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Ethical Management of Erotic Transference in Psychotherapy

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Abstract

Purpose: Erotic transference occurs frequently in psychotherapy. The mismanagement of erotic transference harms the effectiveness of therapy. Therefore, this study aims to identify the ethical issues associated with erotic transference in counseling and clarify valuable strategies to manage this phenomenon. **Methodology:** This study conducted a narrative review of the literature covering empirical and theoretical studies to explain the concept of erotic transference and illustrate related ethical issues and management methods. **Results:** The study suggests that therapists have the responsibility to benefit, not harm, the client, preserve professional and ethical boundaries, consider carefully self-disclosure in therapy, and engage in ongoing learning to properly recognize and address erotic transference. Specifically, therapists should promptly identify the manifestations of erotic transference, refrain from disclosing their sexual feelings toward the client, disillusion the client, reclaim the fantasy, restore the client's ego deficits in the transference, consult professional colleagues and supervisors, consider cultural influences, and, when necessary, terminate therapy promptly or appropriately refer the client. **Conclusions:** The findings contribute to the literature on erotic transference and offer valuable insights into the management of the phenomenon. Future research could explore erotic feelings in female therapist-male client therapy, same-gender therapy, and therapist-minor therapy to provide further insights into the transference.

Keywords: Erotic Transference, Ethical Issues, Management Methods, Psychotherapy

1. Introduction

Erotic transference is a widespread phenomenon in psychotherapy and psychoanalysis. It is defined as a transference manifestation in which clients consciously or unconsciously project their sexual feelings from past relationships onto the therapist (Mann, 2021). The development of erotic feelings that emerge from interactions between the parent and child leads to erotic transference in the therapeutic relationship. However, erotic transference not only represents elements of past relationships but also expresses hope for a different result in the present and future relationship (Mann, 2021). Erotic transference includes not just sexual attraction but also feelings of love toward the therapist in psychological counseling (Colom-Timlin, 2014). Erotic transference is one of the most challenging aspects of counseling, and the therapist plays a crucial role in managing it as it manifests in therapist-client relationships (Barnewell, 2016). If the therapist manages it properly, erotic transference can have a positive influence on therapy (Mann, 2021; Stefana, 2017). Conversely, if the therapist mismanages erotic transference, it could result in sexual acting out between the therapist and client, which harms the client and the therapeutic relationship (Book, 1995). For instance, (1) The immature counselor may fail to identify or actively deny erotic transference; (2) The counselor may struggle to manage countertransference issues; (3) The counselor may consciously harm the female client; (4) The counselor may sexually exploit the client because of delusional commands. Russell (1993) identifies nine possible effects that sexual contact can lead to in counseling, including feeling special, dependency, betrayal of trust, guilt, anger, frustration and hopelessness, ambivalence, poor or distorted self-concept, and isolation. Erotic transference is regarded as a taboo subject in counseling due to its sexual nature (Pope et al., 2006). Few studies focus on the topic of erotic transference, especially concerning female therapist-male client therapy, same-gender therapy, and therapist-child/adolescent therapy (Barnewell, 2016). However, previous research and ethical codes provide limited assistance to counselors in managing erotic transference to protect the client's interests and the therapeutic relationship. Therefore, it is crucial to provide a clear and effective ethical management strategy for erotic transference to assist counselors and remind clients of the standards by which to assess their therapist's behavior. Particularly, this study aims to:

(1) Review the concept of erotic transference to provide a clear explanation of this phenomenon;
(2) Identify the ethical issues associated with erotic transference in counseling; and
(3) Clarify strategies for managing erotic transference in counseling.

2. Erotic Transference

Transference is a phenomenon in therapy where clients often consciously and unconsciously project feelings, expectations, or patterns of behavior from past relationships onto their therapists (Levy & Scala, 2012). In general, transference can be positive, negative, or sexualized. Positive transference refers to pleasurable experiences of past relationships. Negative transference stems from unresolved emotions or experiences related to important figures in the client's life, such as parents, caregivers, or significant others. Specifically, the transference forms that manifest sexual wishes are defined as erotic or sexualized transferences (De Masi, 2012). Freud (1959) addresses that the love transference rooted in unhealthy and insecure childhood experiences is not real and is used defensively to destroy the therapist's authority. The therapist needs to realize that erotic transference is a client's illusion and not an objective perception (Stefana, 2017). In addition, the client's wishes for sexual contact are the repetition of behavior or relationship patterns originating from past traumatic experiences (Stern, 1991). Moreover, erotic transference can be an expression of the pain or once-repressed emotions rooted in early childhood traumatic experiences (Stefana, 2017). We also can state that erotic transference is a window into the internal world of the clients (De Masi, 2012). Schafer (1977) examined that erotic transference is a dynamic state in which clients attempt to combine reality with unreality and progressive with regressive. Stefana (2017) analyzed that clients who cannot build real and mature object relations always defend themselves by idealizing their therapists, which underlies clients' erotic transference to maintain the idealization. However, the erotic dimension of the psychoanalytic process can also be aroused by the intimacy between clients and therapists and cannot be automatically pathologized (Davies, 1998).

Blum (1973) illustrates that erotic transference is regarded as intense, vivid, and irrational erotic feelings toward the analyst and a desire for love and sexual fulfillment from the analyst. The research indicates that erotic transference can develop from loving to sexualized and from a dream state (benign) to a delusional state (malignant) and involve the 'pleasurable to sexual' continuum and the 'preoedipal to oedipal' dimension (Stefana, 2017). To illustrate, the therapy offers a safe and dependable circumstance that facilitates the idealization of the therapist. Clients excessively employ idealization as a defense mechanism and in turn develop erotic transference to maintain the idealization. Clients developing erotic transference cannot build mature object relations because they often idealize their therapist. The eroticism and desire represent clients' personal history and the relationship between internal and external worlds. Meanwhile, the desire for the completion of the erotic feeling encourages clients to act out. Therefore, clients with more idealization are likely to experience more erotic transference, ultimately acting in and/or acting out, which emphasizes the process from the pleasurable to the sexual stage and from the dream to the danger state (Stefana, 2017).

3. Ethical Issues of Erotic Transference

3.1 Beneficence and Nonmaleficence

Clients experiencing erotic transference often feel embarrassed, rejected, and humiliated in psychotherapy when the therapist uses improper methods to manage erotic transference, which may aggravate the client's symptoms of disorders or elicit new mental deficits and wounds (Stefana, 2017). Moreover, De Masi (2012) indicated that clients experienceing erotic transference feel so pleasurable transformation that they are unaware of the dangers of the process and eventually lose their rational minds. Hence, the therapist can conduct further exploration of the client's erotic feelings and focus on why the client has such transference in counseling (Koocher & Keith-Spiegel, 2008). The therapist's responsibility is to disillusion the client, reclaim the fantasy, and restore the client's ego deficits in the transference (Stern, 1991). According to "Principle A: Beneficence and Nonmaleficence" (American Psychological Association, 2017, p. 3) and "Principles: Nonmaleficence and Beneficence" (American Counseling Association, 2014, p. 3), the therapist should be responsible for benefitting and not harming the client and taking care of the manifestation of erotic transference.

3.2 Professional Boundary

The research reported that the therapist's mismanagement of the erotic transference could elicit therapist-client sexual acting out. Hence, the therapist is likely to have sexual behavior with the client experienceing erotic transference (Book, 1995). Nevertheless, sexual activity with clients can destroy a helping environment, evoke the client's negative, guilt, hopeless, isolated, empty, and humiliated feelings, disturb the client's identity, relationship in lives, trust with others, and boundary with the therapist, and increase the risk for suicide or other self-destructive reactions (Koocher & Keith-Spiegel, 2008). Associated with "A.5.a. Sexual and/or Romantic Relationships Prohibited and A.6.b. Extending Counseling Boundaries." (American

Counseling Association, 2014, p. 5), the therapist should prohibit sexual and/or romantic interactions with current clients and deal with erotic transference with great care in counseling.

Generally, it is crucial to preserve professional boundaries with clients and resist clients' seduction and erotic provocation. The client who encounters erotic transference may invite the therapist to have a date or give benefits to seduce the therapist to develop further relationships with the therapist. Some clients desire bodily contact in which they want to cross the boundary between client and therapist and share the same skin to pursue the oneness in therapy (Lijtmaer, 2004). Meanwhile, certain therapists may devalue the importance of erotic transference and promote inappropriate self-disclosure, which encourages improper intimacy and leads to boundary destruction (Bool, 1995). However, therapists should pay attention to self-disclosure in therapy and the importance of erotic transference to avoid boundary violations and protect the client's self-esteem, so the therapist is supposed to prohibit disclosing their sexual feelings toward the client, gradually declare that acting on the client's erotic feelings is unethical, and discuss why the behavior is improper to build a healthy and stable therapeutic alliance with the client (Koocher & Keith-Spiegel, 2008).

3.3 Therapist Competence

The research illustrates that devaluing erotic transference, countertransference issues, and theoretical and technical deficiency play an extremely negative role in identifying and addressing erotic transference (Book, 1995). Likewise, the therapist's technical incapacity to handle the situation or unconscious collusion may lead to a non-psychotic client developing an erotic transference (Stefana, 2017). Thus, therapists should make efforts to ongoing training to develop and maintain their competence. Also, therapists who experience countertransference or incapacity to identify and address erotic transference should counsel professional colleagues or supervisors to seek assistance.

Available studies state that the therapist who engages in sexual interaction with the client usually has some personal impairments, such as feelings of vulnerability, fear of intimacy, idealizing a special client, social isolation, overvaluation of their abilities to heal, etc. (Koocher & Keith-Spiegel, 2008). The therapist who repeats offenders consciously preys on clients, or sexually exploits clients due to delusional commands attends to mismanage erotic transference (Book, 1995). Related to "2.03 Maintaining Competence" (American Psychological Association, 2017, p. 5) and "C.2.a. Boundaries of Competence, C.2.e. Consultations on Ethical Obligations, C.2.f. Continuing Education, and C.2.g. Impairment" (American Counseling Association, 2014, p. 8-9), therapists should monitor themselves, care about their physical and mental health, and seek assistance from colleagues or supervisors to recognize their professional impairments and prevent clients from imminent harm.

3.4 Appropriate Termination and Referral

In some cases, therapists may feel awkward and uncomfortable when clients express sexual or insane love feelings toward them in the therapeutic relationship. Lijtmaer (2004) described the same situation in which the client's expressions of love were talked about repeatedly and the client wanted to have physical interaction with her, and it made her feel discomfort and angry and want to run away. Thereby, there are interpersonal and value conflicts between the therapist and the client. If the therapist is unable to appropriately deal with the conflict, it leads to the disturbance or destruction of therapeutic alliances. Therefore, the therapist should try to resolve these conflicts in a professional way to avoid or minimize harm to the client.

In certain cases, male clients who have erotic longings can experience actively aggressive, murderous, envious, and vengeful feelings which can, in turn, harm the female therapist because of improper management of erotic transference (Celenza, 2006). Indeed, women are generally weaker than men, and female therapists must consider their safety as the paramount importance before any therapeutic issues (Hobday et al., 2008). Accordingly, if the therapist believes that the client's strong sexual or romantic interests are uncontrolled, the best course of action is to refer the client to another professional therapist (Koocher & Keith-Spiegel, 2008).

Based on "A.11.a. Competence Within Termination and Referral, A.11.b. Values Within Termination and Referral, and A.11.c. Appropriate Termination" (American Counseling Association, 2014, p. 6), therapists who estimate the counseling out of their competence or encounter threats of wounds caused by the client should suspend or terminate the counseling or appropriately refer the client to other professional therapists.

4. Cultural Consideration

Research estimates that cultural context plays a significant role in the relationship of counseling in which transference models should be considered differently, so the connection between the client's issues and the cultural context significantly affects the effectiveness of the therapy and the understanding of cultural differences helps the therapist better use transference

and countertransference (La Roche, 1999; Nagai, 2009). For instance, African clients more often manifest transference based on racial stereotypes and Chinese clients more often manifest transference based on cultural assumptions (Tan & Gardner, 1999). In the traditional Latino culture, childrearing practices and values influence particular family dynamics and create specific social schemes and scripts, which reflect different responses to transference and countertransference in therapy (La Roche, 1999). It is crucial for effective therapy to understand and link interpersonal and cultural processes with clients' issues. Transcultural therapy is influenced by the therapist and client together and transference may be a manifestation of the client's sociocultural roots and family-of-origin's cultural heritage. Meanwhile, it is vital to understand and take advantage of the discrepancies between the therapist's cultural values and the client's cultural values (Bonovitz, 2005; Cabaniss, 1994). As a result, erotic transference is regarded as a manifestation of transference, the therapist must consider the significant influence of the client and therapist's cultural context on the therapy.

5. Erotic Transference Management

First, the therapist must maintain ongoing professional training, consult with colleagues and supervisors, and remain mindful of self-disclosure in therapy. Understanding the significance of erotic transference helps in timely recognition and appropriate management (Book, 1995).

Meanwhile, the therapist should uphold professional boundaries and protect the client's self-esteem. The therapist should refrain from disclosing any sexual feelings towards the client, gradually explain that acting on the client's erotic feelings is unethical, and discuss why such behavior is inappropriate (Koocher & Keith-Spiegel, 2008).

Moreover, the therapist must further explore the client's emotions and understand the underlying reasons for such transference in the counseling process (Koocher & Keith-Spiegel, 2008). It is the therapist's responsibility to disillusion the client, reclaim the fantasy, and address the client's ego deficits within the transference (Stern, 1991).

Additionally, the therapist should carefully consider cultural influences on the therapeutic relationship to avoid inappropriate responses to erotic transference (Bonovitz, 2005).

Lastly, if the therapist believes that the client's strong sexual or romantic interests are uncontrollable, the best course of action is to refer the client to another professional counselor (Koocher & Keith-Spiegel, 2008).

6. Conclusion

The manifestation of the client's sexual feelings toward the counselor is regarded as erotic transference, which can emerge from past childhood traumatic experiences, intimacy between the counselor and the client, or the client's idealization of the counselor. The mismanagement of erotic transference due to the counselor's incompetence, countertransference issues, devaluing or denying erotic transference, or active exploitation can lead to several ethical issues, such as harm to clients or therapists, boundary violations, sexual interactions, unethical exploitation, etc. The counselor has the responsibility to benefit, not harm, the client, preserve professional and ethical boundaries, engage in ongoing learning, consult professional colleagues and supervisors, terminate therapy promptly, and appropriately refer the client so that the counselor can properly recognize and address erotic transference. Moreover, the counselor should consider both the client's and the counselor's cultural context in the therapy to effectively manage erotic transference. Furthermore, research has reported that most literature on erotic transference focuses on female clients and male therapists, with less literature on female analyst-male client pairs. Therefore, future research could explore the erotic feelings in female counselor-male clients, counselor-minor therapy, or same-gender counseling pairs to study relevant features, functions, development, and management of erotic transference in such therapies by conducting qualitative and longitudinal research.

References

American Counseling Association. (2014). *2014 ACA code of ethics.* https://www.counseling.org/docs/default-source/default-document-library/ethics/2014-aca-code-of-ethics.pdf

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2002, amended effective June 1, 2010, and January 1, 2017). https://www.apa.org/ethics/code/

Barnewell, Y. (2016). *An exploration of erotic transference in the therapeutic encounter* (Doctoral dissertation, Dublin Business School).

Blum, H. P. (1973). The concept of erotized transference. *Journal of the American Psychoanalytic Association, 21*(1), 61-76. https://doi.org/10.1177/000306517302100104

Bonovitz, C. (2005). Locating culture in the psychic field: Transference and countertransference as cultural products. *Contemporary Psychoanalysis*, *41*(1), 55-75. https://doi.org/10.1080/00107530.2005.10745848

Book, H. E. (1995). The "erotic transference": some technical and countertransferential difficulties. *American journal of psychotherapy*, *49*(4), 504–513. https://doi.org/10.1176/appi.psychotherapy.1995.49.4.504

Cabaniss, D. L., Oquendo, M. A., & Singer, M. B. (1994). The impact of psychoanalytic values on transference and countertransference: A study in transcultural psychotherapy. *Journal of the American Academy of Psychoanalysis*, *22*(4), 609-621. https://doi.org/10.1521/JAAP.1.1994.22.4.609

Celenza, A. (2006). The threat of male-to-female erotic transference. *Journal of the American Psychoanalytic Association*, *54*(4), 1207-1231. https://doi.org/10.1177/00030651060540040401

Colom-Timlin, A. (2014). Mutual desire in the therapeutic relationship. *Irish Association for Counselling and Psychotherapy*, *14*(3), 19-24.

Davies, J. M. (1998). Between the disclosure and foreclosure of erotic transference‐countertransference can psychoanalysis find a place for adult sexuality?. *Psychoanalytic Dialogues*, *8*(6), 747-766. https://doi.org/10.1080/10481889809539292

De Masi, F. (2012). The erotic transference: dream or delusion?. *Journal of the American Psychoanalytic Association*, *60*(6), 1199-1220. https://doi.org/10.1177/0003065112464394

Freud, S. (1959). Observations on transference love, in J. Strachey (Ed. & Trans.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 12, p. 157-171) Hogarth Press. (Original work published 1915)

Hobday, G., Mellman, L., & Gabbard, G. O. (2008). Complex sexualized transferences when the patient is male and the therapist female. *American Journal of Psychiatry*, *165*(12), 1525-1530. https://doi.org/10.1176/appi.ajp.2008.08050479

Koocher, G. P., & Keith-Spiegel, P. (2008). *Ethics in psychology and the mental health professions: Standards and cases*. Oxford University Press.

La Roche, M. J. (1999). Culture, transference, and countertransference among Latinos. *Psychotherapy: Theory, Research, Practice, Training*, *36*(4), 389–397. https://doi.org/10.1037/h0087808

Levy, K. N., & Scala, J. (2012). Transference, transference interpretations, and transference-focused psychotherapies. *Psychotherapy*, *49*(3), 391.

Lijtmaer, R. M. (2004). The place of erotic transference and countertransference in clinical practice. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *32*(3), 483-498. https://doi.org/10.1521/jaap.32.3.483.44775

Mann, D. (2021). *Psychotherapy: An erotic relationship: Transference and countertransference passions*. Routledge. https://doi.org/10.4324/9781003245544

Nagai, C. (2009). Ethno–Cultural and Linguistic Transference and Countertransference: From Asian Perspectives. *American journal of psychotherapy*, *63*(1), 13-23. https://doi.org/10.1176/appi.psychotherapy.2009.63.1.13

Pope, K. S., Sonne, J. L., & Greene, B. (2006). *What therapists don't talk about and why: Understanding taboos that hurt us and our clients*. American Psychological Association. http://dx.doi.org/10.1037/11413-000

Russell, J. (1993). *Out of bounds: sexual exploitation in counselling and therapy* (p. 92). London: Sage.

Schafer R. (1977). The interpretation of transference and the conditions for loving. *Journal of the American Psychoanalytic Association*, *25*(2), 335–362. https://doi.org/10.1177/000306517702500202

Stefana, A. (2017). Erotic transference. *British Journal of Psychotherapy*, *33*(4), 505-513. https://doi.org/10.1111/bjp.12231

Stern, D. A. (1991). Transference as a shared (illusionary) reality: Technical implications for certain types of eroticized treatment relationships. *Psychoanalytic psychology*, *8*(4), 463. https://doi.org/10.1037/h0079300

Tang, N. M., & Gardner, J. (1999). Race, culture, and psychotherapy: Transference to minority therapists. *The Psychoanalytic Quarterly*, *68*(1), 1-20.