody technical' (Int 1, ll 194-226).*

Some participants reflected on the perceived impact of not addressing their clients' erotic feelings for them with them. These participants said that most clients appeared to feel anger, frustration and even resentment for having to handle their feelings on their own. It seems that some clients stayed in therapy, despite the frustration experienced, but others ended therapy when they felt that they could no longer handle their feelings. This was the case for

Bill's client, who had largely ignored her erotic feelings for him: *'When she left she basically said, "Look. I can't see you anymore. It's too difficult for me because my feelings for you are too strong and they're unrequited and that's painful"' (Int 2, ll 126-130).*

Most of the participants who felt attracted to their clients chose to keep their feelings to themselves. Some of them felt safe enough to internally acknowledge their feelings while still working with their clients, which was the case for Daniel: *'If I do get aroused I need to think about what that means and I won't just share that with the client but I might share or rather my thinking will inform something of what I say' (Int 4, 474-478).* Daniel's decision is intended to serve the therapeutic process. Concurrently, there is a sense that it might serve himself to an extent as well. In this sense, some participants' decisions not to disclose their feelings could be seen as strategies to protect both themselves and their clients from the discomfort that such a disclosure could evoke.

Others resisted acknowledging, even to themselves, any feelings of sexual attraction experienced for their clients while still working with them. It seems that this was the case for Julia: *'It's only now after the work has finished that I'm allowing myself to acknowledge that there is a part of me that was actually quite attracted to him and to his helplessness, to his fragility, which is interesting' (Int 10, ll 132-136).* Here, it can be seen that, for Julia, the option of recognising and accepting her feelings for her client while still in therapy with him feels unsafe to her. Based on what Julia disclosed in her interview about her personal life experiences, her attitude could be seen as a defence mechanism. This is because her exposure to sexualised behaviours early in her life led her to think that feelings of sexual attraction equated to sexual action. We might speculate that the failure of participants to recognise that, in therapy, there is a clear distinction between *sexual feelings* (which are normal and expected) and *sexual actions* (which are unacceptable and should be avoided) can result in them denying or repressing their feelings.

3.6 Theme 3: Experiencing the erotic – Therapists' understanding of the erotic and construction of their experience of the erotic

Over time, the participants realised that the experience of erotic feelings in therapy is both an important practice issue and a common therapeutic phenomenon. Moreover, they acknowledged that their experience of the erotic is subjective and that their understanding of it is provisional and ongoing (Blumer, 1986; Mead, 1934; Willig, 2001). Furthermore, they added that their understanding of the erotic is mostly influenced by their clinical experience and quality of supervision. In addition, they identified that the way in which they respond to the erotic is influenced by the meaning they assign to it. Moreover, they supported that their experience of the erotic is constructed through their interaction with training institutions, society, the profession and the regulation of clinical practice. Lastly, they stressed that the inter-relationship between social systems and therapeutic practice constructs not only their experience but also the social world. The factors that the participants identified in terms of how they understand the erotic and the inter-relationships that shape (1) how the participants experience the erotic, (2) how their experience is constructed and (3) how they work with it are presented below.

3.6.1 Sub-theme 1: Factors

3.6.1.1 'In my early years [...] I would have had a secondary trauma from it' – Clinical experience

Many participants commented on learning about the erotic subsequent to their training. Their frequent encounter with it led them to realise that the experience of erotic feelings in therapy is a common phenomenon shaped by the intense and loving character of the therapeutic relationship. Understanding and working with it was (and still is) an ongoing process that seems to develop and change with clinical experience. The enabling character of work experience is illustrated below: *'I think in my early years (of*

being qualified) yeah; if anything, I would have had a secondary trauma from the experience of it (the erotic)' (Int 11, ll 417-120). The extract from Laura suggests that clinical experience can facilitate the work with erotic material, which reflects the views of the majority of participants.

3.6.1.2 'Of course you bloody have these feelings; it's human' – Quality of supervision

Participants stated that having supervision with open-minded and trustworthy supervisors enabled them to feel comfortable and safe enough to discuss the subject with them. Laura, for example, perceived supervision as the place to explore what happens in the room and feel supported: *'I'm very clear (about taking the erotic to supervision) [...] because stuff comes up, you know. I think, "Wow, where did that come from? What was that?" [...] I go back and work it out in my [...] supervision' (Int 12, ll 950-957).* Another participant, Bill, viewed supervision as the place to normalise and accept the development of erotic feelings in therapy, which seemed to transform his perception of the erotic from a subject he should fear and ignore into a subject he could understand and work with: *'My current supervisor would say "Of course you bloody have these feelings; it's human and it's a valuable guide to what's going on and let's think about how to work with it"' (Int 2, ll 813-817).*

However, this was not always the case for Bill. Prior to his current supervisor, he had another supervisor who was perceived not only as unsupportive but also as a source of guilt for him: *'Talking to my supervisor actually left me feeling a bit guilty because you know, she would say "I don't have erotic feelings for my clients" and I would think "Okay, well if I have erotic feelings for my clients, is there something wrong with me as a therapist?"' (Int 2, ll 803-813).* In this case, supervision fails to acknowledge and normalise the erotic, which is highly likely to close any opportunity for exploration and support and to place the supervisory relationship under strain. Being judged and unsupported seems to elicit feelings of confusion, guilt and fear, and lead the participants to wonder if there is something wrong with them. The participants expressed the view that their supervisors' unhelpful attitudes

could have been the result of feeling uncomfortable when discussing sex and sexuality in clinical practice or of being unwilling to disclose their own experiences with the erotic. In this light, supervision has the power to enable or hinder the work with erotic material.

Many participants were concerned about the potentially detrimental effects that poor-quality supervision could have on their work with erotic and sexual feelings. For several, peer supervision appeared to be either a complementary or an alternative option to individual supervision, which was the case for George: *'I have a peer supervision group [...] we know each other very well and I know that if a client brought me any sexual material or erotic material or I had any, sort of, sexual or erotic experience or difficulty in relation to that, I have a setting where I can talk about that completely honestly. With absolute safety' (Int 7, ll 451-460).* The extract suggests that sharing thoughts, feelings and concerns with understanding, reliable and supportive colleagues can enable participants to contain, hold and think of their feelings. This way, they are able to maintain a thoughtful attitude towards the work, preserve a positive self-image as professionals and respond appropriately to the presence of the erotic in their practice. In this sense, the group is perceived as having the power to support and facilitate the work.

Nonetheless, this was not the case for all participants. Some participants described incidents where their peer supervision group discouraged them from exploring the erotic, as demonstrated in this extract: *'I took a client to supervision group and the supervisor said to me, "Don't explore the erotic with him" which was really interesting for me. And the rest of the group said, "Don't go there!" Some panic. Interesting' (Int 3, ll 509-514).* Here, the group appears to give the message that the erotic is a professional taboo they should *not* examine, reinforcing feelings of anxiety that tend to surround the topic. It is evident that the reaction of the group surprises Claire. Luckily, she is confident with herself and she takes their reaction with a 'pinch of salt'. But *what if* she did not have the confidence to do this?

3.6.2 Sub-theme 2: Inter-relationships

3.6.2.1 'I was very, very unprepared for the actual power of it' – The role of training institutions

The group reflected on the training received on the erotic while still studying. Some participants said that they had no, or little, formal training on the subject. This is Bill's experience of his training: *'We (therapists) get very little training in it (the erotic)' (Int 2, ll 92-93).* Others had a lecture or two where the erotic was addressed as a concept, as a subject that needs to be mentioned. This is what Claire says about her experience of training: *'Trainings have become much more tick-box, much more "do the right thing"' (Int 3, ll 737-738).* Consequently, neither the meaning nor the powerful impact that the erotic can have on therapists, clients and therapy were examined. In the following extract, Eddie expresses a view that reflects the group's overall view: *'I didn't know how to deal with it (the erotic). What I'd read about erotic transference, what we'd spoken about it, where we'd touched on it (in training) .. I was very, very unprepared for the actual power of it. And also the seduction of it..' (Int 5, ll 725-730).*

In addition, the topic seems to have been approached mainly intellectually, neglecting both its emotional understanding and management in practice. Eddie talks about therapy training courses promoting a cognitive understanding of the erotic and he adds that more work needs to be done in training: *'I think it (the erotic) is [...] an area that [...] is often under .. not looked at (in training). There is a lot of stuff on erotic transference but I don't think there's enough stuff from the therapists' point of view; how to deal with it, how to handle it, what it makes therapists feel. So we can look at the theory and we can all say, "Yeah, okay, I can recognise it", but [...] We never touched on it to any great extent. And I think it's a really dangerous thing because we go in so unprepared for it [...] There is a lot more needs to be done [...] at training level' (Int 5, ll 31-53).* Hannah refers to the discrepancy between theory and practice, and stresses the need for integration: *'It's the discrepancy between .. you're learning something, you're being taught something as a theory, as a concept, but how do you put that in practice? So*

it's the discrepancy between different types of knowledge I guess – practical knowledge or procedural knowledge, you know?' (Int 8, ll 122-128).

Katrina had an entirely different training experience, in which theory and practice seemed to integrate in a meaningful way to explore the erotic, as illustrated in this extract: *'I did a class with Ernesto Spinelli on sexuality [...] I was very lucky [...] it (the class) dealt with our own sexual feelings and our own bodies and our own kind of level of comfort with ourselves and how that might then be communicated or how we might deal with that in the room with other clients. And, I think it is something that is completely ignored in training' (Int 11, ll 1045-1055).* In Katrina's case, training can be seen to be giving her both the permission and the tools she needs to start thinking about the meaning and use of the erotic in therapy. She believes that she is 'very lucky' to have had the opportunity to attend this class, since this seems to be the exception, not the rule.

3.6.2.2 'My understanding of my sexuality, or my experience of it, is constructive on a social level; I mean, everybody's is' – The role of society

Participants said that their comfort with sexuality, their experience of the erotic in therapy, the construction of their experience and their work with the erotic are heavily influenced by the social and cultural contexts they live and work in. For example, many stated that their own levels of comfort with their own and their clients' sexuality have been hugely influenced by the existing social norms and views on what is 'normal' and 'acceptable', as opposed to what is not. This is what Daniel talks about in the following extract: *'.. being gay [...] is in a sense, counter-cultural, it is not the norm [...] it's been something which society itself has wanted to disallow and deny. If you like, homosexual feelings are sexual feelings par excellence that society represses. Yeah? [...] So [...] on a personal level [...] my understanding of my sexuality, or my experience of it, is constructive on a social level*; *I mean, everybody's is. So I already bring an encounter with social values that very much position, or have positioned, my desire as being unacceptable. Now, it*

seems to me that what needs to emerge in the analysis, as I've said, is precisely what is unacceptable for the client about the nature of their desire. So I think that what I bring is a certain experience, therefore sensitivity, to engaging with, if you like, the unacceptable; the what has to be excluded' (Int 4, ll 1038-1059). Here, it can be seen how, in Daniel's case, the social context (not just the self) can construct how he experiences the erotic and makes meaning of his experience.

Gender roles and sex stereotypes also seem to influence how the participants experience and work with the erotic. For example, in most societies, women are seen as fragile, whereas men are seen as strong. According to Zelen (1985), the inequality in power means that men hold the leading role in the relationship between the two sexes. In this sense, sex stereotypes are likely to tap into therapists' and clients' fantasies for each other. In the extract below, Bill describes the erotic fantasy he has been having for a young, beautiful female client of his: *'She is almost like a fairy' (Int 2, ll 1143-1144). '(Therapy with her) feels very erotic. There's a bit of me that just wants to touch her and hold her and definitely a bit of me that looks at her and finds her very attractive and would like sex' (Int 2, ll 1217-1220). "What's she for me?" The erotic fantasy wants her to be (my) lover' (Int 2, ll 1255-1256).*

Others expressed the view that we live in an overly sexualised society in which sex and sexuality are used to sell, seduce, control and manipulate. In the extract below, George talks about how, in his view, sex is used in our society: *'We [...] sexualised everything [...] I mean, our images of sex, our experience of sex [...] go on the internet [...] there's nothing people don't know about anymore. The mystery of sex and the privacy of sex is gone.. it's a commodity in so many ways; you can buy it in so many ways; you can see it in so many ways [...] we've sexualised everything [...] Advertising – women on cars, you know, it's kind of, it's everywhere' (Int 7, ll 642-660).*

At the same time, it appears that, in most societies, there is a sense of hysteria around sex and sexuality, which makes it difficult for people (including therapists and clients) to talk about the erotic both in life and in therapy. In the following extract, Daniel refers to one of the ways that society's hysteria towards erotic and sexual feelings seems to be manifested in therapy: *'(In our society) there's a general hysteria about sexuality, sex, desire, in general' (Int 4, ll 1122-1123). 'There's a kind of a moralistic thread which [...] creates a kind of hysteria. So, for example, in therapy this emerges around the idea of touch. Yeah? [...] The (name of professional body) is very vague in all of its ethical guidelines but it errs on the side of "Don't touch" [...] You could say that's fairly straightforward [...] but I still think that it's very difficult for us to talk about the issues of touching given the kind of the moralistic [...] discourse around touching; how touching very quickly collapses into something inappropriate' (Int 4, ll 1138-1155).*

With respect to British culture, several participants said that it has an impact on their difficulty to process and talk about feelings, let alone erotic feelings, and feel comfortable with sex and sexuality in life as in therapy. This is what Eddie and Hannah say below. Eddie: *'I think that it (British culture) has a massive impact [...] my experience is that in past I have processed something here (gesture showing his head) cognitively without really looking at the feelings [...] And, I don't think as British people and therapists we are encouraged to do that (looking at feelings including erotic and sexual feelings) I think we are so, "Let's do cognitive therapy, let's all stay in the head"' (Int 5, ll 642-645).* Hannah: *'They (British) are not so open towards exploring that (the erotic) and I guess [...] if you're afraid of it, it becomes a problem..' (Int 8, ll 548-551).* Here, Eddie speaks of British culture as promoting a cognitive understanding of life while an emotional understanding seems to be neglected, and Hannah says that the subjects we are afraid of tend to become a problem. Their concern is that this approach is likely to prevent the erotic not only from being unfolded, but also from being experienced and used therapeutically by therapists who live and work in the United Kingdom.

Lastly, many participants emphasised the significance of being aware and respectful of the social and cultural environments they work in and the ways in which these environments could affect the therapeutic practice. In the following extract, Isabelle talks about the impact of society on both therapists and clients and the importance of therapists respecting and working with their clients' values and beliefs: *'On the whole I think [...] the society you live in, the norms of that society play a part (to the work) and that is also true for your client. So if you have a cross cultural situation where a client is in this country or comes or is influenced by, then you have the dynamic of needing to be also respectful to the belief system that they have but also, when they want it, to challenge it' (Int 9, ll 753-762).*

3.6.2.3 'The profession has put sexuality in the shadows' – The role of the profession

The group believed that the profession has neglected, to an extent, to prepare therapists for the intimate nature of therapy, increasing the possibility of therapists (1) feeling surprise, confusion and stress when they encounter it, and (2) mishandling it. In the following extract, George talks about the profession's attitude and its potential consequences on the work: *'I would say that, to some degree, the profession has put sexuality in the shadows; that which we do not wish to be; that which we do not wish to own. And when you put something in the shadows you see it everywhere, it irrupts, it's mishandled, it's not thought about, so it's, kind of, everywhere' (Int 7, ll 979-985).*

Several participants said that the profession should address the erotic both more clearly and effectively. This is what Katrina seems to say below: *'I am clearly aware of guidelines [...] "Don't have sex with clients", which is kind of "Go figure". Well unfortunately, clearly some therapists do do that, but it's quite obvious that you shouldn't. But they (professional community) could provide some more guidance on (it) [...] (In my view) they are part of the problem' (Int 11, ll 1116-1129).*

3.6.2.4 'The way in which it is done has derogatory effects on therapy' – The role of regulation

The group also believed that the intention of the regulators, which is to promote good and ethical practice, is good. At the same time, the participants expressed the view that the profession's feelings of anxiety towards the erotic seem to have caused anxiety to the regulators as well. This, in their view, has led the regulators to overreact towards allegations of sexual misconduct. In the extracts below, Daniel and Hannah talk about their belief that regulators tend to overreact to allegations. Daniel: *'I think we can easily be hysterical from an ethical [...] and a regulatory position about these issues (the experience of erotic and sexual feelings in therapy)' (Int 4, ll 861-863).* Hannah: *'There is a magazine where all of the people who have been sanctioned or have been under investigation .. when you put up such a big list of people who have been looked upon in suspicion, it kind of makes you wonder sometimes. "Are these all – I don't know – malpractices or have we become too cautious about things?" [...] It's gone a bit too much.. Too far on the other side' (Int 8, ll 626-638).*

Many participants said that the overreaction of regulators is one of the reasons why they do not trust that regulators will be able to handle an allegation of sexual misconduct with fairness. This is what George appears to say in the extract that follows: *'I don't regard it (the role of regulation) positively, I wouldn't really, I wouldn't trust my regulatory body [...] I wouldn't really have a great deal of faith that they would handle a complaint well [...] There's so much anxiety about sex and sexuality and that appearing in the consulting room, that I think it just might be mishandled' (Int 7, ll 698-704).*

Several participants said that regulators' punitive approach towards allegations of sexual misconduct turns the erotic to an unspoken subject, handled either in secret or not at all. Fabian speaks of the impact that the regulators can have on clinical practice in the following extract: *'I think the intention of stopping.. counsellors and therapists [...] having sex with their clients was a good intention. I think however that the way in which it is done has derogatory effects on therapy [...]' (Int 6, ll 477-482). 'In effect .. erotic*

transference becomes unspoken and goes underground' (Int 6, ll 501-503). Here, it can be seen that, for Fabian and for others in the group, the regulators are seen as getting in the way of working with the erotic. He suggests that the fear of punishment leads most therapists to handle the subject secretly. This limits their ability to understand it, which increases their risk of malpractice. In this sense, the way that regulation is implemented seems, to some extent, hinder participants' ability to work with erotic feelings, which brings results that are opposite to those aimed for.

In another extract, Fabian argues that the regulators' use of power and authority to control clinical practice and their punitive approach towards sexual misconduct is similar to a Russian-style justice system: *'The professional bodies regulate [...] not.. on a Western style justice system.. it's more on a Russian-style justice system [...] European justice on the whole works on the principle of "You're innocent until proven guilty", yes? Russian justice works on the principle that "You're guilty until you're proven innocent"' (Int 6, ll 562-572).* Here, Fabian seems to speak of how a suspicious society can employ (1) power and authority and (2) fear to intimidate and control clinical practice, which encapsulates the views of the entire group on the subject.

Lastly, several participants believed that the regulators' approach is disempowering and suggested that the way forward is not to have more rules but more training. In the following extracts, Claire and Isabelle talk about these two subjects respectively. Claire: *'You have to comply with that the big adult governing body is going to say you have to do which is disempowering [...] How do you support individual therapists to become empowered if they're always looking to "big daddy" up there? How are they going to find their own power and authenticity?' (Int 3, ll 744-754).* Isabelle: *'No, not rules. Training. Please no more rules' (Int 9, l 925).*

3.7 Theme 4: The meaning of the erotic

3.7.1 Sub-theme 1: A product of therapy

Participants perceived the erotic as a product of therapy, and more specifically, as erotic transference and counter-transference, a metaphor for the communication of nonsexual issues, an opportunity for transformation and a form of negative transference.

3.7.1.1 'It would be crazy not to believe that at some point, somebody will make some kind of [...] transference [...] It is also crazy to think that you as a therapist are going to sit there and never think "That's a gorgeous person"' – Transference and counter-transference

Most participants seemed to understand their clients' erotic feelings for them as products of erotic transference and their own erotic feelings for their clients as products of erotic counter-transference. Isabelle expresses this view in the following extract: *'.. two people meet .. and because of the way that one (of the two) is dealing with such sensitive material [...] it would be crazy not to believe that at some point, somebody (client) will make some kind of, using an analytical term, transference [...] It is also crazy to think that you as a therapist are going to sit there and never think "That's a gorgeous person". What you do about that is important' (Int 9, ll 177-187).* It is clear that, for Isabelle, the experience of erotic feelings in therapy is part of the process; hence, they are normal and should be expected. She argues that the issue is *not* the presence of the feelings in the work but *how* therapists understand and handle these feelings, suggesting that it is up to them to use the erotic in a way that can benefit and transform their clients' lives.

3.7.1.2 'He went through a period where he would constantly try to invite me for a coffee' – A metaphor for the communication of nonsexual issues

Another theoretical framework that many participants appeared to adhere to was the understanding of the erotic as a metaphor for the communication of nonsexual issues. These participants believed that the experience and expression of the erotic was a way to convey a wide range of nonsexual issues. In particular, they argued that their clients' erotic feelings for them conveyed subjects such as a longing to be accepted, a desire to feel special, a fear to relate in ways other than sexual, resistance, repetition of pathological relational patterns, hostility, avoidance and many others. In the following extract, Maria reflects on a case where her client's erotic feelings for her conveyed hostility: *'I remember one particular patient with whom I had been working many years, he went through a period where he would constantly try to invite me for a coffee. "Can we have coffee?" and we did explore this lots. And I remember saying to my supervisor, "I have this declaration of love from this particular patient and what I feel he wants to do, if he could, is just to kill me, cut my body in parts and throw me in the river Thames"' (Int 13, ll 91-100).* In this case, the client's attempts to seduce his therapist are perceived as a form of attack. Maria connects both her client's present issues and requests for contact out of therapy to his childhood experiences (his mother abused him emotionally and physically) and his inability to openly express the anger and hate he feels towards his mother and other significant women in his life. Her conceptualisation enables her to work with his feelings rather than feel intimidated by them.

As mentioned, the group believed that their own feelings of attraction for their clients were primarily products of erotic counter-transference. Another understanding they appeared to hold was that their feelings could also serve as metaphors for the communication of nonsexual issues. Several participants spoke of cases where their attraction related to rescue fantasies, needs to be loved, admired or appreciated, ways to escape from feelings of inadequacy, and others.

A rescue fantasy seems to be the reason behind the attraction Julia feels for some of her young, male clients: *'There's an ongoing pattern [...] when I'm working with a (young) male client who [...] is particularly fragile, I'll want to kind of take them under my wing, rescue them, save them. I'm actually very maternal towards them and I feel like I'm the only one that can rescue and save them' (Int 10, ll 103-112).* Here, Julia speaks of her urge to be motherly towards some of her male clients, especially those who are younger than her. Her endeavour is to 'rescue' them but she is unsure of from what: themselves, their troubles or the erotic. Her maternal behaviour towards them could be seen as a way to avoid addressing the erotic feelings that developed between them.

3.7.1.3 'When we resolved his family situation he became much more balanced' – An opportunity for transformation

Many participants said that the erotic was an opportunity for growth and transformation. In the extract below Maria describes a case where her caring and loving feelings for her client allowed him to work on his problems, become more balanced, pursue the woman he loved and change his life. At the same time, his caring and loving feelings for Maria allowed her to grow too, as the two of them managed to build a deep and genuine loving relationship which is not only a source of growth, but also a source of pride for her: *'There was the other case, the double (mutual attraction) case which was much more benign and an attachment issue. And this guy.. I am so proud of him. I really like him [...] the way he thinks, what he does, his values' (Int 13, ll 365-374). 'A huge piece of work where he regained his freedom as a man (from the suppressive behaviours of his family). And, when I started working with him he had just broken up with a (nationality) girl that had to go back to her country [...] But he wouldn't allow me to explore anything and we were very busy for many years to work on his family situation. When we resolved his family situation he became much more balanced' (Int 13, ll 400-410). 'He came once in the session and he said to me, "(name) I think I am still thinking about that girl" [...] so he decided, "I am going to take a big leap.*

I am going to visit her" and a few months later they were married. And he is really quite shy [...] I am so proud. And, yes, I have these feelings; there is also a real relationship. It is partly I am proud, partly it is friendship, partly it is love' (Int 13, ll 433-444).

3.7.1.4 'Wouldn't it be nice if we could meet? Have a coffee [...]' - A form of negative transference

Several participants believed that, at moments, some clients attempted to seduce them. Some of these participants viewed their clients' behaviour as a form of negative transference, a way to distract them and, possibly, make therapy less painful for themselves. In the extract that follows Bill talks about a client who was sexually abused as a child by the male members of her family, which had an impact on herself and on the way she approached the opposite sex. Big part of the work focused on the client's past which the client found very painful. In the extract that follows, Bill says that, in his understanding, there were times that his client tried to seduce him which he perceived as a form of negative transference: *'She talked about wanting me in a variety of ways and that's one way of seducing me. "Wouldn't it be nice if we could meet? Have a coffee. Just talk. Go out in the park and hold hands" [...] There was a huge charge in that. So, yeah. She tried to seduce me definitely. And it was very difficult for her that I didn't (reciprocate)' (Int 2, ll 867-879). 'I didn't confirm the pattern [...] The pattern would be, 'This is (family figure). I love him. He says he loves me and then he gives me to (family figure) to have sex with me. This is my (family figure) who plays with me and says he loves me and then he has sex with me". I didn't confirm that pattern. So I separated, or tried to separate, the loving from the abusing' (Int 2, ll 891-900).*

3.7.2 Sub-theme 2: The two faces of the erotic

3.7.2.1 'I have learnt a lot from this because I would have done this (X) before, but now I am doing that (Y)' – The constructive erotic

The group acknowledged that the erotic has two sides for both their clients and themselves: the constructive side and the destructive side. They highlighted that the issue was neither the presence of the erotic nor its experience in the room. It was instead *how* they (therapists) perceived, made sense of and worked with it (Guba & Lincoln, 1989; Kant, 1787/1933). They said that the erotic was constructive when they were able to understand it, normalise it, tolerate the anxiety evoked, contain the feelings experienced and maintain a therapeutic attitude. When they managed to do this, the erotic benefited both their clients and themselves.

In the extract below, Isabelle explains how normalising and working with her client's erotic feelings for her enabled her client to form more caring and secure relationships with her partners: *'(We) talked about how in therapy sometimes this (the erotic) happens and it is very normal - because I didn't want her thinking she was abnormal, you know - it is very normal because of the kind of relationship we have' (Int 9, ll 519-523). 'I had her in therapy for two and a half years [...] And during the last six, seven months, she got a girlfriend and it was a much better relationship and [...] she would say "I have learnt a lot from this (her feelings of attraction for her therapist) because I would have done this (X) before, but now I am doing that (Y)" or "I understand now that sometimes it's okay when other people aren't sure about things [...] because it doesn't mean they don't like me"' (Int 9, ll 583-594).* Here, it is clear that Isabelle is neither anxious nor fearful of her client's erotic longings for her. Through their interaction and the mutual understanding of the story they shared, she managed to help her client contain her feelings for her, understand and confront her fears about love, sex and sexuality, and transform. As a result, her client was able to start building more satisfactory and loving relationships out of therapy.

With respect to the benefit of the erotic to therapists, Julia explained how the erotic helped her realise and accept that the sexual attention she received as a child played into her work. Her realisation led her to pursue personal therapy to work on these issues. She had just started attending therapy when the interview was conducted. In the extract below, she talks about the impact that her childhood experiences are having on her practice: *'The attention that I did get when I was at home and growing up was sexualised [...] So any attention that did get was sexualised and that's all I knew.. I think that plays into my work with my clients as well [...] As soon as somebody (a client) says to me "Oh you have really nice eyes" I'm like that (hooked) .. and that does take me right back to my childhood, because it's [...] all I knew when I was younger' (Int 10, ll 968-985).* In this, it can be seen that Julia is conscious that her sexualised childhood experiences interfere with her work. Although she has an understanding of this, it seems that she needs to examine and work on these issues in the safe environment of her therapy. The benefit appears to be doubly important for her, as she will be able to manage the erotic more effectively as a therapist while understanding herself as a sexual being. In this light, the erotic can be viewed as a mutual healing process for clients and therapists.

3.7.2.2 'There was something about me not wanting to make it too difficult or challenging for him' – The destructive erotic

However, the erotic is not always beneficial. The participants suggested that, at times, it could be destructive. This was the case when feelings were unrecognised, repressed, misunderstood, uncontrollable and, therefore, inappropriately handled. In the extract below, Julia reflects on a case where her difficulty to contain her erotic feelings for her client became an obstacle in her work with him: *'.. there was a lot of avoidance I think, because I was quite enamoured by him I didn't feel that I was kind of staying with the crux of the work, it felt like I could quite easily sway over there. And there were times when I would feel like I was the best therapist on the planet, and then I would be like "Okay, we've done enough work today so we'll just talk about this*

(another subject)".. There was something about me not wanting to make it too difficult or challenging for him' (Int 10, ll 441-452). Here, Julia is aware that because of the attraction she feels for her client, she finds difficult to challenge him and, hence, help him to work on his problems effectively.

When the erotic is destructive, therapists are at risk of 'using' their clients to gratify their own emotional needs, which can jeopardise their clients' wellbeing. In addition, in some cases, therapists are at risk of taking advantage of their clients to satisfy their own sexual needs. In the extract that follows, Bill reflects on his urge to breach the boundaries: *'I was very strongly attracted to her. She was young, very sexy, very keen on me and beautiful and it was really difficult to find a way to.. to listen to this (feelings of mutual attraction) and use it as important stuff about the work which of course it was (Int 2, ll 324-329). '.. part of me just wanted to listen to that bit (attraction) and do it (have sex with the client). So the keenness to find an excuse to breach the boundaries was very strong' (Int 2, ll 344-346).*

When the boundaries are breached, clients are highly likely to feel abused and hurt and to lose trust in the profession. At the same time, therapists are also highly likely to face personal, professional and legal consequences. In the extracts below, Bill talks about discussing with his client the impact that having sex with her would have upon her wellbeing, whereas Fabian reflects on the professional and personal consequences he would face if he had sex with a client. Bill: *'One of the ways (I handled our feelings of mutual attraction) was .. we talked about it a lot and we actually…I mean I remember for example talking to her about how this related to her childhood. "What would happen if I breached that conflict cos that's what she was asking me to do? How would it be if I breached that? Would you feel good or would you feel used again?" And she could see, at least some of the time, that we would then drop into the same pattern and she'd feel used again (as she felt in the past by the male members of her family)' (Int 2, ll 366-376).* Fabian: *'If I were to have sex with a client or to follow.. If you follow that line of thought through to its logical conclusion you end up losing everything that you worked for. I would no longer be a member of the (name of professional*

organisation), I would no longer have two out of three jobs. I would be stripped of (name of professional organisation) membership, my wife would definitely leave me' (Int 6, ll 182-190). In this light, the erotic can be destructive for both clients and therapists.

3.8 Theme 5: Practice implications

3.8.1 'How do you put that in practice?' – Working out an interactive practical approach to learning

With most participants stating that they received inadequate, if any, training on the erotic, it came as no surprise that the group was concerned about the impact that this could have on their practice. One of their major concerns related to their ability to recognise and handle ethical conflicts in real-life practice situations. Hannah expressed both her own and the entire group's concerns when she stated: *'What I've learnt in the actual classroom .. (and) .. the situation that I was faced with sitting down with a client was slightly out .. it was different, so however much I was equipping myself with the theory that we were just learning it wasn't enough in the real situation' (Int 8, ll 99-105). 'You're learning something, you're being taught something as a theory, as a concept, but how do you put that in practice?' (Int 8, ll 123-125).* Here, it can be seen that the participants feel the need to interpret and understand the erotic in terms of usefulness to them and their work (Charon, 2010; Mead, 1934). Training seems to be the key towards this direction. At the same time, theory does not seem to be enough.

Participants argued that, for training to be effective, theory should be combined with experiential learning. Isabelle describes her experience of experiential learning here: *'I was helped because when we did the (academic institution name) course in the 70s, one of the weekend modules was called SAR, Sexual Attitudes Restructuring [...] It was a very interesting weekend. From the beginning to the end you were bombarded with films of every combination, apart from animals, of sexual activity. And then you had to intersperse with group work "How did you feel? What came up for you? If you were working with, what..?" everything.. So, the whole thing was about*

questioning yourself [...] So, if you had problems anywhere [...] then you could talk about that ..' (Int 9, ll 640-661). In this extract, Isabelle offers glimpses of a training that examines the erotic in a more meaningful way. She suggests that the way to do this is to identify, challenge and restructure trainees' perceptions about the meaning and use of sex. In this light, it seems that experiential learning could offer trainees the opportunity to explore thoughts, feelings, fears, bias, values and beliefs about sex and sexuality in a way that a lecture could not offer.

3.8.2 'It's an area that needs to come out' – Breaking the silence

The group appeared to believe that feeling safe to talk about the erotic without the fear of being judged or charged with allegations of sexual misconduct would also facilitate their work with it. Getting the 'green light' to talk openly about it in the context of individual or peer supervision was considered the first step towards feeling confident enough to raise and process the subject: *'.. because I have that setting (peer supervision group) where I could talk about anything, I think that it contains me in the work with the difficult (in this case, the erotic) material. There is somewhere I can go. I think that contains my anxiety which helps me maintain a, kind of, thoughtful position in relation to the work' (Int 7, ll 467-473).* In this extract, it can be seen that, for George and the rest of the group, *being together in it* as opposed to *being on his own* is imperative for his confidence to handle the erotic ethically and effectively. It appears that the participants long to feel free and safe enough to express their thoughts and feelings without being ashamed or discredited. This permits them to experience the erotic as an opportunity for learning and growing.

The usefulness and importance of having the opportunity to talk about the erotic not only in supervision, but also in the professional community was consistently present during the interviews conducted. The participants argued that, due to the profession's feelings of anxiety towards the erotic and attitude of somewhat placing the erotic in the shadows has failed to prepare them for the intimate nature of therapy and the erotic feelings that are likely

to be experienced in the work. For this reason, they regarded their participation in this project as an invaluable opportunity to talk about it. The feedback given by Eddie represents the feedback given by the entire group regarding their chance to be part of this project. It also represents their call for the profession to address the erotic more effectively: *'I think it's an interesting topic. I'm glad that I've sat down; it's helped me to think about the process. I think it's an area that needs to come out, we need to come out and say "Well this does happen or this can happen", and, to address (it)..' (Int 5, ll 890-895).* Here, it can be seen that the participants believe that the profession has the power to desensitise the taboo attached to the erotic and therefore enable therapists to use it ethically and effectively.

3.8.3 'That's not the way forward' – Overcoming restrictions set by society, culture and regulation

As already seen, society, culture and regulation can heavily influence *how* the participants experience erotic feelings in therapy, *how* their experience is constructed and *how* they work with the erotic in their practice. With respect to society and culture, the participants stressed the importance of therapists being aware and respectful of the social and cultural contexts they work in, as they can influence the way in which they relate to their clients and practice. Isabelle talks about this subject from therapists' and clients' points of view, below: *'On the whole I think [...] the society you live in, the norms of that society play a part (to the work) and that is also true for your client. So if you have a cross cultural situation where a client is in this country or comes or is influenced by, then you have the dynamic of needing to be also respectful to the belief system that they have but also, when they want it, to challenge it' (Int 9, ll 753-762).*

Regarding the regulation of the profession, many participants suggested that the regulators should stop policing clinical practice as a way of safeguarding therapy for three reasons: (1) it shows no trust in therapists to do their job, (2) it is punitive, and (3) it is not effective. This is what Hannah says below: *'What I don't like is [...] that, at times, rules become a policing agenda, kind*

of "big brother" gaze and then again it plays again into this "no sex, no sex". It becomes a big thing [...] If somebody's policing you it becomes a bit of an issue in terms of trust [...] in people to do their jobs [...]. (In addition) it kind of punishes all of the therapists for what some would do anyway – because if you don't want to keep to some principles, if you don't have any moral boundaries yourself you would do whatever you would do, anyway' (Int 8, 594-610).

In addition, many participants identified the need for regulators to take a step back and emphasised the benefit of therapists developing their own ethical framework towards the erotic. Claire expresses this view in the following extract: *'I think it's incredibly important to be ethical but an ethical stance needs to be flexible because if your ethical stance is very rigid, that's not going to work for all clients in all situations [...] Therapists (should) empower themselves. And, if you're always looking to a regulatory body who's got the answers, that's not the way forward' (Int 3, ll 724-732).* Here, it can be seen that the requirement for therapists to formulate a flexible and ethical framework towards the erotic, as opposed to allowing the regulators to keep imposing a universal and inflexible stance towards it, is a key issue.

The group argued that having an appreciation of how they understand and experience the erotic, how their experience is constructed and how they work with it in their practice is fundamental for their work. Moreover, and perhaps most importantly, the group suggested that understanding can inform clinical practice, guide action and lead to the changes that society, the majority of training institutions, the profession and the regulators are called to make. Their belief seems to be based on the understanding that the construction of meaning is a two-way procedure that takes place among individuals, society and the 'others' (Blumer, 1986; Charon, 2010). The next chapter discusses the findings of the study.

Chapter 4: Discussion

4.1 Introduction

The organisation of this chapter is as follows. Firstly, a brief account of the findings is presented. A discussion of the most important findings and the implications for practice follow. A reflexive statement on how the researcher approached and handled this project and on how the work has affected her is provided. Furthermore, an evaluation of the study is also presented. The researcher's suggestions for further research complete this final chapter of the thesis.

4.2 A brief account of the findings

As already mentioned, the results of the study are relative to context and time, and are subject to interpretation. They were co-constructed through my interaction with the research participants and the mutual interpretation of the story we shared (Blumer, 1986; Mead, 1934). Hence, the story presented here is considered to be one version among many.

The findings suggest that most participants felt unprepared for their encounter with the erotic. Those who did not expect that a client could develop erotic feelings for them felt a sense of surprise and discomfort towards their clients' feelings. Those, who believed that their clients' erotic feelings for them were beyond their ability to handle felt anxiety and fear. In either case, participants' feelings about their clients' attraction to them led many of them to avoid, ignore or deal with these feelings with hesitance and nervousness. The findings are in line with Dujovne (1983) and Bridges (1994), who argue that the erotic has the power to evoke feelings of distress and, therefore, lead therapists to withdraw, avoid or disregard it. However, the findings also suggest that not all participants felt discomfort, anxiety and fear when the erotic entered the room. Some participants felt a sense of flattery, which seems to link to feelings of vanity, while those who interpreted the presence of the erotic as a sign of therapeutic progress felt a sense of

joy. The findings lend support to Russ (1993) and Natterson (2003), who point out that the erotic can elicit feelings of personal and professional excitement.

All participants were aware of occasions where they felt erotic and sexual feelings for particular clients of the opposite or same sex, echoing Bridges' (1994), Rodolfa et al.'s (1994) and Pope et al.'s (2000) writings. Most of them felt discomfort, guilt, anxiety and shame for desiring their clients and judged themselves as unprofessional. It appears that the way participants experience the erotic and respond to it is influenced by the meaning assigned to it. This lends support to Blumer (1986) and Charon (2010), who argue that the way that people respond to an event or situation is shaped by the understanding and meaning attributed to the situation.

Many participants perceived the erotic as a therapeutic phenomenon that differs from the other phenomena presented in therapy, but they were unable to define how it differed, which made them hesitant to engage with it. The participants speculated that their perception of the erotic as 'different' related to the mystery surrounding the erotic, its association with social and professional taboos (Folman, 1991; Searles, 1959; Stone, 1976), and the power and unique meaning it can have for both therapists and clients (Bridges, 1994; Hartl et al., 2007). The findings are in line with Kant's (1787/1933) argument that people's experience of a phenomenon, event or situation is subjective, interpretative, socially constructed and contextually situated.

The feelings of anxiety and discomfort that most participants experienced when the erotic entered the room were heightened by the challenges encountered. The challenges that most participants came across were (1) the two-fold challenge of maintaining a therapeutic attitude, (2) the challenge of recognising erotic transference and counter-transference, and (3) the challenge of witnessing and validating clients' sexuality from an adult position. The findings lend support to Baur (1997), Gabriel (2005), Mann (1997, 1999) and Orbach (1999), who draw attention to the therapeutic couple and, in particular, to the impact of their background and sub-

conscious communication on their interaction, relationship, work and ability to handle dilemmas and challenges.

The study shows that many participants wondered *if* and *how* they should handle the erotic. Primarily, but not always, some worked with the erotic directly, some indirectly and others not at all. Those who, in most cases, addressed the erotic directly seemed to believe that acknowledging and examining their clients' erotic feelings for them would enable their clients to process their feelings and learn new ways of relating to others. Those who, generally, raised their clients' erotic feelings for them indirectly were concerned that a direct approach could potentially embarrass their clients. Lastly, those who, in the majority of cases, did not address the subject believed that there was neither a benefit nor a reason to do so.

Many participants said that their understanding of the erotic was primarily influenced by their clinical experience and the quality of supervision they received. It seems that clinical experience gave them the opportunity to familiarise themselves with the erotic, as well as process and reflect on it. This is in line with Bridges' (1994) views on this, although she does highlight that experience neither necessarily nor automatically reduces therapists' feelings of anxiety or embarrassment towards the presence of the erotic. With respect to supervision, the participants expressed the view that supervision with unbiased and trusty supervisors supported their understanding and work with the erotic. At the same time, over half of them found it very difficult to seek supervision on the subject. This is in agreement with Pope et al.'s (1986), Stake and Oliver's (1991) and Rodolfa et al.'s (1994) research findings on supervision. More specifically, all of them found that only one in two therapists who are attracted to their clients seek supervision to discuss their thoughts, feelings and practice. The main reasons for this seem to be the therapists' fear of consequences (Hartl et al., 2007; Ladany et al., 1996), feelings of anxiety and shame (Celenza, 1998; Rodolfa et al., 1994; Yourman & Farber, 1996) and feelings of discomfort every time they considered bringing the erotic up (Hartl et al., 2007). The participants who were concerned about the harmful effect of poor-quality

supervision on their work with erotic and sexual material turned to peer consultation groups for advice and support.

The participants also said that their experience of the erotic was constructed through their interaction with their training institutions, society, the profession and the regulators of clinical practice. With respect to training, many said that they had received no formal training on the subject, while others had 'touched' upon the erotic as a theoretical concept only. Therefore, neither the meaning nor the impact that the erotic could have on the therapeutic couple were explored. The vast majority of them added that they had learnt about the erotic after their training. The findings reflect the failure of most training institutions to prepare therapists for the erotic both on a theoretical and a practical level (Bridges, 1994; deMayo, 1997; Folman, 1991; Hartl et al., 2007; Pope, 1988; Pope et al., 1986; Rodolfa et al., 1994). As a result, most participants felt the need to withdraw, avoid or repress the erotic (Bridges, 1994; deMayo, 1997; Folman, 1991; Hamilton & Spruill, 1999; Hartl et al., 2007; Pope et al., 1986; Rodolfa et al., 1994).

Many participants said that both their experience of the erotic and their level of comfort with their own and others' sexuality were also constructed through their interaction with society e.g. social norms on what is considered to be 'normal' and 'acceptable' (as opposed to what it is not), sex stereotypes and culture. With respect to British culture in particular, the participants held the view that it plays a huge role in their difficulty to process feelings and to feel at ease with sex and sexuality in life as in therapy. More specifically, in their view, British culture seems to promote a cognitive understanding of life, jeopardising their work with feelings. The findings are in agreement with Blumer (1986) and Charon (2010), who support that people's interaction with the social and cultural contexts they live and work in influence how they make meaning of a situation they face and how they respond to it.

With respect to the role of the profession and to the role of regulators, the participants believed that the profession's (1) feelings of anxiety and (2) its attitude of somewhat placing the erotic in the shadows combined with the regulators' (1) prohibitions, (2) use of power and authority, (3) punishment and (4) infliction of disciplinary measures to control therapists' practices have a derogatory impact on both their experience of the erotic and their work with it. The findings are in line with the observation that neither the profession nor regulation has addressed the erotic adequately, which has a negative impact on clients, therapists and the profession as a whole (Pope, 1987; Pope et al., 1986). In addition, the attitude of regulators appears to increase the risk of misconduct, as therapists get the message that they should handle the erotic in secrecy. In other words, feeling intimidated and unsupported means that therapists' risk of unprofessional conduct raises. Furthermore, the attitude of the profession seems to hamper, to some degree, the exposure and management of sexual misconduct, potentially contributing to its continuation.

The findings reveal that most of the participants who were attracted to their clients kept their feelings of attraction to themselves. Those who disclosed their feelings to their clients were overwhelmed by them and, therefore, they could no longer contain them. In addition, they believed that being honest with their clients was the only way to have a genuine relationship with them.

The participants understood their clients' erotic feelings for them as products of erotic transference and their own erotic feelings for their clients as products of erotic counter-transference. Another understanding they held was the experience of erotic feelings as a metaphor for the communication of nonsexual issues for both their clients and themselves. The findings are in agreement with some of the most widely known theories on the development of erotic feelings in the context of therapy. Freud (1915/1963 as cited in Pope et al., 2000) sees the role of transference and counter-transference as fundamental to the analytic process and work, and explains the experience of erotic feelings in the room as erotic transference and counter-transference.

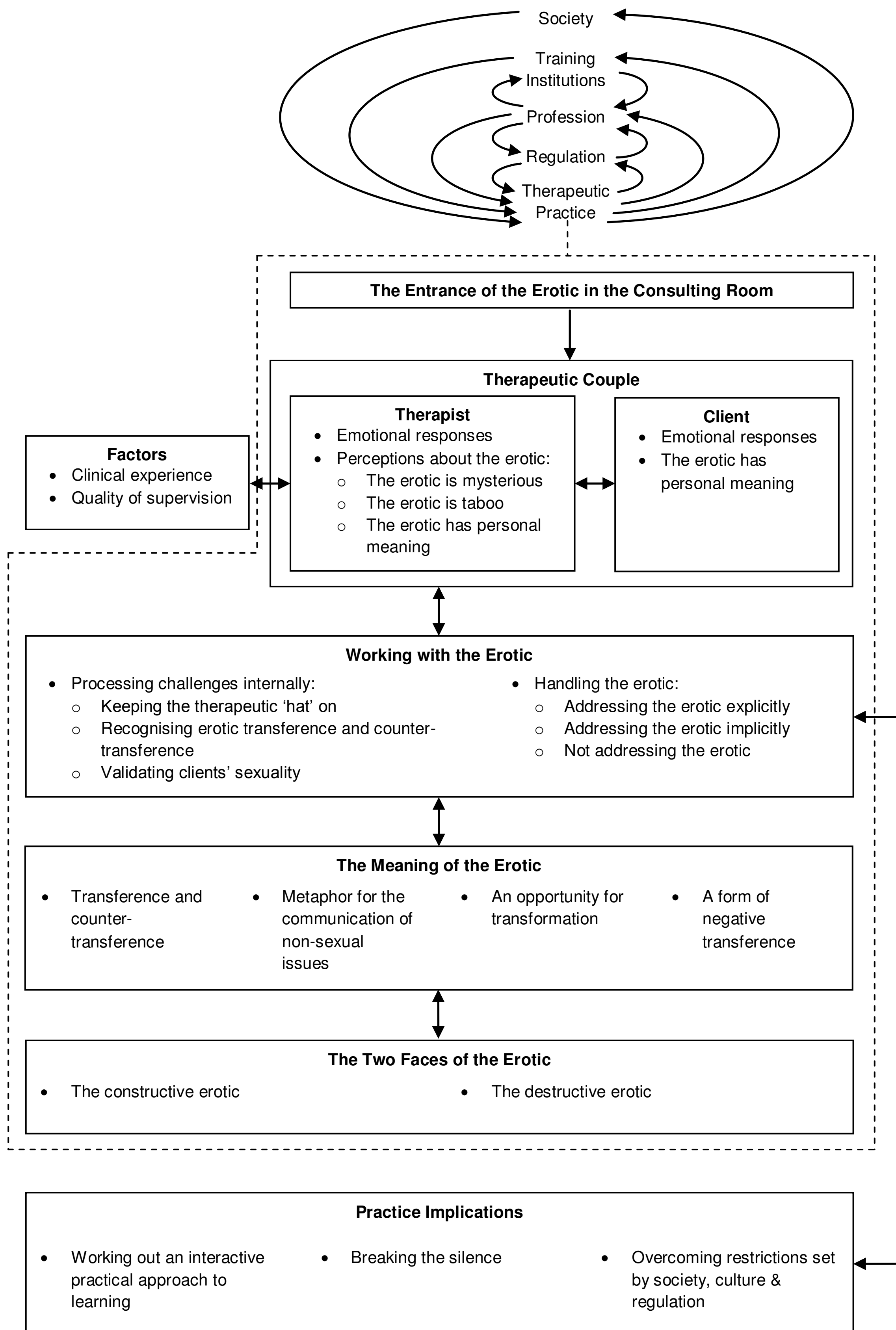
Dujovne (1983) and Bridges (1994) view the erotic as a result of transference and counter-transference. At the same time, they also view the erotic as a metaphor for the conveyance of nonsexual issues for both clients and therapists. Dujovne (1983) argues that the most frequent nonsexual issues conveyed through erotic and sexual feelings are clients' needs for approval and validation, the temptation to seduce therapists, the dismay of connecting in ways other than sexual, feelings of unease evoked by the process, the urge to fulfil their dependency needs, and therapists' rejection. With respect to therapists' feelings, she supports that the most common nonsexual issues conveyed through the erotic are therapists' sense of inadequacy, attempts to bring to an end a challenging piece of work, desires to preserve a positive self-image, and insufficient self-control (Dujovne, 1983). Lastly, Bridges (1994) supports that the erotic can offer invaluable information about the dynamics developed between the therapeutic couple, and she stresses the need for feelings to be explored but not acted on.

Orbach (1999), Wrye and Welles (1994), McDougall (1995), Natterson (2003) and Mann (1997, 1999) view the erotic as an opportunity for transformation as long as therapists are able to understand and handle it therapeutically. On the other hand, Rappaport (1956) views the erotic as a form of resistance, whereas Kumin (1985) thinks of it as negative transference and creates the term 'erotic horror' to describe the uncomfortable feelings elicited in both clients and therapists when they realise the erotic. We might speculate that, while theory is important to situate the erotic in context, some participants' persistence to explain the erotic theoretically could mean that theory can be used as a means to disconnect from the erotic and hence protect themselves from the risks associated with it.

The participants suggested that the erotic has a constructive side and a destructive side for both their clients and themselves echoing the views of Bridges (1994), Dujovne (1983), Mann (1997, 1999) and Orbach (1999). The participants believed that the erotic was constructive for both their clients and themselves when they were able to understand it, normalise it, tolerate the unease elicited, contain the sexual tension experienced, and maintain a therapeutic attitude. Numerous participants reflected on examples of how the erotic had helped them see and accept issues that played into their work. Their realisations had led them to take action, such as to pursue personal therapy to work on these issues or seek additional supervision to support their practice (Bridges, 1994; Dujovne, 1983; Mann, 1997, 1999; Orbach, 1999). However, the study indicates that the erotic was not beneficial at all times. The participants felt that there were times that erotic and sexual feelings were destructive. This was the case when feelings were unrecognised, repressed, misunderstood and therefore inappropriately handled. On these occasions, the erotic had a negative impact on both their clients and themselves.

The participants recognised the need to develop their ability to engage the erotic in their practice and felt that taking part in this research was a step towards this. All of them evaluated their participation in the project as an invaluable opportunity to think, reflect on and learn more about the subject. To finish, all of them also argued that experiential learning, open-minded qualitative supervision and a change of attitude towards the erotic on the part of society, the majority of training institutions, the profession and the regulators of clinical practice is required to enable them to understand and work with erotic and sexual feelings in the consulting room. A diagram that shows how the participants experience erotic feelings in the context of therapy follows.

Figure 1. Therapists' experience of erotic feelings in therapy



4.3 Discussion of the most important findings

The study argues that the participants' experience and response to the erotic is socially constructed. More specifically, the study suggests that the majority of participants struggle to manage erotic and sexual feelings in therapy not only due to their history but also due to the impact of society, the majority of training institutions, the profession and the regulation of clinical practice in the consulting room and on the individuals within it. This is in line with Parker's (2009) argument that social and cultural systems shape not only how we experience our own and others' erotic and sexual feelings and behaviours, but also how we interpret, understand and respond to that experience. In this case, these systems are society, the training institutions, the profession and the regulation of clinical practice.

As seen, in our society, the erotic tends to be treated with feelings of anxiety and discomfort. Although sex is used to sell, control and manipulate people, it seems that, at the same time, erotic and sexual feelings are not subjects that people can talk about openly. In this sense, it could be argued that, in our society, the erotic is largely kept in silence. Most training institutions appear to theorise the erotic, discuss ethical and legal prohibitions, and stress the negative impact of therapist–client sexual relations on clients, therapists and the profession. At the same time, they seem to fail to explore the topic in a meaningful way from the therapists' perspective. In addition, they seem to pay disproportionate attention to the cognitive understanding of the erotic neglecting its emotional understanding (Cohen, 2002; Mace, 2002; Parker, 2002). In this sense, the erotic is somewhat both overlooked and intellectualised. The profession seems to respond to the erotic with a sense of anxiety (Butler & Zelen, 1977; Pope, 1990; Taylor & Wagner, 1976). On the other hand, the profession's initial response of avoidance and denial towards the erotic appears to have been lessened. Lastly, the regulators of clinical practice seem to use a series of prohibitions, their power and authority, the fear of punishment and the enforcement of disciplinary measures to control therapeutic practice. On top of this, being confronted with the increasing evidence of therapists' sexual misconduct (American

Psychological Association Ethics Committee, 2012, 2013, 2014), the regulators appear to have also adopted a somewhat defensive attitude towards the erotic. In this light, the erotic is perceived and handled as an unsafe therapeutic experience that must be regulated and managed.

We might speculate that, due to the inter-relationship between therapists and social systems and the inter-relationships between different social systems (Blumer, 1986; Charon, 2010), the ways that society, the majority of training institutions, the profession and the regulators handle the erotic reflect and shape how therapists experience the erotic, how their experience is constructed and how they handle it. As can be seen, the vast majority of the basic social processes identified by the participants seem to hinder rather than facilitate their experience of the erotic and their work with it.

It must be noted that, despite the comprehensive literature review conducted on the subject, only a few papers were directly related to the inter-relationship between therapeutic practice and social systems, and the inter-relationships between different social systems with respect to the construction of the experience of the erotic (Bridges, 1994; Butler & Zelen, 1997; deMayo, 1997; Folman, 1991; Hare-Mustin, 1974; Hartl et al., 2007; Hillman & Stricker, 2001; Pope, 1988; Pope et al., 1986; Rodolfa et al., 1994; Schwartz, 1993). For this reason, the results are discussed from a broader perspective. In addition, as can be seen in the diagram presented in the previous section, the inter-relationships that the participants have identified are both complex and multiple. However, for reasons of economy, it is impossible for all of them to be analysed in detail here. Therefore, only the inter-relationship between society and therapists' practice and the inter-relationship between the majority of training institutions and therapists' practice are discussed in more depth in this thesis. The remaining inter-relationships are also presented, but not discussed in detail.

4.3.1 Society

The participants said that society has a massive impact on their experience of the erotic, the construction of their experience and the management of the erotic. The structure of society defines and reinforces people's social identities, roles and actions. In addition, values, codes and norms affect how individuals view themselves, what they can (or cannot do), how they relate to others and the dynamics in their relationships (Blumer, 1986; Charon, 2010; Kant, 1787/1933). Therapists, clients and the participants of this study are members of a society and, as such, the way that the erotic is handled in society has a huge influence on how they experience the erotic, how their experience is constructed, and how they work with it in the consulting room.

Haule (1996) argues that, in most societies, the erotic is tied up with the sexual, which is what many participants have said as well. He supports his position by explaining that societies tend to associate erotic feelings with sexual feelings, which causes confusion and leads to suspicion and misinterpretation of the true nature of erotic feelings. As a result, the terms 'erotic' and 'sexual' are mixed up and used interchangeably in everyday language. This adds up to therapists' (and clients') difficulty of distinguishing one from another. In the quotes that follow, George refers to the notion that people confuse the erotic with the sexual, whereas Eddie talks about the risk of engaging the erotic in his work, a risk that seems to result from the confusion. George: *'People do confuse the sexual with the erotic' (Int 7, l 72).* Eddie: *'I feel that it (love) is what I want to create within the (therapeutic) relationship. However, it can be [...] very difficult [...] for the client to receive that. A female client might find me .. confuse that as a romantic notion' (Int 5, ll 66-70).*

We could speculate that the confusion between the erotic and the sexual is a phenomenon observed only in this particular group of participants. However, other studies have found similar results as well. In her study, Rodgers (2011) found that, in her participants' consciousness, there was little differentiation between erotic transference and sexual attraction. Consequently, the two terms were often used interchangeably. McClounan (2012) supports that the

confusion between the erotic and the sexual results from the way in which these feelings are treated in society and adds that the confusion has an immense impact on therapists' ability to tolerate and handle the erotic in their work. Lastly, Mann (1997) argues that the confusion between the erotic and the sexual could be the factor that turns the presence of the erotic in the consulting room into a taboo.

Schaverien (1997) supports that, in most societies, the erotic is a subject frequently linked to feelings of guilt and shame. Eddie reflects on how the society within which he was raised influenced the feelings of shame he experiences every time he feels attracted to a client: *'I think [...] my culture.. I come from a very sort of sexually closed place where sex wasn't discussed, sex wasn't talked about. It went on but nobody discussed it. So I think that influenced my early processing .. sex was.. sexual feelings were wrong. Sexual feelings towards a client were wrong. I think that influenced that, "If you are doing a good job, if you are doing a kind job, if you are doing a caring job, you shouldn't fancy your client"' (Int 5, ll 788-797).* Springer (1995) argues that, in most societies, the erotic is handled with avoidance and silence, preventing people from exploring and understanding it. This is what Isabelle says below: *'.. in a lot of societies sex is still a little bit of a, "Oh, we don't really talk about that type of thing"' (Int 9, ll 227-229).*

This seems to happen regardless of the erotic being everywhere in Western societies. Many participants said that we live in an overly sexualised society in which sex and sexuality are used to sell, seduce, control and manipulate people. In the following extracts, George and Hannah talk about how, in their view, sex and sexuality are used in our society: *'We [...] sexualised everything [...] I mean, our images of sex, our experience of sex [...] go on the internet [...] there's nothing people don't know about anymore. The mystery of sex and the privacy of sex is gone.. it's a commodity in so many ways; you can buy it in so many ways; you can see it in so many ways [...] we've sexualised everything [...] Advertising – women on cars, you know, it's kind of, it's everywhere' (Int 7, ll 642-660).* Hannah: *'Sex is everywhere [...] it is being plastered all over television and magazines' (Int 8, ll 565-567).*

Media seem to play a huge role in how sex is used in societies, as it has the power to shape, change or reinforce the public's views on a wide variety of subjects (Georgas, 1995). It seems that the vast majority of advertisers do not hesitate to use sex and sexuality to convince their target audience that their products will make them attractive and desirable to others; hence, sex and sexuality are used to manipulate people and sell commodities (McClounan, 2012).

Nonetheless, the paradox remains. It seems that, in most societies, there is a sense of hysteria around sex and sexuality, which makes it difficult for people to talk about their erotic and sexual feelings and desires openly both in life and in therapy. Daniel talks about this subject in the extract below: *'(In our society) there's a general hysteria about sexuality, sex, desire, in general' (Int 4, ll 1122-1123). 'There's a kind of a moralistic thread which [...] creates a kind of hysteria. So, for example, in therapy this emerges around the idea of touch. Yeah? [...] The (name of professional body) is very vague in all of its ethical guidelines but it errs on the side of "Don't touch" [...] You could say that's fairly straightforward [...] but I still think that it's very difficult for us to talk about the issues of touching given the kind of the moralistic [...] discourse around touching; how touching very quickly collapses into something inappropriate' (Int 4, ll 1138-1155).* It also seems that, in most societies, there is a sense of discomfort when people's sexuality or way in which they lead their lives do not 'fit' into what is considered 'normal' and 'accepted'. In the following extract, Daniel expresses his perception about the attitude of society towards homosexual feelings: *'.. being gay [...] is in a sense, counter-cultural, it is not the norm [...] it's been something which society itself has wanted to disallow and deny. If you like, homosexual feelings are sexual feelings par excellence that society represses. Yeah? [...] So [...] on a personal level [...] my understanding of my sexuality, or my experience of it, is constructive on a social level; I mean, everybody's is. So I already bring an encounter with social values that very much position, or have positioned, my desire as being unacceptable' (Int 4, ll 1038-1052).*

In addition, it seems that those who dare to either talk or lead a life that it is not in line with the existing social norms are, to some extent, marginalised. In the following extract, Laura says that she has been ostracised by a variety of communities due to her sexuality: *'Being a lesbian practising in Britain means that I have to work with heavy Catholicism. I have been ostracised by various communities' (Int 12, ll 1146-1150).* In this sense, the erotic is not understood. Instead, it is repressed, denying people the opportunity to explore and understand their feelings and desires. A way of looking at this could be the perception of sex and sexuality as a private subject that people should not talk about. This is what Laura says below: *'I think culturally, I think the English find it very difficult to talk about anything sexual [...] Periods, menstrual cycles, when you're first having sex [...] it's a topic that's never talked about [...] you know, "Don't talk about it, you're not allowed"' (Int 12, ll 1126-1143).* Another way of looking at this could be that sex is, for many people, a subject of anxiety and concern. This is how George understands our society's attitude of avoiding talking about sex: *'Sex is a very special subject, it's a focus for anxiety and concern, not just in the therapy room but everywhere. It's a charged subject, it's an important subject, so I guess I'm saying one reason why eroticism in the therapy room might arouse anxiety, it's because it arouses anxiety everywhere it goes' (Int 7, ll 492-499).*

Another way that society seems to influence how therapists experience and work with the erotic is through existing gender roles and sex stereotypes. For example, in most societies, men are seen as having more power than women and hence holding a more dominant role in male–female relationships (Zelen, 1985). In this sense, sex stereotypes may play a role to therapists' and clients' fantasies for each other. In the extract below, Bill describes an erotic fantasy he has been having for a young, beautiful female client of his: *'She is almost like a fairy' (Int 2, ll 1143-1144). '(Therapy with her) feels very erotic. There's a bit of me that just wants to touch her and hold her and definitely a bit of me that looks at her and finds her very attractive and would like sex' (Int 2, ll 1217-1220). "What's she for me?" The erotic fantasy wants her to be (my) lover' (Int 2, ll 1255-1256).*

In addition, sex stereotypes appear to contribute, to some extent, to the frequency of sexual engagements between male therapists and female clients (Pope, 1990; Zelen, 1985). This is almost *as if* the stereotypes grant permission to therapists to act upon their erotic and sexual feelings for their clients. This seems to be supported by numerous studies conducted on sexual intimacies between therapists and clients. All of them have found that, in the vast majority of cases, the therapists who more frequently breach the boundaries and engage in sexual relations with clients are male, middle-aged therapists who become involved with young, female clients (Borys & Pope, 1989; Holroyd & Bouhoutsos, 1985; Holroyd & Brodsky, 1977; Pope et al., 1986; Rodolfa et al., 1994). On the other hand, gender roles and stereotypes seem to have an impact on some therapists' hesitation to talk openly about the presence of the erotic in the room. This is what Daniel seems to say in the extract below: *'I think that (communicating his feelings of attraction to his female client) very much moves into the realm, as far as I'm concerned, of something that's unethical. I think it would scare the bejesus out of the client [...] "So you're aroused and I'm aroused, what do we do about that?" I don't know, I think to my mind, it opens a door let's say similar to if a father were to say, "Yes, you're a very pretty young girl and if I was 20 years younger I'd be very happy to have sex with you". It would be an odd thing to say' (Int 4, ll 460-472).* Nonetheless, it must be noted that the aforementioned view regarding sex roles and stereotypes cannot explain the sexual encounters that take place between therapists and clients of the same sex and orientation (Bouhoutsos et al., 1983).

The literature on feminism details the political implications of sexual engagements between therapists and clients, suggesting that sex in the context of therapy is a new form of exploitative sex (Chesler, 1972 as cited in Dujovne, 1983). Brown (1994) acknowledges that therapy also serves, to an extent, therapists' needs and adds that this is acceptable *as long as* clients' needs come first and boundaries are maintained. She points out that the boundaries are at risk of being violated when there is a conflict between therapists' needs and clients' needs. Consequently, she urges therapists to examine their needs and always set their clients' needs above their own.

This is what Bill talks about in the following extract: *'I was very strongly attracted to her. She was young, very sexy, very keen on me and beautiful [...]* the keenness to find an excuse to breach the boundaries was very strong*' (Int 2, ll 324-346). 'At the same time [...] as a therapist, I really cared for her. I really wanted what was good for her and of course I knew that having sex with her wasn't good for her. So it's quite a complex conflict' (Int 2, ll 349-353).*

Butler and Zelen (1977) also refer to the inter-relationship between society and clinical practice, highlighting that the character of a society and the changes occurring within it can have a significant impact and reflect on the way in which therapists and clients interact and relate. In the following extract, Eddie expresses the view that British society is in a transitional period and he comments on the impact of the transition on how British people seem to feel towards sex: *'We are still living in a transitional period [...] I think we've gone from the titillation of the Victorians who shows a bit of ankle and it's all very sexy and exciting to turn the TV on or turn the internet on in particular and you can see full sex porn. We've gone from one extreme to the other. And I don't think that people have come to a place where they are comfortable' (Int 5, 652-661).*

Butler and Zelen (1977) argue that societies that hold a more open attitude towards sexual expression may grant therapists permission to talk more about sex, disclose more about themselves and share more about their lives and experiences with their clients. In their view, this type of openness can reduce the distance between therapists and clients, erode the boundaries and, potentially, lead to sexual relations. Hamilton and Spruill (1999) approach the same subject from a slightly different perspective. They suggest that, in most Western modern societies, social norms endorse the act of mutual self-disclosure to maintain equity in relationships. This can make therapists reveal more than required for the benefit of the therapeutic work and, potentially, lose sight of the therapeutic relationship. In addition, Hatfield, Traupmann, Sprecher, Utne and Hay (1985 as cited in Hamilton & Spruill, 1999) argue that, in most societies, there is a strong inclination to

reciprocate feelings of being liked to also maintain the equity in the relationship. Below, Eddie describes an incident where he and his client assumed the role of friends, putting the therapist–client relationship on the side for a while: *'At times, in the work, we became pally rather than therapist - client [...] my response, or my reactions, wasn't from a therapeutic stance. It was more from me as a gay man. He mentioned a particular incident and we ended up almost joking about it and making it sort of like two friends talking about something' (Int 5, ll 245-252).*

Schwartz (1993) refers to the role of the individualistic character of modern societies in generating loneliness, and its contribution to therapists and clients becoming tempted to breach the boundaries in order to have their emotional and sexual needs met. Kardener (1974) argues that the feelings of isolation that most therapists who practise privately tend to experience may also play some role in therapist–client sexual engagements. By his understanding, therapists who practise privately are likely to receive less emotional and professional support in comparison to therapists who work in organised settings. This seems to increase the risk of therapists breaching the boundaries. Case studies and surveys conducted on sexual misconduct (Bouhoutsos et al., 1983; Celenza, 1998; Holroyd & Brodsky, 1977; Pope, 1987) seem to support this view. In addition, this also seems to increase the possibility of therapists finding themselves being in a difficult position when working with clients who exhibit sexualised behaviours. In the extract below, Katrina refers to the supportive attitude that the organisation she worked for demonstrated when she said that she felt uncomfortable with a client who she perceived as flirty: *'I did feel uncomfortable with it (his comment) [...] I think he said something like "I find you very attractive" [...] He made me feel very uncomfortable [...] I have to write a report about what happens in the session, and I either speak to one of the people at the agency or they read the report [...] We had a conversation and they said "How do you feel about working with this client?" and "Don't hesitate to talk to me if his behaviour becomes a source of concern for you [...] You don't have to continue working with him". And, that's the policy with any client' (Int 11, 801-829).*

Hare-Mustin (1974) emphasises the importance of therapists being aware of the social and cultural contexts they work in, as they can greatly influence the way they practise. More specifically, she argues that each society and culture have their own social codes, values, principles and moral expectations. This means that what may be acceptable in one community may not be acceptable in another. For this reason, she suggests that therapists ought to be aware and respectful of the social and cultural environments they practise in and the ways that they can shape their relationship, interaction and work with their clients. In the extract below, Isabelle talks about the impact of society on therapeutic work: *'On the whole I think [...] the society you live in, the norms of that society play a part (to the work) and that is also true for your client. So if you have a cross cultural situation where a client is in this country or comes or is influenced by, then you have the dynamic of needing to be also respectful to the belief system that they have but also, when they want it, to challenge it' (Int 9, ll 753-762).*

In summary, it appears that the way the erotic is viewed and treated within a society can have an impact on therapists' experience of the erotic, the construction of their experience and their work with it. Thus, if the erotic is viewed as a 'subject not talked about', this is how most therapists are likely to view and treat the erotic in their work. In turn, the way therapists view and work with the erotic influences society's understanding and attitude towards it. This is because the construction of meaning is a two-way procedure that takes place between individuals and society (Blumer, 1986; Charon, 2010). This means that there is a vicious circle of attitudes towards the erotic that must be broken if a change is to occur.

4.3.2 Training Institutions

Hedges (2010) argues that the experience of erotic and sexual feelings in therapy does not get enough attention in therapy training courses, which is what most participants said. In the extracts below, Maria discloses that the erotic was a taboo during her training and Claire says that many of her colleagues report that the subject has not been included in their training. Maria: *'During my training it (the erotic) was sort of a taboo' (Int 13, l 51).* Claire: *'People (colleagues) tell me [...] "Gosh there is nothing in my training". And that feels an enormous hole. And I don't think there's enough in the literature either' (Int 3, ll 713-717).* Although training courses theorise the erotic and include some form of ethical teaching on the inappropriateness of therapists acting upon erotic and sexual feelings experienced either by clients or by themselves, most courses fail to directly consider the meaning and challenges of working through these feelings in therapy (Rodolfa et al., 1994). This is what Claire says about training below: *'Trainings have become much more tick-box, much more "do the right thing"' (Int 3, ll 737-738).* Failure to look into the subject beyond the theorisation of the erotic, its ethical and legal prohibitions and the negative impact of sexual intimacy on clients means that many therapists are likely to feel stress, guilt and embarrassment when they encounter the erotic in the consulting room.

Pope and Tabachnick (1993) advocate that the erotic is likely to make both tutors and trainees feel uncomfortable. They see this as one of the reasons why the phenomenon is 'kept at some distance' in training. This seems to have an impact on therapists' ability to feel comfortable and confident to think and talk about it. This is what Katrina says below: *'It (the erotic) is a really interesting area and one that isn't looked at (in training) very often [...] We don't think about that. It can be an uncomfortable thing to think about how we think about ourselves sexually, in our sexual relationships and, actually, it is really important, in the same ways we need to think about ourselves, in terms of how our family relationships affect us [...] Why should we ignore that? (It is) one of the things that is obviously going to come up. So it would be really good that it was attended to more so that people (therapists) can discuss that*

and begin to feel more comfortable with, at least open it up as a discourse, you know, something to talk about' (Int 11, 1078-1097).

Rodolfa et al. (1994) suggest that the attitude of training towards the erotic is likely to be influenced by tutors who support the notion that supervision (as opposed to training) is the place for trainees to explore the erotic. According to Rodolfa et al. (1994), these tutors fail to acknowledge that trainees need their training to give them the permission to open up and explore the subject.

Lastly, many (Mace, 2002; Parker, 2002; Rodolfa et al., 1994) argue that the split between theory and practice that seems to exist in the majority of training institutions is another factor that influences therapists' understanding of and ability to work with the erotic. Mace (2002) suggests that the split stems from the fact that training institutions and therapeutic practice have different ways of organising knowledge and argues that the two of them ought to integrate. He defines the term 'organization of knowledge' as 'a process by which knowledge is developed and ordered' (Mace, 2002, p. 359). Most training institutions seem to have a more theoretical approach to knowledge (e.g. they are interested in explanation) while therapy has a more practical approach to knowledge. Hannah's training experience seems to reflect Mace's (2002) argument: *'It's the discrepancy between .. you're learning something, you're being taught something as a theory, as a concept, but how do you put that in practice? So it's the discrepancy between different types of knowledge I guess – practical knowledge or procedural knowledge, you know?' (Int 8, ll 122-128).*

Parker (2002) argues that universities favour cognitions over feelings and use theory as a means of becoming more 'distant' from feelings. This is what Eddie seems to say below: *'I think it (the erotic) is [...] an area that [...] is often under .. not looked at (in training). There is a lot of stuff on erotic transference but I don't think there's enough stuff from the therapists' point of view; how to deal with it, how to handle it, what it makes therapists feel. So we can look at the theory and we can all say, "Yeah, okay, I can recognise it", but [...] We never touched on it to any great extent. And I think it's a really dangerous thing because we go in so unprepared for it [...] There is a lot*

more needs to be done [...] at training level' (Int 5, ll 31-53). 'I didn't know how to deal with it (the erotic). What I'd read about erotic transference, what we'd spoken about it, where we'd touched on it (in training) .. I was very, very unprepared for the actual power of it. And also the seduction of it..' (Int 5, ll 725-730). (In) my training, nobody ever dealt with it and said, "Look you might sit down and find that the client sat opposite you is going to (experience erotic feelings for you) .. and it's okay. It's okay to feel that"' (Int 5, ll 742-746).

Moreover, Parker (2002) highlights that most training institutions seem to promote certain ways of thinking about oneself and what matters in life, shaping not only trainees' identity, but also the ways in which they understand and practise therapy. This is what Bill appears to describe below: *'Client told me she was in love with me [...] I really didn't know what to do with it at the time. I had no idea. "Huh! What's this?" At the time, my model of doing counselling [...] wasn't very relational. It was more about looking at the aspects of herself, the parts of her personality, working with how to support her in integrating those [...] it didn't involve any relational elements [...] Basically I just kept my blinkers on, heard what she said and largely ignored it, which wasn't a great way of dealing with it. I didn't know any better' (Int 2, ll 107-121).* More specifically, if, for example, a training institution favours theoretical understanding as the only way of knowing and understanding the self, the others and the world, then therapeutic practice is at risk of turning into an educational process. Hannah talks about her training experience below: *'What I've learnt in the actual classroom .. (and) .. the situation that I was faced with sitting down with a client was slightly out ... it was different, so however much I was equipping myself with the theory [...] it wasn't enough in the real situation [...] There were parts of me that had to be present to that client more than just the theory of it, so it was me as a whole. Me as this living body being there with another living body interacting [...] (this) wasn't covered in the theory that we were working, so there were unexpressed aspects of the therapeutic relationship that I was coming, you know, in contact with' (Int 8, ll 99-121).* This means that therapeutic phenomena such as transference, projection, therapist's idealisation and so on may not be

processed and handled effectively in the work. Pope et al. (1993) argue that the lack of sufficient training on the erotic is likely to lead therapists to doubt their ability to work with erotic material ethically and effectively. Bridges (1994) takes it a step further, as she holds the view that inadequate training on the subject of the erotic may link, to some extent, to rates of therapists' sexual misconduct. Lastly, Mace (2002), Parker (2002) and Rodolfa et al. (1994) stress that training courses should integrate theory and practice for the benefit of trainees, clients and the profession.

The need for integration between theory and practice was emphasised by the participants. In the extract below, Isabelle describes her experience of experiential learning as a helpful and meaningful training experience: *'I was helped because when we did the (academic institution name) course in the 70s, one of the weekend modules was called SAR, Sexual Attitudes Restructuring [...] It was a very interesting weekend. From the beginning to the end you were bombarded with films of every combination, apart from animals, of sexual activity. And then you had to intersperse with group work "How did you feel? What came up for you? If you were working with, what..?" everything.. So, the whole thing was about questioning yourself [...] So, if you had problems anywhere [...] then you could talk about that ..' (Int 9, ll 640-661).*

In summary, it appears that the ways in which feelings, including erotic and sexual feelings, are treated in training institutions play their own significant role in how therapists process and engage with feelings, reflect on their work, interact with and relate to their clients, and so on. Thus, if (erotic) feelings are approached and understood cognitively in most training institutions, then most therapists are highly likely to approach feelings in a similar way (i.e. theoretically and with a sense of uneasiness) (Pope, Levenson & Schover, 1979). The inter-relationship between the two means that a circle of understandings and behaviours has been established. Similar to the inter-relationship between society and therapeutic practice, the circle has to be broken for change to take place.

4.3.3 The profession and the regulation of clinical practice

The profession advocates that therapists are solely responsible for maintaining the boundaries and keeping the therapeutic relationship intact (Seto, 1995; Zelen, 1985). At the same time, it seems that, to some degree, the profession has neglected to prepare therapists for the intimate nature of therapy (Pope, 1987; Pope et al., 1986), increasing the likelihood of therapists feeling surprise, confusion and stress towards it and thus mishandling or avoiding it. This is a view that many participants expressed. George talks about the profession's attitude in the extract below: *'I would say that, to some degree, the profession has put sexuality in the shadows; that which we do not wish to be; that which we do not wish to own. And when you put something in the shadows you see it everywhere, it irrupts, it's mishandled, it's not thought about, so it's, kind of, everywhere' (Int 7, ll 979-985).* Taylor and Wagner (1976) suggest that a way of looking at the profession's attitude towards the experience of the erotic could be the perception of the erotic as a taboo and thus an unspoken subject.

Hedges (2010), argues that the profession should manage the erotic both more clearly and effectively. This is what Katrina seems to say here: *'I am clearly aware of guidelines [...] "Don't have sex with clients", which is kind of "Go figure". Well unfortunately, clearly some therapists do do that, but it's quite obvious that you shouldn't. But they (professional community) could provide some more guidance on (it) [...] There is a gap that they could offer something a bit more specific, they could address it [...] (In my view) they are part of the problem' (Int 11, ll 1116-1129).*

Elise (2002) advocates that the professional community should facilitate the discussion of the erotic both in the field of training and in case conferences. Sherman (2002) agrees with Elise (2002), highlighting the importance of the professional community assuming a more proactive role in the discussion of the erotic in the context of therapy. The professional community (in this case, the BPS) seems to be consistently working towards this direction. For example, Pliakou's (2009) study on the experience of erotic feelings between male therapists-female clients was presented in a BPS conference in 2009.

At the same time, it seems that more work needs to be done in this area. For instance, the programme for the period from 31st July 2016 to 31st July 2017 - as given on the BPS website as at 31st July 2016 (https://www.bps.org.uk/events/search) - included no events on the experience and management of the erotic in therapy. Although there was an event linked to therapists' dilemmas, called *Don't get caught out: Ethical and professional dilemmas for psychologists and psychotherapists in 2016* (https://www.bps.org.uk/events/don%E2%80%99t-get-caught-out-ethical-and-professional-dilemmas-psychologists-and-psychotherapists-2016), there was no reference to the erotic. Similarly, the subject of the erotic was not included in the programme of approved events organised by the BPS in 2016 for practitioners' continuing professional development (BPS, 2016).

In terms of providing guidance, the BPS, in an attempt to support therapists' ethical practice, has been publishing guidelines relevant to clinical work, including therapists' attitude towards nonsexual and sexual dual relationships. Regarding romantic and sexual feelings, the most recent code of ethics states that psychologists should 'Refrain from engaging in any form of sexual or romantic relationship with persons to whom they are providing professional services, or to whom they owe a continuing duty of care, or with whom they have a relationship of trust. This might include a former patient, a student or trainee, or a junior staff member' (BPS, 2009, p. 22). In addition, the code also includes (1) a decision-making model to enable therapists address ethical dilemmas, (2) the references of sources used to write the code (for further study), and (3) contact information for therapists who wish to obtain ethical advice and support about their practice or research project. On the negative side, although the code (BPS, 2009) provides therapists with guidance, the wording used is vague to some extent, which means that there is space for misinterpretation and/or manipulation. In addition, even though the code (BPS, 2009) includes a decision-making model aimed at assisting therapists to make ethical decisions, the model is generic. This means that it may be difficult to be implemented.

On a different note, in 2005, the BPS created a blog (http://digest.bps.org.uk) in which, every day, at least one psychological study is critically examined. A summary of Martin et al.'s (2011) study on therapists' erotic feelings for their clients was one of the studies presented on the blog. Lastly, it seems that some practitioners (Priestman & Totton, 2011) have started organising workshops on the erotic. Most of these workshops are informative and offer attendees the chance to think about the erotic from their point of view. Although these workshops make an important contribution to the process and management of the erotic, more workshops are required. This way, more and more therapists will be exposed to the erotic, its meaning, its implications for practice and so on.

Due to the interdependence between the profession and therapists' practice the profession's (1) feelings of anxiety and (2) its attitude of placing the erotic in the shadows reflect on therapists' work. This can be seen in most of the research participants' accounts and in the literature as well (Bouhoutsos et al., 1983; Butler & Zelen, 1977; Holroyd & Bouhoutsos, 1985; Pope, 1987, 1990; Pope et al., 1986; Taylor & Wagner, 1976; Wincze et al., 1996). In many cases, participants treated the erotic with feelings of anxiety and an attitude of avoidance, mirroring both the feelings and the attitude of the professional community they are part of. In the extract below, Laura comments on her colleagues' discomfort to even talk about sex: *'I find that a lot of my colleagues feel very uncomfortable talking about sex' (Int 12, ll 79-81).*

Due to the inter-relationship between the profession and training, the attitude of the profession towards the erotic has a direct impact on the attitude that most training institutions hold towards it. This is because it is, largely, the profession that sets the ground rules with respect to how trainees should approach, process and handle practice-related challenges and their clients' feelings and problems. Thus, if the profession treats erotic feelings with a degree of avoidance, this is also how most training institutions are likely to handle the erotic in therapy training courses. In addition, if, for example, the profession pays more attention to the cognitive understanding of therapeutic

phenomena - neglecting their emotional understanding - then this is what most training institutions are likely to do as well (Waller, 2002). In turn, the way that training institutions teach trainees to understand and handle feelings influences how the profession views and treats feelings.

Due to the interdependence between the profession and regulators, the profession's feelings of anxiety towards the erotic seem to have resulted in regulators feeling anxiety as well and, potentially, overreacting towards allegations of sexual misconduct. In the following extracts, Hannah and Maria talk about regulators overreacting to allegations. Hannah: *'There is a magazine where all of the people who have been sanctioned or have been under investigation .. when you put up such a big list of people who have been looked upon in suspicion, it kind of makes you wonder sometimes. "Are these all – I don't know – malpractices or have we become too cautious about things?" [...] It's gone a bit too much.. Too far on the other side' (Int 8, ll 626-638).* Maria: *'I used to read the example of malpractice on the (name) journal. Some of them make sense, some of them I was like "Hold on a minute, what is wrong with this?" Peculiar and scary' (Int 13, ll 749-753).* As a result, many participants seem not to trust that an allegation of sexual misconduct would be handled with fairness. This is what George says below: *'I don't regard it (the role of regulation) positively, I wouldn't really, I wouldn't trust my regulatory body [...] I wouldn't really have a great deal of faith that they would handle a complaint well [...] There's so much anxiety about sex and sexuality and that appearing in the consulting room, that I think it just might be mishandled' (Int 7, ll 698-704).*

The fact that regulators appear to have no specific guidelines on how misconduct should be evaluated and on how therapists should be disciplined (Gottlieb et al., 1988; Sell et al., 1986) implies that allegations may be treated with inconsistency. For example, some therapists are suspended by their employer and professional organisation but they are allowed to resume work in the mental health field at a later time (McNulty et al., 2013). However, others are dismissed and excluded from their professional organisation and are not allowed to recommence work in the field anymore (McNulty et al., 2013).

In addition, many participants described regulators' attitude of using (1) the rule of a series of prohibitions, (2) power and authority, (3) fear of punishment, and (4) infliction of disciplinary measures to control therapists' practice as policing therapy. This is what Hannah speaks about in the following extracts: *'It's good to have some principles' (Int 8, l 588). 'What I don't like is [...] that, at times, rules become a policing agenda, kind of "big brother" gaze and then again it plays again into this "no sex, no sex". It becomes a big thing [...] If somebody's policing you it becomes a bit of an issue in terms of trust [...] in people to do their jobs [...]. (In addition) it kind of punishes all of the therapists for what some would do anyway – because if you don't want to keep to some principles, if you don't have any moral boundaries yourself you would do whatever you would do, anyway' (Int 8, 594-610).*

Furthermore, many participants seemed to view the regulators' approach as both ineffective and disempowering. Fabian and Claire express these views below. Fabian: *'What regulators are trying to do is regulate a person's behaviour, an individual's behaviour. It's never been done before [...] Even the criminal justice system cannot stop people from doing what they want [...] So, what chance has a regulatory body of therapists got, to stop the therapists from doing .. (what they want)?' (Int 6, ll 595-618).* Claire: *'You have to comply with that the big adult governing body is going to say you have to do which is disempowering [...] How do you support individual therapists to become empowered if they're always looking to "big daddy" up there? How are they going to find their own power and authenticity?' (Int 3, ll 744-754).*

Lastly, all participants viewed training (as opposed to rules) as the way forward and some of them supported that there is need for exceptions. Isabelle captures participants' views on the first subject in just one sentence and Maria explains the reasons why, in her view, exceptions are required. Isabelle: *'No, not rules. Training. Please no more rules' (Int 9, l 925).* Maria: *'If [...] you really want to be with this person, what on earth do you do? Do (you) lose your licence? Is there any room for exception? What do you do?*

Do you put yourself at risk? And if this relationship is real, and it could be, then what? Then bloody what?' (Int 13, ll 713-720). 'The point is there must be an exception. Because life is life, the real things happen' (Int 13, ll 738-739).

Due to the inter-relationship between the regulators and clinical practice, the attitudes that regulators and therapists hold towards the erotic have a direct impact on each other, reinforcing beliefs and practices in this area. For example, the punitive approach that regulators take towards therapists leads many therapists handling erotic and sexual material in secrecy. In turn, handling erotic and sexual material in secrecy seems to reinforce the regulators' view that erotic and sexual feelings should be regulated, controlled and managed. In the extracts below, Fabian and Maria talk about the disparaging effects of regulators' punitive approach to clinical practice. Fabian: *'I think the intention of stopping.. counsellors and therapists [...] having sex with their clients was a good intention. I think however that the way in which it is done has derogatory effects on therapy [...]' (Int 6, ll 477-482). 'In effect .. erotic transference becomes unspoken and goes underground' (Int 6, ll 501-503).* Maria: *'It is a punitive approach; there is no space for anything and we hide' (Int 13, ll 798-800).*

4.4 Implications for practice

The study suggests that participants' experience, construction of their experience and work with the erotic are socially and culturally constructed. As discussed earlier, the inter-relationship between therapeutic practice and social systems and the inter-relationships between different social systems (Blumer, 1986; Charon, 2010) reflect on and shape how therapists experience the erotic, how their experience is constructed and how they work with erotic and sexual feelings in their practice.

Based on the participants' accounts, society seems to have a direct and great influence on their experience and work with the erotic. For this reason, the participants said that societies ought to re-examine and restructure their position towards the meaning and management of the erotic in therapy and in life. Challenging feelings of anxiety and discomfort, as well as attitudes of avoidance, silence and control, will enable therapists to contain the feelings evoked by the erotic and support their work with erotic and sexual material in a professional, therapeutic and effective manner.

In addition, according to the participants, it seems that (more) training institutions and therapy training courses must integrate theory and practice in a model of experiential learning (Cohen, 2002; Folman, 1991; Jacobs, 2002), make a clear distinction between erotic feelings and actions (Folman, 1991; Hamilton & Spruill, 1999) and model ethical and effective ways of working with erotic material (Folman, 1991). More specifically, a theoretical understanding of how and why erotic feelings develop in the context of therapy seems essential, but not enough for its effective and ethical management. For this reason, many participants said that experiential learning is fundamental in this area of work. Workshops could offer trainees the opportunity to examine and challenge their attitudes towards sex and sexuality (Hamilton & Spruill, 1999), practise strategies of dealing with ethical dilemmas and uncomfortable feelings, and learn how to use decision-making models (Folman, 1991; Kitchener, 1988). In addition, workshops could offer trainees the chance to learn how to differentiate feelings from actions, accept feelings as normal and expected, and understand that feelings are to be

examined but not acted upon (Folman, 1991). Lastly, workshops could educate trainees on the role and use of boundaries (Hamilton & Spruill, 1999; Smith & Fitzpatrick, 1995) and promote open and honest communication with supervisors (Folman, 1991; Smith & Fitzpatrick, 1995).

Moreover, many participants said that therapists' work with erotic material would further benefit if the profession keeps working actively on the subject of the erotic. Based on the participants' views, the profession ought to contain its feelings of anxiety towards the erotic more effectively, take a more proactive role in terms of discussing the presence, experience and management of the erotic from therapists' point of view, and instruct training institutions and therapy courses to promote both a cognitive and an emotional understanding of the subject (Cohen, 2002; Jacobs, 2002). Other ways that the profession could further support therapists' ethical practice is to write the codes of ethics in a way that space for misinterpretation and manipulation is minimised, offer non-judgemental assistance to therapists who breach the boundaries for the first time (Butler & Zelen, 1977) and provide regulators with an effective set of disciplinary measures for therapists who get sexually involved with clients more than once (Butler & Zelen, 1977).

To finish, based on participants' accounts, therapists' work with the erotic would highly benefit if regulators replace suspicion with empathy and offer rehabilitation measures (Gottlieb, 1990; Pope, 1990) instead of punishment. This view seems to be supported by the high rates of sexual misconduct (American Psychological Association Ethics Committee, 2012, 2013, 2014), which suggest that neither the power of regulators nor the fear of punishment are strong enough to stop some therapists from becoming sexually involved with their clients. One of the ways of looking at the failure of regulators to regulate clinical practice effectively could be that regulators target therapists' behaviours, neglecting the inter-relationship between behaviours and attitudes. In other words, regulators target therapists' practices but not their outlook. However, people's behaviours are guided by the cognitive and emotional aspects of their attitudes. This means that, if attitudes change, behaviours will change as well (Georgas, 1995). A reflexive statement on

how I approached and handled this project and on how the work has affected me follows. Suggestions for further research on the subject are made at the end of the chapter.

4.5 Researcher's reflexivity

As seen, a central feature of Thematic Analysis is that researchers have an active role in the analysis and interpretation of the data (Braun & Clarke, 2006, 2013). This means that their perspective is an integral part of the collection, analysis and interpretation of the data (Braun & Clarke, 2006, 2013). For these reasons, researchers must be transparent and critically reflective of how they approach the research subject, the research tools they use, and the impact of their subjectivity on the collection, analysis and interpretation of the data (Braun & Clarke, 2006, 2013).

Braun and Clarke (2006, 2013) recommend that researchers should keep a research journal in which they record their thoughts, feelings and reflections on both the research process and themselves. I started keeping a journal when I started thinking about the project. They also recommend that researchers, especially those who do a Constructionist Thematic Analysis study, should complete a comprehensive literature review on the subject following the analysis of data to avoid 'forcing' the data into preconceived categories (Braun & Clarke, 2006, 2013), which I followed as well. Lastly, Braun and Clarke (2006) recommend that researchers should include the technique of member checking as a means to establish credibility of the results, which I have also done twice. Both the email I sent to the participants asking for their feedback on the results and some respondents' feedback can be found in Appendices 8 and 9 respectively. Information and remarks that could disclose a respondent's identity have been deleted. Respondents gave me their written consent to include their feedback in the Appendices.

Furthermore, as it can be seen throughout the thesis, I have been transparent about myself, background, choice of research subject and specific question. I have also been explicit about all the decisions I have made and their rationale. Thirdly, I have been transparent about the impact of my personality, presence and subjectivity on the research process and interpretation of the findings, as well as about the challenges I encountered. Lastly, I have employed a number of strategies and techniques (see Section 4.6) to ensure that the story presented here is as close as possible to the story the participants have shared with me.

Working on this project has been a long and challenging journey that has affected me in several ways. For example, I never knew the amount of self-determination and commitment I can show for a project, which, at moments, I perceived as rather draining. In addition, although I knew that many people love and support me, I did not know how deeply devoted they were to me. I am very grateful to them all. Lastly, now, I am much more able to understand the erotic, reflect on my experience, understand how it was constructed, and use it therapeutically. This allows me to enjoy my work with my clients even more than before. In the next section, the evaluation of the study is presented.

4.6 Evaluation of the study

Qualitative research methodologies have been criticised for being subjective, overly reliant on researcher's skills and not open to scrutiny (Willig, 2001). The fact that there is not a specific set of core criteria to evaluate qualitative studies explains this critique. The absence of a specific set of criteria is attributed to the fact that different qualitative research methodologies are based on different assumptions and, therefore, use different evaluation criteria (Yardley, 2008). This has led to a debate within the field of qualitative research as to what criteria are the most appropriate to evaluate qualitative studies (Morse, Barrett, Mayan, Olson & Spiers, 2002; Rolfe, 2006; Sandelowski, 1993). It is therefore important to discuss the criteria used to evaluate the present study.

4.6.1 Evaluation criteria of trustworthiness

Based on the literature review (Denzin & Lincoln, 2005; Guba & Lincoln, 1989), trustworthiness seems to be the most significant criterion in the evaluation of qualitative studies. The assessment of trustworthiness is particularly relevant to studies where findings are mutually constructed by researchers and participants, which is the case with the present study. The criteria selected to evaluate the trustworthiness of the study are the criteria recommended by Guba and Lincoln (1989). These are the criteria of credibility, transferability, dependability and confirmability (Guba & Lincoln, 1989). The criteria assess not only the methodological aspects of a study, but also its theoretical and practical aspects. Both the criteria and the ways in which they were met are presented next.

4.6.1.1 Credibility

According to Guba and Lincoln (1989), credibility is the extent to which participants' constructed realities are accurately represented by the researcher. Credibility was ensured through a variety of techniques. These were the techniques of member checking, peer debriefing, inquiry audit, triangulation, checking the researcher's subjectivity, and negative case analysis. These are described below.

Member checking

According to Guba and Lincoln (1989), member checking is crucial for ascertaining credibility and is particularly relevant to constructionist studies. This is because, in constructionist studies, the interaction and collaboration between researchers and participants plays a central role in the research process and outcome. According to Sandelowski (1993) and Yardley (2008), member checking can occur at various stages of a study. As a means of member checking, I asked the participants to give me their feedback on their transcribed interviews and make alterations if they wished so. The participants had the opportunity to add or eliminate the content of their transcripts to the level they felt comfortable with. All thirteen of them read

and confirmed that their interviews were accurately transcribed. In addition, when the results of the study were ready, I sent the participants a copy, asking for their feedback on these as well. The participants' feedback were recorded, analysed and became part of the results. The vast majority of the respondents said that they were happy with the results, that they were highly credible, and that they could see themselves and their experiences in them. Only one respondent said that he did not see much of himself in the results but he added that he understood that the results were based on the analysis of all interviews.

In summary, the respondents said that the erotic is an area in which the majority of therapists lack support and understanding. In addition, many emphasised their feelings of discomfort and/or fear to raise the erotic with their clients for mostly two reasons: (1) feeling embarrassed to talk about sex and sexuality and (2) worrying that their clients may judge them as unprofessional. Also, several commented on the lack of meaningful training provided by training institutions on the subject, as well as on therapists' inclinations to hide behind theory to reduce their feelings of distress evoked by the erotic. Furthermore, many referred to their hesitance to discuss the erotic in supervision due to feeling uncomfortable, and they highlighted (1) the importance of good-quality supervision and (2) the role of peer supervision. In addition, many referred to the hindering effect of the regulators' punitive approach on their experience of the erotic and their ability to work with it. Also, many commented on the role of cultural beliefs and social norms on their experience of the erotic, the construction of their experience and their work with it. Lastly, several expressed the view that their accredited/professional bodies do not offer enough support to therapists regarding to the understanding and management of the erotic.

Peer debriefing

Peer debriefers provide an external check of the research process and contribute to the transparency and integrity of the study. I asked two colleagues of mine who had good understanding of the methodology to act as my peer debriefers. The debriefers and I met twice. The first time was when the collection and analysis of data were still in process with a view to discussing the initial findings. The second time was when the collection and analysis of data were completed with a view to discussing an early perspective on the results. The debriefers questioned unclear points, tested out the findings and supported me psychologically (Guba & Lincoln, 1989; Padgett, 2008) throughout the process of analysing and discussing the data.

Inquiry auditor

The audit trail refers to linking raw material to the final thesis to certify that the study was done carefully and professionally (Yardley, 2008). Birks and Mills (2011, p. 173) define 'audit trail' as 'a record of decisions made in relation to the conduct of research'. Raw material such as digital recordings, coded interview transcripts, field notes, memos, diagrams and descriptions of the participants have been reserved for this purpose. The material will be kept for five years and then destroyed, as required by City University. Furthermore, I asked an inquiry auditor (Guba & Lincoln, 1989; Lincoln & Guba, 1985; Padgett, 2008) to examine the relevant documentation of the research process and verify that the data collection, coding and analysis procedures were done following the principles of the methodology used in the project (Guba & Lincoln, 1989). The method verified transparency and rigour in the research process. The inquiry auditor used for this purpose was my external supervisor.

Triangulation

The use of multiple sources, methods, researchers and theories in the accomplishment of a study is called triangulation (Creswell, 1998; Patton, 1990). Triangulation adds rigour, breadth and depth to studies by approaching the studied phenomenon from different perspectives, studying it in depth and enriching its understanding (Patton, 1990). Initially, triangulation was seen as a validation strategy (Denzin, 1978 as cited in Flick, 2004) and, therefore, it was strongly criticised. However, nowadays, triangulation is seen as a way of gaining a deeper understanding of the studied phenomenon - which is how triangulation is used in this study - as opposed to a way of setting questions of validity (Silverman, 2005). The sources I used to gain an in-depth knowledge of the phenomenon in question were the literature on the subject, my supervisor's feedback and the debriefers' work regarding the analysis and interpretation of the data (Patton, 1990).

Checking the researcher's subjectivity

In Thematic Analysis, researchers co-construct meaning with the participants through their interaction and the mutual interpretation of the story they share. For this reason, researchers are required to be reflexive towards both the research process and themselves (Braun & Clarke, 2006, 2013). To do this, I closely monitored my subjectivity throughout the entire research process. A way to do this was to have a self-reflexive interview on the research subject before interviewing the research participants. The aim of this was to (1) experience what it feels like to be interviewed on the subject and (2) further raise my awareness of my assumptions and beliefs on the phenomenon in question. Another way I monitored my subjectivity was to keep a reflexive journal where I recorded my thoughts, feelings, fears and hopes related to working on the project. I also recorded my assumptions on the subject and my expectations from the study, which I archived. At regular intervals, I again recorded my assumptions on the research question, my expectations and my constructions. I then compared them and reflected on them. This process ensured that I paid attention to the constructions offered by the participants,

as opposed to finding only what I expected to find (Guba & Lincoln, 1989). Keeping the journal helped me to be reflexive and transparent towards both myself and the research process from beginning to end. To finish, the techniques that have just been described in the previous sections have further helped me monitor and manage the impact of my subjectivity at every stage of the research process.

Negative case analysis

Negative case analysis is the purposive and systematic search for data that do not fit the identified themes and sub-themes (Creswell, 1998; Padgett, 2008; Silverman, 2005; Willig, 2001). According to Creswell (1998), negative cases should be analysed and reported as well. Their analysis and report make sure that researchers present all data and not only those that fit the identified themes and sub-themes. Furthermore, negative cases can indicate the limits of a study and suggest areas for future research (Yardley, 2008). Consequently, I actively sought data that did not fit the identified themes and sub-themes to give a full picture of the results. An example of negative case analysis is the unhelpful reaction of some peer supervision groups towards colleagues who decided to discuss the erotic with them.

4.6.1.2 Transferability

According to Guba and Lincoln (1989), transferability is the extent to which a study can be transferred and applied appropriately in settings and/or contexts similar to those from which the data were generated. The transferability of a study can be judged based on the readers of the study and other researchers. The researcher's responsibility is to give a clear and extensive description of all aspects of the study. The aim is to provide readers and other researchers with as much information on the project as possible to enable them to determine the transferability of the study (Guba & Lincoln, 1989).

In this study, the final dissertation serves as a thorough description and a means of addressing transferability. Digital recordings, interview transcripts, field notes, memos, diagrams, descriptions of participants and other information related to the study have also been reserved for this purpose. The material will be kept for five years following publication. Upon the completion of five years, all material will be destroyed to maintain participants' confidentiality and to adhere to the guidelines of City University.

4.6.1.3 Dependability

According to Guba and Lincoln (1989), dependability is the extent to which procedures are applied appropriately and data reflect the changing nature of the phenomenon in question. The dependability of the study was ensured by asking an inquiry auditor (Guba & Lincoln, 1989; Lincoln & Guba, 1985) who had an understanding of the methodology to examine and verify that all data collection, coding and analysis procedures were applied appropriately following the principles of the methodology used, and to confirm that the data reflected the accounts of the participants. The inquiry auditor used for this purpose was my external supervisor.

4.6.1.4 Confirmability

According to Guba and Lincoln (1989), confirmability is the extent to which another researcher can confirm that the findings of the study are based on the data when they are presented with the data. To ensure confirmability, I kept all raw materials, such as digital recordings, transcripts and notes related to the project. I also asked the inquiry auditor (Guba & Lincoln, 1989; Lincoln & Guba, 1985; Padgett, 2008) to study the data and confirm that the product of the study was based on analysis. It must be noted that an inquiry auditor's task is different from the peer debriefer's task. The first assesses the quality and appropriateness of the inquiry process, while the second is involved in the interpretation of the data throughout the research process (Guba & Lincoln, 1989).

4.6.2 Limitations of the study

Despite the importance of the subject and the impact of erotic feelings in clinical practice, little has been written on the erotic from theoretical perspectives, other than the psychodynamic approach (Bridges, 1994; Dujovne, 1983; Freud, 1915/1963 as cited in Pope et al., 2000; Mann, 1997, 1999; McDougall, 1995; Natterson, 2003; Orbach, 1999). This means that the review on the existing literature comes from the field of psychoanalysis. Little has also been written in the United Kingdom. Most studies have been completed in the United States of America, which means that the majority of papers used in this study come from the United States of America. This might indicate that US-based therapists are more aware of the erotic, its meaning and use in clinical practice than therapists who live and work in other continents. It is noted that the first British survey on the subject was conducted in 1994, which makes me wonder how prepared therapists in the United Kingdom feel to look into the experience of erotic feelings in therapy. Moreover, it seems that most writers on the subject are men. A way of looking at this could be women's reluctance to draw attention to their sexuality and sexual selves (Russ, 1993). Regardless of the reason why, the fact that the majority of papers come from male writers means that their views on the subject may have been over-represented.

Another limitation of the study is the effect of time on participants' memory (Rohde et al., 1992), as most cases were recalled retrospectively. Some cases were only a few months old, but other cases were over 10 years old. This means that both the recollection of what exactly happened in these cases and the participants' reflections on how they experienced and responded to the erotic may differ, to an extent, from how the cases were dramatised and experienced at that moment in time. A further limitation of the study is the impact of participants' awareness of the limits of confidentiality. Such awareness could lead the participants to make a selective case disclosure and, therefore, results may be biased to some degree. An additional limitation is the impact of the participants'/volunteers' motives for participating in the study. Volunteers are likely to have given

more thought to the research subject than other therapists (Thorn, Clayton, Shealey & Briggs, 1993). They are also more likely to be more open towards the presence, exploration and impact of the erotic in their work. As a result, the sample is not representative of the population of therapists. The impact of my own subjectivity in the research process and findings has already been discussed earlier in the thesis.

4.7 Suggestions for further research

In summary, this study is among the very few qualitative studies of which I am aware (Elliott et al., 2007; Kotaki, 2010; Martin et al., 2011; McClounan, 2012; McNulty et al., 2013; Pliakou, 2009; Rodgers, 2011; Spilly, 2008) that examine how therapists experience erotic feelings in therapy, how their experience is constructed and how they work with these. The research question(s), design, results and limitations of these studies are presented in Chapter 1 (Introduction). As they get a close look at the phenomenon of the erotic from therapists' perspective, they make an invaluable contribution in this area of practice. It is hoped that the present study has succeeded in representing the participants' experience, informing therapists' practice, suggesting practical applications, contributing to existing knowledge and highlighting the need for society, training institutions, the profession and the regulators to keep reflecting and working on their attitudes towards the erotic in order to enable therapists to work with it ethically and effectively. It is also hoped that the present study can spark further research on the subject from the therapist's point of view, as the phenomenon (although it is common) is still under-researched. For example, despite the comprehensive literature review conducted on the erotic, I have not come across a study on the experience of the erotic in a group setting. Hence, further research could explore how therapists experience and manage erotic and sexual feelings developed in group therapy. Researchers could explore therapists' experience(s), the dynamics developed in the room and the impact of the presence of group members on how therapists experience and manage the erotic.

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Appendix 1: Participant Information Sheet

School of Social Sciences **PSYETH**
11/12 011
College Building
Northampton Square
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Participant Information Sheet

"An exploration of how therapists experience their clients' erotic feelings for them."

My name is Venetia Kotaki and I am a Counselling Psychologist. I am currently undertaking a Doctorate in Psychology (DPsych) - Post Chartered ('Top Up') course at City University. I am conducting this research project to fulfil the requirements of the course.

Aim of the research project

The aim of the project is to explore how therapists experience their clients' erotic feelings for them.

How you can help

I am recruiting ten therapists who have a minimum of 5 years of post qualification experience. Therapists may come from any discipline and work with any model. They may practice either privately or in an organisation (voluntary or statutory).

What would be required of you if you volunteered to be a participant?

Participation in the study will involve one 75 minute session: a 60 minute semi-structured interview and a 15 minute debrief. We will mutually agree the date, time and location of the session. The interview will be audio recorded and transcribed. Participation is voluntary and you are free to withdraw from the study at any stage up to the analysis of the data, without giving any reason and without your decision affecting you in any way. In this case, I will immediately destroy all collected personal data, audio recordings and transcripts related to you and any forms you have signed.

The data will be analysed using Grounded Theory and will be discussed. My supervisor(s) and the examiners of the project will have access to anonymised data. The results will be presented in a written thesis. The thesis itself and/or a summary of it will be published. A copy of it will be displayed in the library of City University and it will also be available at the internet. An electronic copy of the thesis will be sent to you, if you want one.

Confidentiality

Every effort will be made to ensure that confidentiality will be maintained in all research stages. All tapes will be anonymised and then transcribed using a Transcription Service adhering to a strict confidentiality policy. Transcripts will be given a reference number to protect the participants' identity and an electronic copy will be sent to you for transparency reasons. The location and name of the agencies from which the participants will be recruited will also remain anonymous.

The researcher will keep tapes, all data and notes in a secure location – a locked filling cabinet in her home - away from unauthorized usage. Anonymised tapes and transcripts might be heard by or be shown to the supervisor(s) of the researcher and the examiners of the module. Personal data, sensitive personal data and direct anonymised quotations from the interview may be used at the thesis and/or publications of it. Audio recordings, transcripts, Participant Consent Forms and notes will be retained and disposed all in accordance with the requirements of the Data Protection Act (City University, 2010). Information that links transcripts to names will be kept until the data are fully analysed, and then the information will be destroyed. The transcripts will be kept until the project is examined and marked, and then all transcripts will be destroyed.

Confidentiality will be maintained but it is the researcher's responsibility, according to the British Psychological Society's (BPS) Code of Conducts and Ethics, to report any disclosure of practice that might be considered as ethically questionable. The researcher also has the responsibility to report a participant's disclosure of serious intention to harm themselves or others. In such a case the researcher will first discuss the disclosure with the participant, then with her research supervisor(s) and lastly she will consider reporting the disclosure to the appropriate professional body and/or person. The researcher will inform the participants, in advance, about both the limits of confidentiality and the procedure she will follow before making the decision to report any disclosure.

Debriefing

Participating in this research is entirely voluntary. It is hoped that you will find your participation rewarding as you will explore your thoughts and experiences in this area of practice. It is also hoped that the study will contribute to the body of the literature in this important area of work.

It is possible, your participation to evoke feelings of distress and lead you to reflect on your practice. You have the right to decline to answer a question and stop the interview and/or take a break at any time. You also have the right to withdraw from the research at any stage up to the analysis of the data, without giving any reason and without having any implications. If you feel concerned by issues raised in the interview, time will be set aside at the end of the interview to offer advice and support. In case you feel troubled by your participation in the study, I will remind you of the sources of support to turn to to further address your concerns.

These would be your professional supervision, personal therapy and the professional body you are registered with.

Ethics clearance

This study has been reviewed by, and has received ethics clearance by the Research and Ethics Committee of the Department of Psychology of City University, London. The principal supervisor of this study is Dr Rosemary Rizq, who is based at Roehampton University, School of Human & Life Sciences, Whitelands College, Holybourne Avenue, London, SW15 4JD. She can be contacted at: [redacted] and/or on [redacted]. Please feel free to contact her, if you have any concerns about the way this study has been conducted.

University complaints procedure

If you would like to complain about any aspect of the study, City University, London, has established a complaints procedure via the Secretary to Senate Research Ethics Committee. To complain about the study, you need to phone [redacted], ask to speak to the Secretary to Senate Research Ethics Committee, inform her about the name of the project "An exploration of how therapists experience their clients' erotic feelings for them" and express your complaints.

You could also write to the Secretary at:
Anna Ramberg - Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London, EC1V 0HB
Email: [redacted]

Comments, concerns or observations procedure

This project has been approved by the Research and Ethics Committee of the Department of Psychology of City University, London (project approval number PSYETH 11/12 011). If you have any comments, concerns or observations about the conduct of the study or your experience as a participant, please contact the Secretary to the Committee, Mr Peter Aggar, quoting the above project approval number.

Telephone: [redacted]
Email: [redacted]

Postal Address:
Mr Peter Aggar - Secretary to Psychology Department Research and Ethics Committee
School Office
Schools of Arts and Social Sciences
City University London
Northampton Square
London, EC1V 0HB

If you would like to participate in this study please e-mail the researcher Venetia Kotaki at: [redacted] and/or call her on [redacted].

Venetia Kotaki, Counselling Psychologist – DPsych Candidate

Appendix 2: Advertisement of the Research Project

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Advertisement of the research project

Has your client ever expressed erotic feelings for you?

I am recruiting therapists to explore how they experience and process their clients' erotic feelings for them. If this is something you have come across I would very much like to hear from you.

Participants should have a minimum of 5 years of post qualification experience, may come from any discipline and work with any model. They also may practice either privately or in an organisation (voluntary or statutory).

Interviews will last 60 minutes and 15 minutes of debrief will follow. This research is undertaken as part of the Doctorate in Psychology (DPsych) - Post Chartered ('Top Up') course, which I currently attend at City University, London.

University complaints procedure

If you would like to complain about any aspect of the study, City University, London, has established a complaints procedure via the Secretary to Senate Research Ethics Committee. To complain about the study, you need to phone [redacted] ask to speak to the Secretary to Senate Research Ethics Committee, inform her about the name of the project "An exploration of how therapists experience their clients' erotic feelings for them" and express your complaints.

You could also write to the Secretary at:
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Telephone: [redacted]
Email: [redacted]

Postal Address:
Mr Peter Aggar - Secretary to Psychology Department Research and Ethics Committee
School Office
Schools of Arts and Social Sciences
City University London
Northampton Square
London, EC1V 0HB

Should you need more information or if you are interested in participating, please e-mail me at [redacted] and/or call me on [redacted]. I will then send you a copy of the Participant Information Form to give you a more detailed picture of the project.

Appendix 3: Interview Schedule

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Interview Schedule

Note: The main interview questions are four (in bold) and they all are open questions. Opening to the interview questions, such as how they came to the field and what their interest in the subject is, will be asked to help participants to relax and to get introduced to the interview. Additional questions will probably be used as probes to encourage the participants to explore their experiences.

1. **Tell me something about your experience (when, how etc).**

2. **How does it feel like to you when a client expresses erotic feelings for you?**

- What are your thoughts and responses to the client?
- What is the meaning of the experience to you?

3. **What is the impact of the experience on you?**

- How do you understand/explain the experience?
- What are the challenges and dilemmas you encounter?

4. **What is the impact of the experience on the therapeutic relationship and work with the client?**

- What would it happen if you crossed the boundaries? (reflect on possible scenario).
- Where do you turn to to ask for guidance and support?

Appendix 4: Participant Consent Form

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Northampton Square
London
EC1V 0HB

PSYETH

Participant Consent Form

"An exploration of how therapists experience their clients' erotic feelings for them."

Statement

1. ☐ I confirm that I have read and understood the Participant Information Sheet about the research and that I have had the opportunity to ask questions.
2. ☐ I consent to my personal data (gender, age, family situation, years of post qualification experience, model of work, type of practice and UK location) to be used for this research project.
3. ☐ I consent to my sensitive personal data (sexual orientation) to be used for this research project.
4. ☐ I understand that my participation is voluntary and that I am free to withdraw from the study at any stage up to the analysis of the data, without giving any reason and without my decision affecting me in any way. In this case, the researcher will immediately destroy all collected personal data, audio recordings and transcripts related to me and any forms I have signed.
5. ☐ I understand that the researcher will stop using my data and will destroy them if their use causes substantial distress to me or others.
6. ☐ I agree for the interview to be audio recorded and transcribed.
7. ☐ I agree the interview to be transcribed by a Transcription Service.
8. ☐ I understand that the information I will provide will be treated in confidence and all tapes and transcripts will be anonymised to protect my identity.
9. ☐ I understand that anonymised tapes and transcripts might be heard by or be shown to the supervisor(s) of the researcher and the examiners of the module.

10. ☐ I understand that confidentiality will be maintained but it is the researcher's responsibility, according to the British Psychological Society's (BPS) Code of Conducts and Ethics, to report any disclosure of practice that might be considered as ethically questionable, as well as any disclosure of serious intention to harm myself and/or others. In such a case, the researcher will first discuss the disclosure with me, then with her research supervisor(s) and lastly she will consider reporting the disclosure to the appropriate professional body and/or person.

11. ☐ I understand that a copy of the thesis will be displayed in the library of City University.

12. ☐ I understand that a copy of the thesis will be available at the internet.

13. ☐ I understand that the produced thesis and/or a summary/part of it will be published.

14. ☐ I agree for direct anonymised quotations from the interview to be used at the thesis and/or publications of it.

15. ☐ I confirm that the researcher has provided me with an identical copy of this form to sign and retain for my records.

16. ☐ I agree to take part in the above research project.

Comments, concerns or observations procedure

This project has been approved by the Research and Ethics Committee of the Department of Psychology of City University, London (project approval number PSYETH 11/12 011). If you have any comments, concerns or observations about the conduct of the study or your experience as a participant, please contact the Secretary to the Committee, Mr Peter Aggar, quoting the above project approval number.

Telephone: [redacted]
Email: [redacted]

Postal Address:
Mr Peter Aggar - Secretary to Psychology Department Research and Ethics Committee
School Office
Schools of Arts and Social Sciences
City University London
Northampton Square
London, EC1V 0HB

Participant's full name:

Participant's signature:

Date:

Appendix 5: Debriefing Information Form

School of Social Sciences **PSYETH**
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London
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Debriefing Information Form

I would like to thank you for participating in the study. Your contribution is highly valued. Please use this time to ask questions and discuss your experience of being interviewed, as well as any concerns you may have. Please note that if you want to ask any questions or raise any concerns after the interview session, you may contact me at: [redacted] and/or call me on [redacted]. You may also contact my supervisor Dr Rosemary Rizq at: [redacted] and/or on [redacted]

If you have experienced distress related to any issues discussed at the interview, please remember that a range of sources of support are available to you such as your supervisor, personal therapist and the professional body you are registered with.

The collected data will be analysed using Grounded Theory and the results will be presented in a written thesis. The thesis itself and/or a summary of it will be published. A copy of it will be displayed in the library of City University and it will also be available at the internet. An electronic copy of the thesis will be sent to you, if you want one.

University complaints procedure

If you would like to complain about any aspect of the study, City University, London, has established a complaints procedure via the Secretary to Senate Research Ethics Committee. To complain about the study, you need to phone [redacted], ask to speak to the Secretary to Senate Research Ethics Committee, inform her about the name of the project "An exploration of how therapists experience their clients' erotic feelings for them" and express your complaints.

You could also write to the Secretary at:
Anna Ramberg - Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London, EC1V 0HB
Email: [redacted]

Comments, concerns or observations procedure

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Telephone: [redacted]
Email: [redacted]

Postal Address:
Mr Peter Aggar - Secretary to Psychology Department Research and Ethics Committee
School Office
Schools of Arts and Social Sciences
City University London
Northampton Square
London, EC1V 0HB

Appendix 6: Phase 2 - Generating initial codes

Example – An extract from Claire's interview

Initial Codes	Transcript (raw material)	Line
	Could you tell me a bit more about what it is that makes you to respond to the erotic the way you do? Earlier you mentioned the client's personality and the client's problems.	
Disclosing a personal factor that affects how she responds to the erotic: the importance of being in a good personal relationship. Feeling comfortable enough to confide in about the impact of feeling happy and content on (1) her sexuality and (2) ability to work with the erotic. Introducing the role of therapists doing personal work on the subject of the erotic. Trusting me enough to tell me about the fears she has worked on and got over. Expressing her interest in and position towards the erotic.	I think that it's much easier now that I'm in a very good personal relationship. I got married recently. We've been together for (number) years. And I noticed in the last (number) years I'm much more confident in my own sexuality in myself and I'm much more able to work with other people. And it feels like I've done an awful lot of work on my own process and my own self over the last (number) years that means I'm a lot less scared of men. I'm a lot less scared of anger. I'm a lot less scared of physicality. I'm a lot less scared of sex. A lot less scared of my own sexuality. This is an area that I'm interested in and feel empowered in. And so that feels like a really good resource for me to then work with clients.	667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683
	So one of the factors you identify is the work you have done with yourself. Is this through supervision and therapy?	
Clarifying for me.	Supervision and therapy workshops.	684
	The other factor you identify is that you are in a stable relationship and you feel confident, secure and safe.	
Feeling personally fulfilled seems to reduce the risk of therapists getting lost in the erotic.	And so that my needs are met. Because I think what's really important if someone isn't in an on-going, well isn't in a relationship where they feel that they're fulfilled, then it's much easier for that stuff to spill out with clients and to get lost in the erotic charge.	685 686 687 688 689 690
	More vulnerable?	
Accepting my interpretation.	More vulnerable. That's a very good way of putting it.	691 692
	Earlier, you mentioned the role of regulatory bodies contributing in therapists' perception of the erotic as a taboo. Did I understand well?	
Confirming and explaining her position. Touching in therapy is a taboo. Permission to touch a client comes with responsibility.	Yes, yes. I mean it's different between different regulatory bodies, but I know in some parts of the counselling and psychotherapy world just touching clients is incredibly taboo and it feels like within my line .. in my area of practice there is quite a lot of permission. But I think that giving permission to touch clients also gives a lot of	693 694 695 696 697 698 699 700

The regulatory bodies seem to be concerned about touching.	responsibility and a lot of call to be very awake actually to erotic charge. And I think that there's this fear of "oh you touch a client and then where will it go? Basically it will end up in the client and therapist being in bed with each other".	701 702 703 704 705 706
	They are jumping in to conclusions.	
Accepting my interpretation. Feeling relaxed to laugh together.	Massively (laughter).	707

Appendix 7: Sample of memo

Memo 04/07/2012

The participants' experience and work with the erotic appears to link to the level of comfort they feel with sexuality and sex in general

In order to understand how the participants experience and work with the erotic in their practice, we have to look into ***how comfortable they feel with their sexuality, others' sexuality and sex in general****. Some participants seem to* ***feel fairly comfortable with their sexuality****. Bill (Int 2, ll 64-69), for example, says that he enjoys sex and that he feels comfortable with himself as a sexual being. It seems that most of those* ***participants who feel comfortable with their and others' sexuality have done a lot of work on these topics****. Bill (Int 2, ll 70-73), for instance, explains that his current comfort is the result of having worked on these areas in his* ***personal therapy*** *(including working with a therapist he felt attracted to). Claire (Int 3, ll 671-679) also reports that she has worked on the areas of her sexuality and sex* ***over a number of years****. As a result she now experiences (1) higher levels of confidence with both her own and others' sexuality and (2) lower levels of fear towards physicality and sex.*

Other participants appear to ***experience a sense of discomfort, even shame, towards their sexuality****. This seems to have a* ***negative impact on how they experience and handle the erotic*** *in the room. Eddie (Int 5, ll 285-291), for example, says that his own sexual shame and perception of sex as a means of 'manipulation' and 'power' makes him feel ashamed for feeling attracted to his clients.*

Lastly, other participants appear to ***be uncertain about the meaning and use of sex and sexuality*** *which, in most cases, seems to be* ***the result of past personal sexual experiences;*** *therefore, they currently explore their sexual identity and views and feelings towards sex. Julia (Int 10, ll 610-633), for instance, is currently in therapy exploring (1) her sexual identity and (2) the impact of her personal sexual experiences on her work with the erotic (e.g. being enamoured by a client).*

Appendix 8: Email I sent to participants asking for their feedback on the results of the study (member checking)

from: Venetia Kotaki [redacted]

to: [redacted]

date: [redacted]

subject: Re: Feedback request on the results of the study 'How do therapists experience erotic feelings in therapy?'

Dear (participant's name),

I hope my email finds you well.

You may remember that some time ago you participated in a study exploring how therapists experience erotic feelings in therapy.

Within the context of evaluating a study, researchers use a variety of techniques to check the credibility of the results of their study. Members' checking is a very popular technique that does this and one of the techniques I use for the evaluation of my project too. Although the findings of the study (please see attached report) are based on the accounts of all participants it is hoped that you can see aspects of your experience in these. The attached report is part of the thesis.

- Could you please read the report and give me a brief feedback on it as well as a suggestion on one area you recommend I highlight when reporting the results?

Please note that the deadline for your feedback is in two weeks time.

Please also note that in a week's time I will send you a reminder about the deadline.

Lastly, please note that if I don't hear from you by the end of the deadline I will assume that you have no comments to make.

As agreed, when the thesis is submitted and marked, I will send you an electronic copy of the thesis unless you advise me differently.

Once again, thank you very much for participating in my study. It has been a long but rewarding journey. I hope you enjoy reading the results. Also, thank you in advance for taking the time to read this email and attached report.

I am looking forward to hearing from you.

Kind regards
Venetia Kotaki - Counselling Psychologist
Tel: [redacted]

Appendix 9: Member checking - Participants' feedback on the results of the study

Response 1

from: [redacted]

to: Venetia Kotaki [redacted]

date: [redacted]

subject: Re: Feedback request on the results of the study 'How do therapists experience erotic feelings in therapy?'

Hello Venetia

Thank you for sending me a copy of your brief account of your findings. I found your results highly credible – both in that I could see aspects that fitted with my own experience, but I also found that a variety of different positions and experiences were represented. Your report seemed like a very effective portrait of the wide variety of positions and concerns presented by the many junior practitioners I have supervised.

I appreciated you mentioning the importance of peer consultation groups and the difficulty of approaching a supervisor senior to us.

I also appreciated you mentioning social norms. Whatever ease I have about discussing the erotic with clients must be at least partly informed by my experience as a gay man, and a certain familiarity with voicing material that others might position as transgressive.

You've described so many issues well, that it seems difficult to pick one out for further examination. However, what stands out to me is the hindering effect of the regulation of clinical practice on discussion of the erotic. Relations within the consulting room seem to be becoming increasingly regulated and sanitised – much like outside the consulting room. I also think that an important part of clinical work is making space for what cannot be thought about or spoken about elsewhere. By definition that material will at times be disconcerting in the ears of a third party. If the content of the consulting room becomes so regulated that it is no longer disconcerting, then an important part of the work has probably been lost.

I hope you get a positive response to your research - you must be looking forward to finally being finished.
Kind Regards.

[redacted]

Response 2

from: [redacted]

to: Venetia Kotaki [redacted]

date: [redacted]

subject: Re: Feedback request on the results of the study 'How do therapists experience erotic feelings in therapy?'

Hi Venetia,

Thank you for your email. All the best with you submission.

As therapists, I believe this to be a area that we lack support and understanding. This may be due to a number of factors, like culture beliefs, lack of training, as well as or own discomfort of talking about our sexuality.

On a more personal level I would like to stress points 3, and 4: (3) fear of punishment, and (4) infliction of disciplinary measures to control therapists' practice have a derogatory impact on therapy.

The judgement and lack of support from accredited bodies or supervision is a grave concern, which creates secrecy and shame for the therapist. I believe that therapists are so afraid of being sued or judged we avoid and retreat from this area of discussion. One last thing, let's not forget about our own shame.. which may be triggered or activated by the clients' transference or counter-transference experience.

Kind Regards

Response 3

from:

to: Venetia Kotaki

date:

subject: Re: Feedback request on the results of the study 'How do therapists experience erotic feelings in therapy?'

Dear Venetia

Thank you for sending this report. I have read it with great interest. Overall I am very happy with what you have written. I will provide a few comments.

1. Lack of clarity

Clients do not always talk about their erotic attachment to their therapists - probably for fear of embarrassment, rejection or humiliation. As a result I have sometimes had a strong sense that a client had erotic feelings about me which have not been put into words. This makes it even more difficult to discuss / process this erotic transference. Will the client think I am being inappropriate if I allude to the possibility of erotic transference?

2. What do the words transference and counter-transference actually mean?

We use these words all the time but I have seen vastly different definitions. For some they seem to mean that the feelings are not "real or current" but are replays of old feelings - for our parents - brought out by the nature of the therapy relationship. For others any feelings that exist between client and therapist are defined as transference and counter-transference, including those feelings that may not be repetitions.

3. Difficulties in raising the erotic in supervision

I like your discussion of the ways in which British Culture, the U.K. therapy organisations and the quality of supervision can lead therapists to avoid raising the erotic in supervision which may increase the risk of unprofessional conduct.

4. Hiding behind theory

I also like your discussion of how we can use theory as a way to hide from the immediacy of erotic feelings.

5. The two faces of the erotic

In your table at the end you mention the two faces of the erotic. As you say in the text, the possibility that the erotic can be constructive or destructive is more about how we handle the erotic when it appears. If we can tolerate our fears and process the erotic as part of the material present in the relationship then the erotic is more likely to be constructive rather than destructive, though it is still possible that the client's fear of the erotic or fear of a possible rejection or humiliation can lead make the erotic destructive despite the best efforts of the therapist.

I do hope this is helpful to you.
All the best for your final paper.
I look forward to reading it.

SECTION D: Critical literature review

How do therapists approach nonsexual dual relationships with current and former clients?

1. Introduction

Nonsexual dual relationships form the basis of a long-lasting debate within the professional community. The aim of the present review is to critically examine how therapists approach nonsexual dual relationships with current and former clients. The objectives of the review are to explore therapists' beliefs and behaviours on the subject and discuss the implications for practice. Although various forms of dual relationships are discussed in the literature (e.g. dual relationships between professors and students or supervisors and supervisees), this review focuses on how therapists approach nonsexual dual relationships with their clients. In this review, the terms 'dual' and 'multiple' relationships are used interchangeably. Additionally, the term 'therapists' is reserved primarily for psychologists, whereas the term 'clients' refers to those who are over 18 years old and receive psychological services.

2. The present review

Therapists are frequently called to handle numerous dilemmas during their career. A dilemma that many seem to encounter in their practice concerns their engagement in dual relationships with current and former clients (Borys & Pope, 1989; Gottlieb, 1993; Kitchener, 1988; Koocher & Keith-Spiegel, 1998; Pope & Vetter, 1992). Dual relationships in therapy have been receiving increasing attention in the literature over the last few decades. The majority of studies have been conducted in the United States of America, whereas the subject has received less attention in the United Kingdom. Initially, studies focused on sexual dual relationships, mostly between therapists and clients. A large number of studies explored the conceptualisation of attraction (Bridges, 1994; Dujovne, 1983; Freud,

1915/1963 as cited in Pope, Sonne & Holroyd, 2000; Kumin, 1985; Mann, 1997, 1999; McDougall, 1995; Natterson, 2003; Orbach, 1999; Rappaport, 1956; Wrye & Welles, 1994), therapists' failures to comply with boundaries and frequencies of sexual misconduct (Borys & Pope, 1989; Holroyd & Bouhoutsos, 1985; Holroyd & Brodsky, 1977; Pope, Keith-Spiegel & Tabachnick, 1986; Rodolfa, Hall, Holms, Davena, Komatz, Antunez & Hall, 1994), impact of sexual intimacy on clients' wellbeing (Bouhoutsos, Holroyd, Lerman, Forer & Greenberg, 1983; Butler & Zelen, 1977; Holroyd & Bouhoutsos, 1985; Pope, 1990; Taylor & Wagner, 1976; Wincze, Richards, Parsons & Bailey, 1996), and therapists' rehabilitation measures following sexual misconduct (Gottlieb, Hampton & Sell, 1995; Pope, 1990).

It was not until the 1980s that authors started studying and writing about nonsexual dual relationships. Most studies focused on measuring and reporting practitioners' beliefs and behaviours on the subject (Akamatsu, 1988; Anderson & Kitchener, 1996; Baer & Murdock, 1995; Borys & Pope, 1989; Gibson & Pope, 1993; Holroyd & Brodsky, 1977; Kitson & Sperlinger, 2007; Lamb, Catanzaro & Moorman, 2004; Lamb, Woodburn, Lewis, Strand, Buchko & Kang, 1994; Nigro, 2004; Pope, Tabachnick & Keith-Spiegel, 1987; Salisbury & Kinnier, 1996). Additionally, a substantial number of studies focused on assessing and managing the risks involved in dual relationships using ethical decision-making models (Anderson & Kitchener, 1998; Gottlieb, 1993; Haas & Malouf, 1989; Kitchener, 1988; Younggren & Gottlieb, 2004). Lastly, several papers focused on the theoretical analysis of dual relationships (Backlar, 1996; Corey, Corey & Callanan, 2003; Haas & Malouf, 1989; Herlihy & Corey, 1992; Herr, 1999; Kitchener, 1988; Koocher & Keith-Spiegel, 1998; Lazarus, 1994; Moleski & Kiselica, 2005; Pedersen, 1997; Schank & Skovholt, 1997; Smith & Fitzpatrick, 1995; Sonne, 1994).

Nonsexual dual relationships between therapists and clients are not prohibited. However, both American and British codes of ethics warn therapists to avoid them when possible to avoid a risk of harm (American Psychological Association, 1992; British Psychological Society, 2001) (Appendix 1). At the same time, they provide therapists with little or no guidance on how to address the situation in a practical manner. Little or no training on this subject (Borys & Pope, 1989; Gibson & Pope, 1993) seems to add to the problem. It is within this context that therapists are expected to assimilate their understanding of the codes with sound professional judgement to make a decision on how to handle nonsexual dual relationships in their practice (Gibson & Pope, 1993; Moleski & Kiselica, 2005). Given the impact that nonsexual dual relationships can have on clients and therapists, it is vital that we examine therapists' approaches towards these and discuss the implications for clinical practice.

2.1 The question

This review aims to critically examine how therapists approach nonsexual dual relationships with current and former clients.

2.2 Methods

The search for sources consisted of two parts. The first part of the search was based on using a wide range of electronic and published sources. Some of the key words used in the search were 'therapists', 'psychologists', 'counsellors', 'clients', 'patients', 'dual relationships', 'multiple relationships', 'therapeutic', 'ethics', 'boundaries', 'beliefs', and 'behaviours'. The second part of the search was based on examining the lists of references included in the originally identified sources. The criterion set for the selection of the sources reviewed for the study was their attempt to answer the specific question. Sources that focused exclusively on nonsexual dual relationships between tutors and students or between supervisors and supervisees were excluded.

3. Results

Through the screening and eligibility process, 69 articles, books, electronic sources and research studies were included in the review. This literature review on how therapists approach nonsexual dual relationships with current and former clients revealed three areas of concern. The first related to the identification of dual relationships in practice. The second referred to the diversity of the existing beliefs and behaviours on the subject. The third linked to the process of making an ethical decision on how to address nonsexual dual relationships in their day-to-day practice. Each of these areas are described and critiqued.

3.1 Identifying dual relationships

3.1.1 Defining dual relationships

The definitions provided by the APA (APA, 2002) and the BPS (BPS, 2001) are included in Appendix 2. Malley and Reilly (1999) and Herlihy and Remley (2001) support that a dual relationship exists when therapists have, in addition to the professional relationship, some other relationship with their clients: professional or personal. Corey et al. (2003) advocate that a dual or multiple relationship exists whenever practitioners have other relationships with their clients, whether professional or non-professional, in addition or in succession to the therapeutic relationship. Pope (1991) argues that a dual relationship occurs when therapists engage in another, notably different relationship with their clients. The two relationships may be concurrent or sequential. Despite the similarities in definitions, the most complete definition appears to be offered by Corey et al. (2003), as it refers both to the types and nature of dual relationships.

3.1.2 Recognising dual relationships

According to Kitson and Sperlinger (2007), although dual relationships seem fairly easy to define, it appears that therapists find it difficult to recognise them in practice. This could be attributed to the relative simplicity and abstraction of the existing definitions (Kitson & Sperlinger, 2007). Seven sources explore the nature and types of dual relationships, whereas one also reflects on the therapist–client level of involvement. The sources offer clarity, increasing therapists' chances of recognising dual relationships in practice.

Pope (1991), Sonne (1994) and Zur (2014) argue that dual relationships can be either concurrent (if they develop at the same time with the therapeutic relationship) or sequential (if the secondary relationship develops after the therapeutic relationship has ended). Moleski and Kiselica (2005) advocate that dual relationships may develop by choice or by chance. Zur (2014) supports that, when therapists and clients are engaged in dual relationships, their level of involvement can be low, medium or intense depending on the frequency and type of their interaction. According to Zur (2014), the level of involvement is low when therapists meet their clients by chance, whereas it is medium when therapists and clients meet occasionally. Furthermore, the level of involvement is evaluated as intense when therapists and clients work together, are part of the same group, or socialise regularly.

Typically, dual relationships are classified as either sexual or nonsexual (Moleski & Kiselica, 2005; Pope, 1991). The term 'sexual' refers to a variety of both overt and covert sexual behaviours. Coleman and Schaefer (1986) describe several explicit and implicit behaviours that constitute a sexual relationship. Explicit sexual behaviours include practices such as kissing passionately, fondling, making sexual comments and remarks, having sexual intercourse, performing oral or anal sex, and carrying out sexual penetration with objects. Implicit sexual behaviours include practices such as giving sexual gazes, giving sexual hugs, seducing through dressing or gestures, paying over attention to clients' appearances and asking sexual questions aimed to serve their curiosity as opposed to the work.

The term ‘nonsexual’ refers to the formation of a dual relationship other than sexual. Nigro (2004) reports eight types of nonsexual dual relationships between therapists and current clients. These are circumstantial encounters, professional dual relationships, workplace related relationships, business/financial dual relationships, client overlap incidences, social dual relationships, familial dual relationships and cases of incidental boundary crossings. Anderson and Kitchener (1996) describe eight types of nonsexual dual relationships that therapists may have with former clients. These are personal or friendships, social interactions and events, business or financial, collegial or professional, supervisory or evaluative, religious affiliation, collegial or professional plus social, and workplace relationships.

3.2 Existing beliefs and behaviours towards nonsexual dual relationships – Psychological and research literature

The authors who write on the subject appear to have diverse beliefs on how therapists should approach nonsexual dual relationships with current and former clients. Some writers advocate that dual relationships can complement therapy. Others support that they are highly problematic and should be avoided. A third group of writers suggests that dual relationships can range from positive to negative. These three positions are described and critiqued below.

Many authors (Corey et al., 2003; Herlihy & Corey, 1992; Kiselica, 2001 as cited in Moleski & Kiselica, 2005; Koocher & Keith-Spiegel, 1998; Lazarus, 1994; Pedersen, 1997; Schank & Skovholt, 1997; Smith & Fitzpatrick, 1995) support that nonsexual dual relationships can complement, enrich and assist the therapeutic work and outcome regardless of setting and clinical population. Herlihy and Corey (1992) describe several cases where therapists who work in small and rural communities need to assume multiple roles to serve the community effectively. Schank and Skovholt’s (1997) study, conducted on the ethical dilemmas encountered by 16 psychologists who practised in rural communities, found that the psychologists who got

involved with the community were perceived with trust. On the other hand, those who maintained the boundaries inflexibly emphasised the power differential between the inhabitants and themselves and were perceived with suspicion. In light of these findings, therapists' denial to engage in a dual relationship could potentially prevent people who are in need of therapy to ask for help.

Pedersen (1997) supports that the formation of dual relationships is a practice observed in the field of cross-cultural counselling as well. He explains that, in some cultures, people do not share their problems with strangers, let alone ask for their help to handle them. In this case, the formation of a dual relationship can facilitate the sense of familiarity required for trust and connection to develop and, hence, therapy to be provided (Pedersen, 1997). This highlights the significance of therapists respecting their clients' cultural background and adjusting the way in which they practise in order to connect and have the chance to work with them therapeutically (Herr, 1999; Pedersen, 1997).

Apart from the aforesaid social and cultural reasons, there are also cases where therapists may need to cross the boundaries for therapeutic purposes. In 2001, Kiselica (Kiselica, 2001 as cited in Moleski & Kiselica, 2005) prompted therapists who worked with adolescent boys to re-examine their boundaries regarding dual relationships. He argued that therapists should be prepared to meet their clients in less formal settings than the therapeutic room as a means of communicating acceptance, building rapport and enhancing the therapeutic relationship. He also argued that, when appropriate, therapists should disclose something about themselves as a means of building trust and modelling openness. In light of these arguments, dual relationships could strengthen the therapeutic relationship and support the work.

Other writers argue that all dual relationships should be strictly avoided. Kitchener (1988), for example, supports that all dual relationships are likely to become ethically problematic. Consequently, she stands by the position of therapists setting firm boundaries and avoiding engaging in dual relationships. Sonne (1994) argues that all dual relationships undermine the fiduciary relationship that therapists have with their clients. She stresses that some therapists may not hesitate to place their own interest above their clients', betray their trust and compromise their wellbeing. For this reason, she also stands by the position of therapists avoiding any type of dual relationship.

Pope (1991) supports that dual relationships have the potential to erode the nature of the therapeutic relationship, cause conflicts of interest, impair the objectivity of therapists, increase clients' vulnerability to therapists' suggestions due to the power imbalance, and interfere with the cognitive processes essential for clients to maintain the benefits of therapy following termination. Subsequently, he warns therapists against any type of dual relationship. To finish, Pope et al. (1986) draw attention to the notion that post-therapy relationships may disrupt the healthy resolution of transference, having a negative impact on former clients.

Although nonsexual dual relationships involve a risk for harm mostly for clients, therapists may be at risk for harm as well. Moleski and Kiselica (2005) mention, as an example, therapists who recover from alcohol abuse and attend the same Alcoholics Anonymous (AA) meetings with their clients. In this occasion, the therapist–client secondary relationship is likely to jeopardise not only the therapeutic work, but also the therapist's recovery, career and right to anonymity.

A third group of writers supports that dual relationships can vary from unhelpful to helpful depending on their type, aim, benefits and risks. Moleski and Kiselica (2005) advocate that dual relationships can range from destructive to therapeutic as they have the potential to either sabotage or aid the therapeutic relationship. Backlar (1996) holds a similar view to Moleski and Kiselica's (2005) and argues that dual relationships can range from

involving a high risk for harm to comprising a low risk for harm. Lazarus (1994) suggests that, although nonsexual dual relationships include the potential for some harm, they do not always cause harm. Lastly, Koocher and Keith-Spiegel (1998) point out that not all dual relationships can always be avoided in practice, despite the codes' warning against them.

The research literature reflects the diversity of opinions that seems to exist on the subject. In the context of this review, nine research papers were reviewed. Some of the most significant findings of these studies are presented below. It must be noted that the majority of studies include questions about both sexual and nonsexual dual relationships. Although therapists' approaches to sexual dual relationships are out of the scope of this review, it is worth briefly mentioning some of these results, as they may be of interest. Studies are presented in chronological order.

Pope et al. (1987) sent a survey to 1,000 psychologists (500 male and 500 female) who were randomly selected. The primary aim of the survey was to explore the beliefs and behaviours of psychologists towards 83 listed behaviours. A total of 456 (45.6%) questionnaires were returned and analysed. For 7 of the 83 behaviours, at least 90% of the respondents indicated that they had engaged in them, at least on rare occasions. Two of these almost universal behaviours involved self-disclosure 'Using self-disclosure as a therapy technique' and 'Telling a client that you are angry at him or her'. These findings indicate that the therapist attitude of 'blank screen' appears to be a rare practice among the respondents of the study.

The behaviours that at least 20% of the respondents answered 'don't know/not sure' were defined by Pope et al. (1987) as difficult to judge. There were 12 behaviours that the respondents found hard to evaluate in terms of ethicality. Some of these behaviours were about 'Accepting goods (rather than money) as payment', 'Sending holiday greeting cards to your clients', 'Engaging in sexual fantasy about a client', 'Inviting clients to an office open house' and 'Allowing a client to run up a large unpaid bill'. These findings suggest that the respondents are uncertain of the ethicality of financial, social, and sexual dual relationships.

In his survey, Akamatsu (1988) mailed a questionnaire to 1,000 APA members of the Psychotherapy Division who were randomly selected. The survey aimed to obtain information about practitioners' attitudes and behaviours in reference to sexually intimate relationships with former clients, but items about nonsexual dual relationships were also included. A total of 395 (39.5%) usable questionnaires were returned and analysed. Among respondents, 44.7% said that post-therapy intimate relationships were highly unethical, 23.9% believed that they were somewhat unethical, 22.9% expressed the view that they were neither ethical nor unethical and the remaining respondents said that they were somewhat or highly ethical. The main factor that determined the ethics of the situation was the time elapsed since termination. Eleven per cent admitted that they had been engaged in an intimate relationship with a former client, whereas 3.1% admitted that they had been involved in an intimate relationship with a current client.

Of the whole sample, 87.5% believed that some types of nonsexual dual relationships with former clients were ethical. Specifically, informal socialising, friendships and nonsexual close friendships were perceived as ethical by 75.1%, 57.2% and 36.6% respectively. Female respondents viewed the formation of nonsexual close friendships and friendships as less ethical than their male colleagues. The findings show that the respondents have divergent opinions on the subject of ethics of sexual dual relationships with former clients, whereas they seem to be clearer on the ethicality of nonsexual dual relationships e.g. social relationships. Divergence of opinions could be one of the reasons the ethics committees find it difficult to address the therapist–client sexual dual relationship phenomenon effectively.

Borys and Pope (1989) posted a survey to 4,800 psychologists, psychiatrists and social workers who were randomly selected. Of these, 2,400 were male and 2,400 were female. The main aim of the survey was to examine practitioners' attitudes and practices regarding dual professional relationships, social interactions, financial affairs and incidental encounters. A total of 2,332 questionnaires were returned, of which 2,133 were usable.

The majority of respondents rated five behaviours as never ethical. Most stated that they had rarely or never been involved in these behaviours. The behaviours rated as never ethical referred to ‘Sexual activity with a client before termination of therapy’ (98.3%), ‘Selling a product to a client’ (70.8%), ‘Sexual activity with a client after termination of therapy’ (68.4%), ‘Inviting clients to a personal party or social event’ (63.5%), and ‘Providing therapy to an employee’ (57.9%). More male participants than female were engaged in both sexual and nonsexual dual relationships, which is consistent with Gibson and Pope’s (1993) and Baer and Murdock’s (1995) findings.

Less than 10% rated the behaviours of ‘Accepting an invitation to a client’s special occasion’ (6.3%) and ‘Accepting a gift worth less than $10’ (3.0%) as never ethical. In addition, less than 10% were unsure about the extent to which any particular item was ethical. The results suggest that behaviours related to sexual involvements and behaviours that involve extra-fee financial arrangements with clients are seen as less ethical than behaviours related to incidental involvements, social relationships and special fee arrangements. The behaviours rated as the most frequently occurring were ‘Accepting a gift worth less than $10’ (82.5%) and ‘Providing concurrent individual therapy to a client’s partner’ (61.2%). The findings of this cross-disciplinary study indicate that training may be required to increase practitioners’ sensitivity to dual relationships.

In 1993, Gibson and Pope posted a survey to 1,024 randomly selected certified counsellors by the National Board for Certified Counsellors (NBCC). One of the primary aims of the survey was to explore counsellors’ beliefs about whether a range of 88 listed behaviours relevant to providing therapy were ethical. A total of 579 usable questionnaires were analysed. Twenty-one behaviours were judged as unethical by at least 90% of the respondents. About one fourth (24%) of these behaviours concerned sexual practices. ‘Engaging in erotic activity with a client’ (100%), ‘Engaging in sexual contact with a client’ (100%), ‘Disrobing in the presence of a client’ (100%), ‘Allowing a client to disrobe’ (98%), and ‘Engaging in sex with a clinical supervisee’ (98%) were overwhelmingly rated as unethical behaviours. Male respondents

were less conservative in their views about engaging in sexual relationships with clients than female respondents, which is in agreement with the findings of Borys and Pope (1989). Less experienced respondents were less certain of the ethicality of dual relationships. Other behaviours that were highly rated as unethical related to confidentiality ('Discussing a client by name with friends': 99%), competence ('Providing services outside areas of competence': 97%) and finances/business ('Going into business with a client': 91%).

Some behaviours were judged as controversial. In this study, controversial behaviours were defined as those at least 40% of respondents viewed as ethical and at least another 40% viewed as unethical. There were 12 behaviours that met this criterion. Forty-two per cent involved fees. Another 42% involved some type of nonsexual dual relationship. 'Providing counselling to one of your employees' (40%), 'Providing counselling to student or supervisee' (44%), 'Going into business with a former client' (46%), 'Inviting clients to an office open house' (54%), and 'Becoming social friends with a former client' (59%) were some of these behaviours. The findings suggest that respondents may have clear views of the ethicality of dual sexual relationships but they seem to lack consensus on the subject of the ethicality of professional, business and social dual relationships. Such controversy can have significant implications for training and practice.

Lamb et al. (1994) mailed a survey to 1,000 psychologists (500 clinical and 500 counselling) who were randomly selected. The primary aim of the survey was to examine psychologists' sexual and business relationships with former clients. A total of 348 questionnaires were returned, of which 327 were usable. Twenty-one respondents (6.5%) admitted that they had been involved in post-termination sexual relationships. Male respondents reported being involved in this type of relationship four times the rate of female respondents. The frequency of involvement ranged from once (70%) to 10 times (5%). Ninety-four respondents (29%) reported that they had been engaged in business relationships with former clients. Male respondents reported being involved in this type of dual relationship at a higher rate than

females. The frequency of incidence ranged from once (39%) to 3 times (11%).

The findings suggest that male are significantly more likely than females to get involved in post-termination sexual and business relationships, which is consistent with the findings of other studies (Akamatsu, 1988; Salisbury & Kinnier, 1996). In addition, those who were more experienced were also more likely to engage in post-termination relationships than those who were less experienced, which is in agreement with Salisbury and Kinnier's (1996) findings. The figure of 6.5% of respondents who got involved in post-termination sexual relationships differs from other available figures. In their studies, Salisbury and Kinnier (1996) and Akamatsu (1988) found a 4% and an 11% respectively. The difference in findings could be attributed to several factors e.g. the amount of time participants provide services per week or participants' professional speciality (Lamb et al., 1994).

Respondents rated post-termination sexual and business relationships as more inappropriate if they occurred immediately after termination, whereas rating decreased as time passed. They also rated practitioners' engagements in sexual relationships as significantly more inappropriate than their engagement in business relationships. The factor that mostly determined the appropriateness of these relationships was the time that passed since the termination of therapy, which is consistent with Akamatsu's (1988) findings.

Baer and Murdock (1995) sent a survey to 300 male and 300 female APA accredited psychologists who were randomly selected. The aim of the survey was to explore the roles of the therapist's gender, theoretical orientation, interpersonal boundaries and client's gender in predicting their judgements of the ethicality of nonsexual dual relationships with their clients. A total of 230 (38%) questionnaires were returned, of which 7 were not usable. Overall, respondents expressed the view that nonsexual dual relationships between therapists and clients are ethical in only limited circumstances at best. Respondents evaluated social/financial affairs with clients as the least ethical of the three subscales of dual relationships they were presented with. The

subscales included incidental, social/financial, and dual professional relationships. Respondents' lower scores for the ethicality of social/financial relationships suggest that respondents believed that these types of dual relationships involved a high risk for harm to clients.

Male respondents had a less conservative approach than female respondents towards dual relationships, which is in line with Borys and Pope's (1989) and Gibson and Pope's (1993) findings. Psychodynamically orientated respondents were more conservative than respondents from other approaches. Those who experienced low levels of stress endorsed nonsexual dual relationships as more ethical than those who experienced high levels of stress. This finding seems to be in conflict with researchers' predictions and theories. Overall, the results suggest that respondents' judgements of the ethicality of nonsexual dual relationships are influenced by their gender, theoretical orientation and capacity to manage interpersonal boundaries.

In 1996, Salisbury and Kinnier posted a survey to 100 male and 100 female counsellors who were members of the American Mental Health Counselor Association (AMHCA). The sample was randomly selected. The survey aimed to explore counsellors' behaviours and attitudes with reference to friendships and sexual relationships with former clients. Ninety-six questionnaires were returned, of which 80 were usable. Four per cent of the sample (two men and one woman) admitted that they had been involved in one or more post-therapy sexual relationships. The two male respondents reported that they had been engaged in many post-therapy friendships as well; 25 and over 50 respectively. On the other hand, the female respondent reported that she had been engaged in one post-therapy sexual relationship and one friendship. Thirty-three per cent stated that they had been engaged in post-therapy friendships once or twice. Most of these respondents (54%) were experienced practitioners having 11 or more years of professional experience. Less experienced respondents (12%) were less likely to form post-therapy friendships, which is consistent with Lamb et al.'s (1994) findings. A total of 70% of respondents expressed the view that a post-

therapy friendship with a client could be acceptable and 33% had the opinion that a sexual relationship could be acceptable as well. The average amount of time after termination before such a relationship would be considered acceptable was two years for friendships and five years for sexual relationships. Overall, the respondents were concerned about the probability of dual relationships causing harm to their client, the impact on their client's mental health, the ethical and legal consequences for themselves, the likelihood that counselling may be reactivated and the effect of counter-transference issues.

The findings show that only a small percentage (4%) of the sample was involved in one or more post-therapy sexual relationships. This falls on the low end of evaluations in comparison to Akamatsu's (1988) findings (11%). Respondents who had engaged in post-therapy friendships typically had engaged in one or two, with the exception of two male respondents who had become involved in numerous friendships. It would be interesting to explore these respondents' definitions of the term 'friendship' in addition to their beliefs regarding post-therapy friendships. More experienced respondents were more likely to engage in post-therapy friendships than were the less experienced, which is in line with Lamb et al.'s (1994) findings.

Lamb et al. (2004) posted a survey to 1,000 APA accredited psychologists (500 clinical and 500 counselling) randomly selected. The survey aimed to explore how psychologists identify, evaluate and proceed when confronted with possible dual relationships with their clients, supervisees or students. The findings presented here relate to the respondents' behaviours and rationales in relation to their clients only. Two hundred and ninety-eight (31%) questionnaires were returned and analysed. With respect to the frequency of discussing new relationships with current and former clients, respondents reported discussing social interactions most frequently (676 times), followed by collegial or professional relationships (301 times) and business or financial relationships (41 times). These new relationships were discussed with clients 664 times. The types of new relationships that were discussed more frequently with clients were social, business or financial, and

religious affiliation relationships. Discussions with former clients occurred more frequently (1,165 times) than with current clients (599). Social and religious affiliation relationships were the types of relationships most frequently discussed with current clients, whereas social, and collegial or professional relationships were most frequently discussed with former clients.

With reference to actions suggesting that a potential sexual relationship with a client was possible, 38% said that they thought of initiating a relationship but they did not pursue it, whereas 49% said that clients initiated a potentially sexual relationship but they were not interested. The respondents said that they considered a sexual relationship more often with current clients (68%) than with former clients (32%). With respect to the rationales that the respondents used to avoid engaging in a sexual relationship with a client, most of them reported personal ethics (89%) and perpetuity (65%).

The findings concerning nonsexual dual relationships indicate that engaging in social, business or financial, and religious affiliation relationships is a subject frequently discussed with clients. The findings relating to participants and clients considering or initiating a sexual relationship restate that sexual attraction is a common phenomenon in therapy (Bridges, 1994; deMayo, 1997; Dujovne, 1983; Hartl, Marino, Regev, Zeiss, R., Zeiss, A. & Leontis, 2007; Orbach, 1999; Phillips & Schneider, 1993; Pope, 1987; Pope et al., 1986; Pope et al., 2000; Pope & Tabachnick, 1993; Rodolfa et al., 1994; Shepard, 1971). Lastly, the findings concerning the reasons why respondents did not pursue a sexual relationship suggest that prohibitions may have some impact on their thinking, although prohibitions alone do not seem to be powerful enough to always prevent therapist–client sexual involvements.

Kitson and Sperlinger (2007) posted a survey to 1,000 BPS accredited clinical psychologists who were randomly selected. The survey aimed to examine the correlation between psychologists' attitudes towards dual relationships (sexual and nonsexual) and various characteristics such as (1) their training and (2) their supervision and years of work experience for comparison with the results of previous studies. A total of 434 questionnaires were returned, of which 424 (42.4%) were usable.

The vast majority of respondents believed that it was never professionally appropriate to 'Have a sexual relationship with a current client' (99.8%), 'Have dinner with a client in a quiet, romantic restaurant soon after the therapy work together had finished' (94.3%), and 'Have a sexual relationship with a client in the year after treatment has finished' (91.5%). These findings complement other research findings, indicating the existence of a consensus among respondents about the inappropriateness of sexual dual relationships (Borys & Pope, 1989; Gibson & Pope, 1993). Two behaviours that were also highly rated as never appropriate referred to professional dual relationships. 'Provide therapy to one of their friends' and 'Provide therapy to a current trainee clinical psychologist on placement in their agency' concentrated 78.5% and 66.7% respectively. Questions about business relationships ('Develop a business relationship with a former client': 39.7%) and social involvements ('Go to lunch with a client, soon after the course of therapy': 40.1%, 'Go to a client's special event': 40.5%, and 'Become friends with a former client': 47.8%) were rated as appropriate under limited conditions, which is in line with Baer and Murdock's (1995) findings. Female, young, recently qualified, psychodynamically orientated practitioners who worked in urban settings rated dual relationships as less appropriate than the rest of the respondents, which is in agreement with the findings of other studies (Baer & Murdock, 1995; Borys & Pope, 1989; Gibson & Pope, 1993). Generally, the results of this study are seemingly consistent with the results of other studies that explore dual relationships (Baer & Murdock, 1995; Borys & Pope, 1989; Gibson & Pope, 1993).

3.3 Making an ethical decision on how to address nonsexual dual relationships in practice

Due to (1) the lack of specific guidelines, (2) limited training, and (3) diversity of opinions on the subject, practitioners who face the challenge of dual relationships are required to balance their understanding of the ethical codes with their own values and life experiences. To assist therapists in this process, several authors have provided a set of guidelines and decision-making models. The present review includes five sources that describe some of these guidelines and models.

Rest (1983) suggests a four-component model that seems to cover the entire action process. Component I acknowledges an ethical situation is present. Component II examines the situation. Component III refers to choosing a course of action based on competing values. Component IV entails carrying out the chosen action. Woody (1990) advocates a five-dimensional model. The five dimensions are theories of ethics, codes of ethics, therapists' theoretical orientation, the current social and legal context, and therapists' personal/professional identity. Haas and Malouf (1989) propose a five-stage decision-making model. Every stage corresponds to a question that needs to be assessed and addressed. These are:

Stage 1: What are the relevant professional, legal or social standards?
Stage 2: What is the reason to diverge from the standards?
Stage 3: What are the ethical dimensions of the dilemma?
Stage 4: What are the possible courses of action, and what are the consequences of the chosen course for those involved?
Stage 5: Is the chosen course of action ethical and feasible to implement?

The first two models seem to cover all the stages in the therapist's process of making a decision. However, they offer general guidelines only. The third model is more specific, but it is still generic. Consequently, it does not offer therapists the level of assistance they may need.

Kitchener (1988) proposes a model that provides therapists with three guidelines aimed to enable them to differentiate between dual relationships that have high probability of causing harm to clients and those that do not. The model is based on Role Theory (Mead, 1934). The first guideline refers to the role of conflict and states that, as the incompatibility of expectations increases between roles, so will the likelihood for harm. The second guideline refers to the conflict of interest and loss of objectivity and argues that, as the obligations linked to different roles deviate, the likelihood for loss of objectivity and divided loyalties will increase as well. The third guideline refers to the power differential and clients' vulnerability; it suggests that, as the power and status between professionals' and clients' roles increase, so will the potential for exploitation. Kitchener's (1988) model appears to be simple and self-explanatory. What is important in this model is that it uses literature from the field of psychology to enable therapists understand (1) the complexity of the therapeutic relationship and (2) the risks involved in dual relationships. On the other hand, the model seems to pay a disproportionate amount of attention to potential risks, neglecting potential benefits.

The model that Younggren and Gottlieb (2004) suggest differs from the aforementioned models, as it takes the decision-making process from a theoretical and abstract level to a practical level. The questions included in this model focus on clients' and therapists' welfare and aim to address a number of key concerns. Furthermore, the model acknowledges therapists' personal and professional aspects, as both sides are involved in the decision-making process. The questions that the model proposes are the next five:

1. Is entering into a relationship in addition to the professional one necessary, or should I avoid it?
2. Can the dual relationship potentially cause harm to the patient?
3. If harm seems unlikely or avoidable, would the additional relationship prove beneficial?

4. Is there a risk that the dual relationship could disrupt the therapeutic relationship?
5. Can I evaluate this matter objectively (Younggren & Gottlieb, 2004, pp. 256–257)?

4. Discussion

The discussion presented here is mindful of space limitations. It aims to highlight some of the major patterns in therapists' approaches to the subject based on the reviewed literature. No attempt was made to provide an in-depth analysis of the complex ethical issue of therapist–client nonsexual dual relationships.

4.1 Discussing the findings

This review of the literature on how therapists approach nonsexual dual relationships with current and former clients unveiled three areas of concern for them. The first linked to the definition and recognition of dual relationships in practice. The second was about the diversity of existing opinions and behaviours on the subject. The third related to the process of making an ethical decision on how to address nonsexual dual relationships in their practice.

The review of the psychological literature showed that therapists seem to struggle to recognise dual relationships in practice (Kitson & Sperlinger, 2007). This could be explained by the simplicity of the existing definitions (Kitson & Sperlinger, 2007). Additionally, it could be also attributed to therapists receiving limited or no training on the subject (Borys & Pope, 1989; Gibson & Pope, 1993).

In addition, the review revealed that the authors who write on dual relationships appear to have diverse opinions on the subject. This is likely to cause confusion among therapists when considering the most appropriate way to approach nonsexual dual relationships with their clients. Some writers support that dual relationships can complement therapy (Corey et al., 2003; Herlihy & Corey, 1992; Kiselica, 2001 as cited in Moleski & Kiselica, 2005; Koocher & Keith-Spiegel, 1998; Lazarus, 1994; Pedersen, 1997; Schank & Skovholt, 1997; Smith & Fitzpatrick, 1995). These writers discuss examples where crossing the boundaries can facilitate and support the therapeutic work. Other writers advocate that dual relationships are highly problematic and therefore should be avoided (Kitchener, 1988; Pope, 1991; Pope et al., 1986; Sonne, 1994).These writers argue that roles, responsibilities and tasks must be clearly defined so therapists and clients know where the limits are. A third group of writers suggests that dual relationships can range from positive to negative (Backlar, 1996; Lazarus, 1994; Moleski & Kiselica, 2005). These writers acknowledge the potential risks involved in dual relationships but they do not believe that all dual relationships are meant to cause harm. Thus, they endorse the examination of each case in an individual basis.

Based on the review of the research literature, the majority of respondents seemed to agree that dual sexual relationships with former and current clients are unethical and/or inappropriate (Borys & Pope, 1989; Gibson & Pope, 1993; Kitson & Sperlinger, 2007; Lamb et al., 1994). This seems to be in conflict with Akamatsu's (1988) findings, as the respondents in his survey expressed divergent views on the subject of the ethics of sexual dual relationships with former clients. Divergence could partly explain ethics committees' difficulties in efficiently addressing therapist–client sexual involvements (Akamatsu, 1988).

In several studies, a small minority of respondents seemed to be open to the possibility of engaging in sexual relationships with clients under certain circumstances (Lamb et al., 1994; Salisbury & Kinnier, 1996). Most of these respondents were male. Male appeared to be less conservative than female respondents in terms of their beliefs and behaviours towards the possibility of engaging in sexual dual relationships with clients (Akamatsu, 1988; Borys & Pope, 1989; Gibson & Pope, 1993; Kitson & Sperlinger, 2007; Lamb et al., 1994).

The findings reaffirm that sexual attraction is a phenomenon that frequently appears in the context of therapy (Bridges, 1994; deMayo, 1997; Dujovne, 1983; Hartl et al., 2007; Orbach, 1999; Phillips & Schneider, 1993; Pope, 1987; Pope et al., 1986; Pope et al., 2000; Pope & Tabachnick, 1993; Rodolfa et al., 1994; Shepard, 1971). Therapist–client sexual involvements can have detrimental effects on clients, therapists, and the profession (Bouhoutsos et al., 1983; Butler & Zelen, 1977; Holroyd & Bouhoutsos, 1985; Pope, 1990; Pope et al., 2000; Taylor & Wagner, 1976; Wincze et al., 1996). Studies suggest that training (undergraduate and postgraduate) and regular supervision could support therapists in addressing this issue ethically and effectively (deMayo, 1997; Pope et al., 1986; Rodolfa et al., 1994; Smith & Fitzpatrick, 1995).

Nonsexual dual relationships seem to be a subject frequently encountered in therapy (Akamatsu, 1988; Borys & Pope, 1989; Gibson & Pope, 1993; Kitson & Sperlinger, 2007; Lamb et al., 2004; Lamb et al., 1994; Pope et al., 1987; Salisbury & Kinnier, 1996). Respondents' opinions and behaviours on the subject seem to be diverse. In Gibson and Pope's (1993) study, half of the identified as controversial behaviours related to professional, business and social dual relationships. Pope et al. (1987) found that behaviours related to financial, social and sexual dual relationships were perceived as difficult to judge in terms of their ethicality. Borys and Pope's (1989) study revealed that practices related to sexual involvements and practices involving extra-fee financial arrangements with clients were judged as less ethical than practices related to incidental involvements, social relationships and special fee

arrangements. Lastly, Baer and Murdock (1995) found that social/financial affairs with clients were evaluated as less ethical than incidental and dual professional relationships. Diversity of approaches can have significant implications for clinical practice.

The main factor that appeared to determine the ethicality and/or appropriateness of dual relationships was the time elapsed since the termination of treatment (Akamatsu, 1988; Lamb et al., 1994; Salisbury & Kinnier, 1996). Another factor seemed to be personal ethics. Respondents who had been engaged in sexual relationships with former clients were highly likely to evaluate nonsexual close friendships and friendships as ethical (Akamatsu, 1988). A third factor appeared to be the therapist's gender. Male respondents were more likely to engage in social affairs, business/financial relationships, and friendships than female respondents (Akamatsu, 1988; Baer & Murdock, 1995; Borys & Pope, 1989; Gibson & Pope, 1993; Kitson & Sperlinger, 2007; Lamb et al., 1994; Salisbury & Kinnier, 1996). Experience seemed to play a role as well. Less experienced respondents appeared to (1) be less certain of the ethicality of nonsexual dual relationships and (2) engage less frequently in these (Gibson & Pope, 1993; Kitson & Sperlinger, 2007; Salisbury & Kinnier, 1996). Lastly, Baer and Murdock (1995) found that respondents' gender, theoretical orientation and capacity to manage interpersonal boundaries played a role in their judgement of ethical nonsexual dual relationships. It seems that respondents' beliefs and behaviours regarding nonsexual dual relationships are influenced by a mixture of contextual, personal and professional factors, which could explain the diversity of approaches.

The review revealed that several authors have provided therapists with decision-making models aimed to enable them to make an ethical decision on how to practically address dual relationships in their daily practice. Kitchener's (1988) model uses literature from the field of psychology, which distinguishes it from other models. Younggren and Gottlieb's (2004) model takes the decision-making process from a theoretical to a practical level,

which makes possible for therapists to make a thoroughly analysed and well-grounded decision.

4.2 Methodological critique

During the searching and screening process followed for this review, no qualitative studies were identified. Thus, the studies reviewed for the purpose of this essay were quantitative. This means that the focus was on description, measurement (Patton, 1990) and data statistical analysis (Christensen, 2001; Patton, 1990; Yardley, 2008).

The research findings presented in this review should be interpreted with caution for several reasons. One of these reasons is the use of small samplings. The anonymity of respondents meant that, in several studies, follow-up procedures were not possible, which is likely to have compromised the return rate (Kitson & Sperlinger, 2007; Lamb et al., 1994). Some surveys were complex and lengthy (Baer & Murdock, 1995; Lamb et al., 1994), which possibly also affected the return rate. In addition, the request for providing sensitive information about behaviours that may be seen as debatable may also have played a part on the low return rate (Lamb et al., 1994).

Another reason that findings should be interpreted with caution is that studies used diverse sampling (psychologists, psychiatrists, social workers, counsellors). This makes it difficult to apply findings to all mental health practitioners (Gibson & Pope, 1993). In addition, studies have involved different populations e.g. practitioners based in the United States of America and in the United Kingdom. This means that results are not necessarily relevant to each other due to differences in culture, training, etc. (Kitson & Sperlinger, 2007). Likewise, some studies sampled an equal number of male and female practitioners (Baer & Murdock, 1995; Borys & Pope, 1989; Pope et al., 1987; Salisbury & Kinnier, 1996), whereas others did not. The use of different sampling procedures means that the comparison of results for male and female respondents is difficult.

In studies examining ethical beliefs and behaviours, it is possible that participants provided responses that are biased in terms of social desirability (Borys & Pope, 1989). In addition, the absence of definitions of important concepts and wording in general is likely to have confused some participants as to what they were asked. This means that their beliefs and behaviours are likely to have been misrepresented (Borys & Pope, 1989; Salisbury & Kinnier, 1996). Discrepancies in findings across the reviewed studies could (1) relate to wording, (2) indicate an actual change in respondents' behaviours, or (3) reflect participants' fear of being identified and disciplined for disclosing ethically questionable behaviours (Borys & Pope, 1989). Lastly, it is possible that those who choose to participate in studies differ from those who do not. For example, practitioners who encounter dual relationships frequently and/or feel concerned by this encounter are more likely to invest the time and energy required to participate in a study (Kitson & Sperlinger, 2007).

4.3 Implications for practice

Despite the limitations of the studies reviewed, the findings highlight that there is diversity to how therapists approach nonsexual dual relationships with current and former clients. Diversity of approaches has significant implications for practice. Some of these implications relate to the need for therapists to:

- Receive pre- and post-qualification training on the subject to get the knowledge required to recognise, understand and think about it in a clear and practical manner (Borys & Pope, 1989; Gibson & Pope, 1993; Kitson & Sperlinger, 2007).
- Have training on how to use decision-making models (Anderson & Kitchener, 1996; Kitson & Sperlinger, 2007) to ensure that the situation is carefully examined and that their decision is ethically and professionally based (Anderson & Kitchener, 1996; Kitchener, 1988; Younggren & Gottlieb, 2004).

- Seek supervision and/or consultation to secure that they are adequately supported throughout the decision-making process (Borys & Pope, 1989; Corey et al., 2003; Gibson & Pope, 1993; Kitson & Sperlinger, 2007; Koocher & Keith-Spiegel, 1998).
- Conduct qualitative studies on the motives and effects of nonsexual dual relationships (Kitson & Sperlinger, 2007; Moleski & Kiselica, 2005; Salisbury & Kinnier, 1996).

Qualitative research could enable therapists to gain a greater understanding of this complex area of professional practice. A subject that seems to be under-researched concerns the meaning and implications of nonsexual dual relationships on clients from clients' points of view. Research in this area could not only inform therapists' practice but also contribute to the development of codes of ethics that respond to therapists' needs for clarity and practical guidance.

5. Conclusion

Based on the present critical literature review, it appears that there is diversity in how therapists approach nonsexual dual relationships with current and former clients. Therapists' beliefs and behaviours on the subject seem to be influenced by a variety of factors. Some of these factors are the therapist's gender, personal ethics, clinical experience, theoretical orientation and ability to manage boundaries, as well as time elapsed since the termination of therapy. In light of these findings, training, supervision and/or consultation, further research and a revision of the codes of ethics seem to be what is needed to support therapists to form, to the extent this is possible, a shared and coherent approach to address the dilemma of engaging in nonsexual dual relationships with clients.

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Appendix 1: The position of the American Psychological Association and the British Psychological Society towards nonsexual dual relationships

The APA *Ethical Principles of Psychologists and Code of Conduct* states, '(a) In many communities and situations, it may not be feasible or reasonable for psychologists to avoid social or other nonprofessional contacts with persons such as patients, clients, students, supervisees, or research participants. Psychologists must always be sensitive to the potential harmful effects of other contacts on their work and on those persons with whom they deal. A psychologist refrains from entering into or promising another personal, scientific, professional, financial, or other relationship with such persons if it appears likely that such a relationship reasonably might impair the psychologist's objectivity or otherwise interfere with the psychologist's effectively performing his or her functions as a psychologist, or might harm or exploit the other party. (b) Likewise, whenever feasible, a psychologist refrains from taking on professional or scientific obligations when pre-existing relationships would create a risk of such harm' (APA, 1992, p. 1601).

The BPS *Code of Conduct, Ethical Principles and Guidelines* states, 'Some dual relationships may not be harmful although the risks of damage to either the normally impartial professional role of the more senior partner, or to the personal or social status of the more junior partner, are high. Such relationships carry the risk of deleterious consequences for the more junior partner, a conflict of interests for the senior partner, a risk of impairment to professional judgement, and the risk to the quality of the working environment for others' (BPS, 2001, pp.42-43).

Appendix 2: American Psychological Association's and British Psychological Society's definitions of dual or multiple relationships

According to the *Ethical Principles of Psychologists and Code of Conduct* of APA 'A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person' (APA, 2002, p.6).

The *Code of Conduct, Ethical Principles and Guidelines* of BPS define dual relationships as following: 'Dual relationships are those in which the psychologist is acting in at least one other role besides a professional one; for example, the psychologist is supervising a student to whom s/he is married or the psychologist is teaching a student s/he is dating' (BPS, 2001, p.42).