

**How do Child & Adolescent Psychotherapists work with the erotic transference with adolescents?**

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## Abstract

Adolescence is a period of profound psychological and physical transformation, during which early feelings, desires, and conflicts are reactivated. Sexuality plays a central role in this developmental phase, and the emergence of sexual and erotic feelings can be particularly unsettling when they arise within the therapeutic relationship. The phenomenon of erotic transference, the displacement of unconscious sexual and loving feelings onto the therapist, poses distinctive clinical and ethical challenges, yet remains underexplored within child and adolescent psychotherapy (Jackson, 2017; Lena, 2017; Brady, 2018; Davids, 2022).

This qualitative study explores how Child and Adolescent Psychotherapists (CAPTs) understand and work with erotic transference in adolescent psychotherapy, the risks and opportunities it presents, and the reasons it continues to be a comparatively under-addressed topic within the profession. Semi-structured interviews were conducted with six qualified CAPTs trained within a Kleinian or post-Kleinian framework. Interviews were transcribed verbatim and analysed using Reflexive Thematic Analysis (Braun & Clarke, 2006, 2019, 2022).

Five overarching themes were identified, including one with subthemes. Findings highlight the importance of recognising and giving meaning to sexuality within therapeutic work, attuning to the adolescent's developmental stage, and maintaining a reflective stance on the therapist's own countertransference. The study also underscores the personal, institutional, and cultural resistances that can inhibit open engagement with erotic material. Avoidance of these dynamics risks reinforcing shame and limiting the adolescent's capacity for integration and relational development.

The research calls for greater openness and reflection on erotic transference within training, supervision, and clinical discourse, emphasising its developmental and therapeutic

significance when handled ethically and thoughtfully. Implications for clinical practice, training, and future research are discussed.

**Keywords:** erotic transference, erotized transference, transference love, adolescence, child and adolescent psychotherapy, sexuality, countertransference, defence

## Introduction

Psychoanalytic theory has long recognised the centrality of sexuality in emotional life and development. Since Freud's (1915/1958) exploration of transference love, clinicians and theorists have grappled with how erotic feelings emerge within the analytic relationship and what they reveal about the patient's inner world. Later authors have refined this concept, differentiating between erotized, loving, and affectionate transferences (Blum, 1973; Bolognini, 1994; Person, 1985). While psychoanalysis has developed a rich understanding of erotic transference in adult treatment, far less attention has been given to its manifestations in work with adolescents, despite adolescence being the developmental stage in which sexuality, identity, and dependency undergo profound transformation (Brady, 2018; Davids, 2022; Jackson, 2017; Lena, 2017).

In clinical practice, erotic feelings can arise vividly in work with young people, often catching both therapist and system off guard. My own professional experience across different clinical settings has shown how the presence of sexuality in the therapeutic space can evoke discomfort, avoidance, and heightened anxiety among practitioners. In non-psychoanalytic contexts, direct exploration of erotic material was discouraged; even in psychoanalytic training, explicit discussion of these dynamics was notably limited. This absence suggested a broader culture of unease surrounding sexuality in adolescent psychotherapy, a tension that prompted the present research.

The concept of taboo offers a useful way of understanding this phenomenon. Within psychoanalytic thinking, taboo can be understood not only as a moral prohibition but as a shared, often unconscious, defence against material that evokes anxiety or threatens established boundaries (Freud, 1913; Steiner, 1985). Erotic transference, particularly in work with adolescents, may acquire a taboo quality because it touches upon intersecting anxieties about sexuality, safeguarding, and professional identity. These anxieties can generate fear of

misinterpretation or boundary transgression and lead clinicians to avoid attending to erotic material in their clinical thinking, teaching, and supervision (Brady, 2018; Jackson, 2017; Davids, 2022). In this sense, the taboo lies less in the presence of erotic feeling itself than in the difficulty of thinking and speaking about it within professional culture.

Given the centrality of sexuality in adolescent development and the paucity of empirical research exploring how Child and Adolescent Psychotherapists (CAPTs) work with erotic material, there is a clear need for formal investigation. Understanding how CAPTs recognise, conceptualise, and manage erotic transference can help reveal the tensions between clinical containment, ethical responsibility, and developmental facilitation. It can also help identify what supports or constrains open thinking about erotic dynamics within therapeutic and institutional contexts.

This study therefore aims to explore how CAPTs understand and work with erotic transference in adolescent psychotherapy, and to examine the perceived risks and opportunities surrounding this phenomenon.

The central research question guiding this study is:

*How do Child and Adolescent Psychotherapists work with the erotic transference in adolescents?*

To answer this question, CAPT participants were invited to share their reflections on how the erotic transference presents in adolescent work, how they manage and understand it, what they perceive as its risks and benefits, and whether and why it may function as a taboo within the field.

Considering the sensitive nature of the topic, this project focused on qualified CAPTs with experience of working with the erotic transference with adolescent patients, including clinicians already engaged with the publication or dissemination of related ideas. To explore

their perspectives, the study adopted a qualitative design using Reflexive Thematic Analysis (Braun & Clarke, 2006) to analyse and interpret semi-structured interview data.

## Literature review

### Introduction

In this section, I will present an overview of the current literature on the erotic transference in adolescent work, beginning by setting the scene through an exploration of the evolution of sexuality in psychoanalytic thinking and its role in adolescent development. Then, I will provide an overview of the literature on the erotic transference and on the erotic transference in adolescent work. I will conclude by outlining existing research on the erotic transference with adult patients due to the absence of empirical studies with adolescents.

After an explorative approach to the literature search highlighted the dearth of research on the topic, a systematic approach was used to find the existing literature. Of note, a full, systematic literature review was beyond the scope of this project. This project's research question guided the identification of concepts used for the database literature search: erotic transference, adolescents, and child psychotherapy. The databases used were APA PsycINFO and PEP Archive, using a combination of the keywords and their synonyms, including truncations and Boolean operators as recommended by Aveyard (2014). The results of my first attempts were mixed, often leading to either excessive and mostly irrelevant, or limited results. I realised that the concept of child psychotherapy was superfluous and removed it from the search. Table 1 illustrates the final list of synonyms used for the search.

**Table 1**

*Search terms*

| <b>Synonyms</b>       |                  |
|-----------------------|------------------|
| <b>Concept 1</b>      | <b>Concept 2</b> |
| “erot* *transference” | adolescen*       |

|   |              |
|---|--------------|
| “sexual* *transference”   | teenage*     |
| “lov* *transference”  | young adult* |
| <p><i>Note.</i> Quotation marks are used to ensure both words are included in the search. Truncation (*) allows for further terms to be considered in different version e.g. erotic transference, erotic countertransference, adolescence, adolescent, etc.</p> |              |

Searching the individual concepts using the Boolean operator “OR” and then combining the searches using the operator “AND” concluded with 671 results. By selecting the age (adolescence and young adulthood), results were filtered to 26 (see Image 1).

## Figure 1

### Database search

| Search History/Alerts       |  |   |  |
|-----------------------------|--|---|--|
| Search ID#                  | Search Terms   | Search Options  | Actions  |
| <input type="checkbox"/> S4 | S1 AND S2  | Expanders - Also search within the full text of the articles; Apply equivalent subjects<br>Narrow by SubjectAge: - young adulthood (18-29 yrs)<br>Narrow by SubjectAge: - adolescence (13-17 yrs)<br>Search modes - Proximity | <a href="#">View Results (26)</a>   <a href="#">View Details</a>   <a href="#">Edit</a>        |
| <input type="checkbox"/> S3 | S1 AND S2  | Expanders - Also search within the full text of the articles; Apply equivalent subjects<br>Search modes - Proximity   | <a href="#">View Results (671)</a>   <a href="#">View Details</a>   <a href="#">Edit</a>       |
| <input type="checkbox"/> S2 | adolescen* OR teenage* OR young adult*                                   | Expanders - Also search within the full text of the articles; Apply equivalent subjects<br>Search modes - Proximity   | <a href="#">View Results (1,314,983)</a>   <a href="#">View Details</a>   <a href="#">Edit</a> |
| <input type="checkbox"/> S1 | "erot* *transference" OR "sexual* *transference" OR "lov* *transference" | Expanders - Also search within the full text of the articles; Apply equivalent subjects<br>Search modes - Proximity   | <a href="#">View Results (1,963)</a>   <a href="#">View Details</a>   <a href="#">Edit</a>     |

While this search allowed me to find relevant papers regarding the topic, Greenhalgh and Peacock (2005) highlight the importance of using different approaches to identify literature when undertaking a literature search. In screening, most papers found referred to

adult literature, where the concept of erotic transference is explored in much more detail. Therefore, a snowball sampling approach (Greenhalgh & Peacock, 2005) was chosen to explore selected papers on the evolution of psychoanalytic thinking about sexuality, the concept of erotic transference, and the developmental task of adolescence, in order to set the scene for my research question. Additionally, given the dearth of empirical research on working with the erotic transference with adolescents, a similar process was used to identify empirical papers on the erotic transference with adults.

### **The evolution of the role of sexuality in psychoanalytic thinking**

Over the years, the role of sexuality has undergone an evolution in psychoanalytic thinking and, consequently, in how it is thought about and used in the consulting room. In early psychoanalysis, sexuality was considered the centre of development and emotional life. In “Three Essays on the Theory of Sexuality” Freud (1905/1953) argued that sexuality is present from birth, taking polymorphously perverse forms before gradually becoming organised around the genital function. Development, in this model, is based on a set of preordained tasks which one comes upon at predetermined stages in life. Once one has achieved a task, there is no turning back (Young, 2001). This redefinition of sexuality as developmental, rather than exclusively reproductive or adult, laid the groundwork for understanding how unconscious sexual and aggressive drives shape psychic life. Freud (1896/1962) initially believed that mental illnesses, particularly hysteria, were caused by actual child sexual abuse. He later came to the view that what patients bring are not factual memories, but infantile phantasies of a wished-for seduction aimed at oedipal gratification (Royston, 2001).

Freud’s (1905/1953) Oedipus complex, which in his view takes place between the ages of three and a half and six years, then later reprised in adolescence, consolidates this perspective by positioning infantile sexual desire within triangular family dynamics. The

child's love and desire for one parent, and rivalry with the other, became understood as a universal developmental challenge involving conflict and castration anxiety. For Freud, successful resolution of the Oedipus complex was critical in shaping gender identity, object choice, access to genital love and the superego. His model also gave a privileged position to the father as the bearer of prohibition, casting the paternal function as decisive in psychic structuring. If these incestuous desires remain unconsciously fixed on the original object, sexual relationships may be inhibited. Freud therefore identified the Oedipus complex as the nucleus of neuroses and the foundation of mental, emotional and sexual life. In Freud's theory, the object has little intrinsic importance: as the child is polymorphously perverse, any object may serve the drive, and it is only after this fortuitous "bumping together" that the object acquires meaning (Royston, 2001).

Freud's emphasis on drives, conflict, and repression was, however, not universally maintained. Melanie Klein's theories of early object relations shifted the focus from the Oedipal stage to the infant's earliest phantasies, anxieties, and identifications. Klein proposed that an object always exists in the mind, and that desire is only ever desire for something (Royston, 2001). Development does not follow a predetermined chronology, but it is instead characterised by a constant oscillation between core feelings and nuclear affective structures, which she calls the paranoid-schizoid (Klein, 1946/1997) and the depressive position (Klein, 1935/1998). In her view, destructive impulses and reparations towards the maternal object are bound up with erotic wishes, long before the Oedipal phase. Klein's work therefore displaced sexuality from a strictly developmental sequence to a constant, unconscious feature of psychic life, intricately bound with aggression and dependency.

In Kleinian theory, oedipal anxieties are refracted through earlier object relations: hostility toward the parental couple and exclusion from their sexual relationship are lived alongside guilt and reparation. The resolution of the Oedipus complex is not a single

milestone, but a repeatedly reworked constellation linked to movements between paranoid-schizoid and depressive positions. Clinically, this shift relocates the meaning of erotic communications, which are understood not only as drive derivatives but as ongoing, sometimes primitive, negotiations of dependency, destructiveness, and exclusion that predictably surface in the transference with adolescents.

Freudian theory was criticised for its phallogentric view of sexuality (Harding, 2001). Klein complemented Freud's ideas by emphasising the centrality of object relations in the psychic structure, and by installing the idea of a mother as provider of the breast alongside the father. In Kleinian theory greater emphasis is given to aggression and destructiveness in sexual development, which are considered more problematic than eroticism because they lead to the splitting of objects (Harding, 2001). Sexual development is understood in terms of feeding and nurture rather than ecstasy in mutual enjoyment.

Since Klein, the culture of psychoanalysis has changed: sexuality has been demoted, and the focus is less on the oedipal triangle and more on mothers and babies and the internal world of patients (Royston, 2001). The mother has not been put alongside the father but has become his substitute; the analytic couple is now considered to be that of an analyst-mother and her patient-baby. In this light, sexual problems are seen as defences against primary sources of difficulty, such as, dependency and separation anxiety, and as a symptom of an impairment of the capacity for intimacy due to damage during the early relationship between mother and infant. Sexual drives may take on destructive impulses if infantile conflicts are not resolved (Royston, 2001). While this model deepens understanding of early vulnerability, it also risks de-sexualising later psychic life.

Royston (2001) proposes that a sexual theory from an object relations perspective can be described as follows:

Sex is good between loving adults who have resolved infantile conflicts; it is a bridge between loving people; it is something emotionally profound which one both gives and receives in the act of intercourse; it may also, however, embody the destructiveness that derives from the psychic world of infancy (Royston, 2001, p. 40)

Sexuality can be thought about as infancy in a new erotic form: the oral stage is transported to later phases in life and stamped on all aspects of a child's emerging sexuality (Royston, 2001). The prospect of becoming vulnerable and exposed in sexual relationships is what may render intimacy disturbing, and sexualising the vulnerability may be a defence against infantile anxiety and helplessness (Harding, 2001). Painful and disturbing experiences may be sexualised to master what was originally frightening or humiliating (Royston, 2001).

Subsequent theorists problematised Freud's emphasis on instinctual drives. Winnicott (1951), for example, argued that the child's capacity for play and the emergence of the transitional object offered an alternative developmental focus. While not denying sexuality's role, Winnicott de-centred it, placing greater emphasis on relational experience and the facilitation of a holding environment. Another view was where Fairbairn (1943) de-emphasises the importance of sex in development, particularly in the Oedipus complex. Libido is not sexual in nature, but loving relationships are necessary for psychic growth. A child's sexual attraction towards a parent is not natural or inevitable but happens when the child's normal efforts to make loving contact with a caretaker fail. Erotising the relationship is therefore a desperate attempt from the child to have more to offer to the negligent parent.

Similarly, Glasser (1979) points out how in core complex anxiety, one both longs to merge with the other and fears being absorbed by them. As a response to this, one may react aggressively in self-defence, but only to then find oneself isolated. A solution is to eroticise their aggression as a sort of damage control measure. The relationship with the object is then maintained at a safe distance by relating to each other sado-masochistically. Here, erotization

is no longer primarily an expression of desire but a way of avoiding intimacy and of reinventing the primal scene in phantasy to deceive both self and other (Glasser, 1979).

Mendoza's (2001) formulation further situates this dynamic by emphasising that sexual relationships always involve both sexual drives and the need for intimacy. The eroticisation of aggression can be understood as a distortion of the fundamental tension between desire and closeness. Mendoza warns that when patients and clinicians are viewed as de-sexualised, the psyche risks being split between mind and body, leading clinicians to overlook difficulties that may emerge in adult sexual and intimate relationships.

These post-Freudian developments have significant implications for how erotic transference is understood in clinical work. If sexuality is considered a constant developmental pressure, as in Freudian and Kleinian theory, erotic desire in the analytic setting can be read primarily as the reactivation of infantile wishes. By contrast, if relational experience is foregrounded, as in Winnicott's and Fairbairn's views, erotic transferences may be better understood as expressions of disrupted or unfulfilled needs for connection and recognition. These divergent models create different technical stances toward erotic material in the consulting room.

### **The role of sexuality in adolescent development**

The conceptualisation of adolescence has changed significantly over the years. While it is generally accepted that adolescence begins with the onset of puberty, the transition into adulthood is thought to extend into the mid- to late-twenties (Briggs, 2008). Parenthood and marriage, which traditionally signalled the arrival of adulthood, tend to occur much later in contemporary society. Entering adulthood too soon is considered a potential disadvantage, carrying risks of social isolation and curtailed opportunities for personal development. This shifting socio-historical context complicates earlier psychoanalytic models of adolescence that assumed a more linear and time-limited transition into adulthood.

As Briggs (2008) and Laufer (1997) emphasise, adolescence is a period during which the risks of emotional disturbance, psychic fragmentation, and long-term impairment are acute if the developmental tasks of this stage are not worked through. Meltzer (2008) notes that, within psychoanalysis, adolescence is used metapsychologically to represent a global organisation of the personality, which can remain until it is replaced by either progression or regression. Anderson and Dartington (1998) further describe adolescence as “one of the most radical of all the developmental periods” (p. 2). The adolescent is confronted with the formidable challenge of adapting to rapid physical transformations: changes in body shape and size, the deepening of the voice, the onset of menstruation, and the emergence of sexual maturity with the capacity to conceive or impregnate (Anderson & Dartington, 1998; Healy, 2003).

Sexuality is a key component of the sense of identity that is forming. In Freud’s (1905/1953) view, in post-pubertal adolescence, component instincts are integrated and directed towards an object-choice. The storms of adolescence are a necessary upheaval to leave childhood behind and move from infantile sexuality to an adult one (Brady, 2022). Early infantile conflicts, led by the new genital drive, re-emerge and need to be worked through again (Harris, 1976; Meltzer, 2008). Sexual feelings can be experienced by adolescents as explosive, overwhelming, unwelcome and even traumatic, leaving them feeling out of control of their own bodies and minds. Their psychological development often lags behind their growing and changing bodies, making the experience even more confusing and overwhelming (Jackson, 2017). The adolescent mind must “catch up” with the body, integrating dramatic changes into a coherent sense of self (Brady, 2018). Yet this integration is rarely smooth. The adolescent is tasked not only with accommodating the unfamiliarity of a newly sexual body but also with renegotiating their relationship to infantile fantasies and desires, which resurface with new urgency.

The adolescent's attitude to the body often reflects this tension. Horne (2001) interprets the frequent neglect of personal hygiene seen in early adolescence as an unconscious attempt to postpone the acknowledgement of sexual maturity, while later preoccupations with grooming may represent a tentative acceptance of bodily ownership. The capacity to integrate these bodily changes into a secure sexual identity depends heavily on both the degree of ego strength established in earlier development (Brenman-Pick, 1988) and the quality of the adolescent's early physical and emotional intimacy with parental figures (Harris, 1969). Thus, adolescent sexuality cannot be understood in isolation but as the return of earlier relational dynamics under the pressure of maturation (Harris, 1969).

Adolescence also involves the reworking of familial relationships, a movement towards independence, and the formation of intimate and sexual bonds outside the family (Anderson & Dartington, 1998; Healy, 2003). It is, as Wilson (1995) observes, a developmental phase in which no sphere of life is left untouched by change. Healy (2003) proposes that adolescents often develop new forms of transitional phenomena (Winnicott, 1951), such as adolescent culture, friendships, or substance use, to mediate the passage from childhood to adulthood. These cultural and social practices can be both creative and defensive: they protect the adolescent from the anxieties of separation while also enabling experimentation with new identities.

This process of development is inseparable from loss. Anderson and Dartington (1998) and Lampl-De Groot (1960) emphasise that adolescence entails a conflict between the drive towards growth and the pull of infantile dependencies. The psychic work of adolescence thus requires a form of mourning: relinquishing childhood attachments and accepting the impossibility of regressive fusion with parental figures. Wilson (1995) highlights the loneliness and alienation that often accompany this process, while Winnicott (1963) describes the paradoxical coexistence of dependence and defiance. Lombardi (2017) develops this

further, suggesting that adolescents are confronted with a decisive choice: either to face the turbulence of growth or to retreat into defensive strategies aimed at denying change.

The Oedipus complex becomes reanimated in this. Alvarez (2010) argues that post-Oedipal sexuality can only emerge through mourning and internalisation. The adolescent must renounce narcissistic identification with or possession of the primary object and accept exclusion from the parental couple. This psychic acceptance is neither straightforward nor inevitable. The return of Oedipal conflicts, combined with the enhanced sexual and aggressive potential of the adolescent, creates anxieties of overwhelming destructiveness. Anderson and Dartington (1998) observe that with new capacities for sexual and violent expression comes an intensified fear of losing control. The adolescent task is therefore not only to master instinctual drives but also to integrate these experiences into a stable sense of self without disintegration (Wilson, 1995).

This helps explain the profound fragility of adolescence as a liminal stage. Adolescents are “caught between lost childhood and unrealised adulthood” (Waddell, 2018, p. 34) and can oscillate between clinging to the familiar and exploring the unknown (Wilson, 1995). The adolescent may idealise surrogate objects like friends, groups, ideologies, and invest them with exaggerated significance, temporarily alleviating feelings of incompleteness through identification by proxy (Wilson, 1995). As such, anxiety, vulnerability, and power are central organising themes of the adolescent experience (Briggs, 2008). Regression to earlier defences is common (Wilson, 1995), particularly if early development was marked by disturbance (Brenman-Pick, 1988). Those with histories of trauma, neglect, or inconsistent caregiving are especially vulnerable to disintegration under the pressures of adolescence. Wilson (1995) describes such adolescents as easily feeling inadequate, haunted by intrusive thoughts, and estranged from their bodies, which may be experienced as abnormal or alien (Laufer, 1997). Betrayal by idealised parental figures, or by the social world more broadly,

may lead to despair and helplessness about the future. Temperamental sensitivity further amplifies these vulnerabilities (Wilson, 1995), while social marginalisation based on gender, sexuality, race, or class compounds the psychic burden (Briggs, 2008).

The psychic strategies available to such adolescents often involve reliance on narcissistic defences. Wilson (1995) describes compensatory retreats into omnipotent fantasy, addictions, or delinquent behaviour as attempts to deny dependency and vulnerability. Others may withdraw from external life in non-psychotic ways, dropping out of school or retreating into their bedrooms in a form of passive resistance, tormenting parents through absence rather than action. Patel et al. (2007) report that between one in four and one in five adolescents meet criteria for a mental disorder, and that many adult disorders originate during this period, even if not detected until later.

While psychoanalytic accounts often foreground turmoil, several authors caution against a one-sided view. Wilson (1995), Healy (2003), and Briggs (2008) all stress that adolescence is also a phase of creativity, discovery, and vitality. The adolescent who can tolerate guilt and shame about emerging sexual and intimate feelings may experience intense pleasure and excitement in new forms of self-expression. Like integrating bodily changes, such resilience depends heavily on the internalisation of parental love and the ego strength established in earlier childhood (Laufer, 1997).

For clinicians, these dynamics present profound challenges. The emerging sexuality of adolescence, when encountered in the transference, may evoke overwhelming anxieties both in the patient and in the therapist (Klein, 1927). The clinician is confronted with projections of infantile longings, oedipal rivalries, and omnipotent defences, all intensified by the adolescent's new bodily capacities. To meet the adolescent in this precarious position, torn between infantile dependency and adult potential, fragility and omnipotence, mourning and creativity, requires sensitivity not only to the developmental tasks of adolescence but also to

the ways in which sexuality, loss, and the Oedipus complex form the central terrain upon which the adolescent drama is played out. In this frame, adolescent erotic communications in treatment are over-determined: they condense newly sexual bodily experience, revived oedipal longings, and the work of separation/mourning. This makes erotic transference in adolescent psychotherapy both likely and clinically central, not incidental.

### **Introduction to the concept of erotic transference**

Erotic feelings in the analytic relationship are a well-recognised phenomenon, yet the reasons they arise are not immediately obvious. Patients falling in love with their analysts is not merely a matter of attraction to the person of the analyst; rather, it reflects the reactivation of infantile longings and unresolved oedipal desires projected onto the therapeutic figure (Person, 1993). Freud was the first to conceptualise this as “transference love”, tracing its origins to early relationships and the Oedipus complex. He initially encountered the phenomenon indirectly through Josef Breuer’s treatment of Anna O., in which she developed feelings for her therapist (Breuer, 1895/1955; Harding, 2001). Freud’s initial response was to attribute transference love to the qualities of the therapist, denying that his own patients could experience such feelings. Yet, over time and with repeated clinical observation, including his own experience of erotic feelings towards patients, he recognised that such attachments are an intrinsic part of the analytic process (Person, 1993). Transference love, Freud concluded, is a displacement of the child’s erotic and oedipal longings for the parents onto the analyst: “Falling in love with the doctor is a case of mistaken identity: the patient has unwittingly muddled the doctor with the desired parent” (Harding, 2001, p. 11).

Initially, Freud considered these feelings an obstacle to therapy, a resistance emerging as the patient neared the uncovering of repressed material (Freud, 1915/1958). He emphasised that the patient needed to recognise the impersonal nature of these emotions; failure to do so could undermine the analytic process. While this early view framed erotic transference as

problematic, contemporary psychoanalysis situates it at the very heart of the therapeutic encounter. Transference is now understood not as a barrier but as a primary means through which unconscious material is accessed. Its exploration offers a unique avenue for understanding early object relations, unresolved desires, and the emotional conflicts that shape adult relational patterns (Person, 1993; Harding, 2001).

From an object relations perspective, erotic transference reflects a regression to early infantile experiences, in which primitive confusions between self and other, inside and outside, desire and fear, can be re-experienced within the safety of the analytic relationship. This regression provides an opportunity for mourning and reworking oedipal and pre-oedipal conflicts, facilitating a gradual reorganisation of the self and more realistic engagement with others (Harding, 2001). In this sense, transference is simultaneously an expression of desire and a form of mourning: the patient must negotiate the loss of the primary object's exclusive hold while integrating sexual and aggressive impulses that were once intolerable.

The countertransference is equally critical in this dynamic. Heimann (1950) proposed that all feelings experienced by the analyst towards the patient are constitutive of countertransference and provide a vital tool for understanding the patient's unconscious. Yet these feelings require careful self-awareness: without recognition of the analyst's own conflicts and anxieties, the countertransference can be misattributed, distorting the therapeutic work. The analyst's sensitivity must therefore be extensive rather than intensive, allowing them to navigate the erotic and aggressive material embedded in the transference without acting it out. When managed well, countertransference offers a compass to locate the core of the patient's conflicts and to guide interpretations that foster emotional insight and integration.

The analytic situation, by its very nature, places both patient and analyst in a regressed, vulnerable position. This vulnerability can intensify the emergence of infantile and

erotic feelings, which may manifest as attempts to recapture lost love or repair the pain caused by early object relationships (Bergmann, 1994). When the analytic relationship is de-erotised, these dynamics are often overlooked, reducing the depth of understanding of the patient's experience. The intense erotic fantasies that may underlie infantile wishes (to merge with the mother, to intrude upon or be intruded by her, to devour or be devoured) reflect the complexity of early relational experience (Mann, 1997). Failing to recognise these aspects risks both theoretical and clinical impoverishment: the analyst may be unable to appreciate the full significance of the patient's transference, and the patient's capacity for mourning, symbolisation, and relational growth may be curtailed.

At the same time, the potential for enactment poses ethical and clinical dangers. If the analyst loses awareness of their own erotic feelings and boundaries, they may abuse the position of power inherent in the therapeutic relationship. Recognising and managing erotic countertransference is therefore not only a matter of ethical practice but also central to the analytic task of helping patients work through unresolved oedipal and infantile conflicts (Mann, 1997). In this way, erotic transference, when held and explored safely, becomes both a mirror of early relational trauma and a vehicle for mourning, allowing the patient to integrate previously unmanageable feelings and to renegotiate their capacity for desire, intimacy, and emotional connection.

In sum, erotic transference represents a complex interplay of desire, mourning, and the unfinished work of the Oedipus complex. Far from being an impediment, it provides a unique window into the patient's internal world, offering opportunities for reparation, integration, and the gradual transformation of infantile longings into relational capacities that can be enacted safely within and beyond the analytic setting (Bergmann, 1994; Harding, 2001; Mann, 1997; Person, 1993). Understanding this process requires not only theoretical knowledge but also careful attention to the lived experience of both patient and analyst as they navigate the

intensity of erotic feelings within the analytic frame. While this conceptualisation is well established in adult psychoanalysis, its application to adolescent psychotherapy raises distinct developmental, ethical, and technical questions that remain under-theorised.

### **Categories of erotic transference**

Erotic transference is a complex phenomenon that can manifest across different levels of psychic functioning and developmental maturity, reflecting the patient's ongoing negotiation with early relational experiences. It is crucial to appreciate that erotic transference is not a uniform or purely pathological phenomenon. Alvarez (2010) distinguishes between normal and perverse erotic transference, arguing that the indiscriminate pathologisation of all erotic transferences risks overlooking their developmental and adaptive significance. In infancy, for example, the capacity to experience potency and a sense of agency, and the ability to delight a responsive caregiver, forms the roots of sexual self-worth in adulthood. Erotic transference can therefore represent the continuation of these early relational capacities, providing a potential bridge to symbolising and integrating sexual feelings within later development.

During adolescence, the analyst may take on the role of the post-oedipal parent (Davies, 2003). Here, the patient projects onto the analyst the love endeavours they attempt in the external world, and the analyst must, like the parent, tolerate disappointment and exclusion. When the patient has failed to experience reciprocal oedipal love or has faced intolerable frustration from early caregivers, masochistic and entrenched love transferences may arise. These are characterised by the patient demanding love from the analyst only to anticipate and experience rejection, confirming deep-seated feelings of unlovability. This dynamic underscores the continuity of early infantile conflicts, revealing how unresolved oedipal and pre-oedipal anxieties may shape adolescent and adult relational patterns.

Perverse or erotized transference further illuminates the ways in which early relational trauma and unresolved conflicts can shape analytic interactions. Etchegoyen (as cited in Kohen de Abdala, 2022, p. 187) conceptualises perverse transference as the patient's attempt to distort the analytic link through erotization, testing the analyst's capacity to tolerate intense and ambivalent feelings. In adult patients, these dynamics are often covert and encrypted, whereas in children and adolescents, they may be expressed overtly through behaviour or insistence on physical closeness. This developmental difference has important technical implications, as overt manifestation reduces the analyst's protective distance from the disturbance. Person (1985) defines erotic transference as a mixture of tender, erotic, and sexual feelings directed toward the analyst, forming part of a positive transference. While potentially confusing and anxiety-provoking for the patient, these feelings also offer an opportunity for exploration and working through early relational and oedipal conflicts (Brady, 2018; Kohen de Abdala, 2022).

Erotic transference can be understood as a neurotic repetition of cathexis and fixation on an unattainable or socially prohibited object, often evoking the oedipal constellation (Bolognini, 1994). The analyst represents the oedipal object without being it, allowing the patient to replay, symbolise, and eventually mourn unfulfilled early desires. The oscillation between grandiosity and vulnerability, seduction and withdrawal, mirrors the unresolved outcomes of the oedipal complex and early primary object relationships. Bolognini (1994) emphasises that manic seductiveness functions to deny inferiority and protect the narcissistic self, while Bollas (1994) highlights how erotic transference can forge a psychic bridge between instinctual drives and the lived presence of another, enabling the patient to experience relational and sexual desire in a symbolic and contained form. Together, these perspectives highlight how the erotic may function both defensively and creatively within the analytic relationship.

### *Erotized transference*

Erotized transference represents a particularly intense, primitive, and potentially regressive variant of erotic transference. Blum (1973) describes it as an intense, vivid, and ego-syntonic preoccupation with the analyst, characterised by overt demands for love and sexual fulfilment, which resist interpretation. This form of transference functions as a psychotic-like defence against the anxiety of separation and abandonment, maintaining an illusory narcissistic fusion with the pre-oedipal object (Bolognini, 1994; Gabbard, 1994a). In such instances, the patient may struggle to maintain dual awareness of unconscious wishes and reflective insight, experiencing action and satisfaction of these wishes as the only viable solution. This collapse of symbolic space renders interpretation itself potentially traumatic rather than containing. The intensity of erotized transference can have profound consequences for the patient's external relationships, rendering romantic or sexual partnerships unsatisfactory due to comparison with the idealised, unattainable object represented by the analyst (Davies, 2003).

Kotze and Meares (1996) liken erotized transference to a milder form of Clerambault's syndrome, or "pure erotomania", wherein the patient harbours a delusional belief that the person they desire reciprocates their feelings. While the preoccupation is obsessive, it serves to protect against emptiness and preserve the coherence of self, particularly in patients with early developmental disruptions. Contrary to earlier assumptions, such dynamics are analysable and can be meaningfully addressed within the therapeutic frame.

For the analyst, erotized transference presents challenges. It is often accompanied by hostility, testing, and a desire to harm, reflecting the patient's attempts to recreate and master early relational frustrations (Gabbard, 1994b). Analysts may experience erotized countertransference and mistake these feelings for genuine relational attachments and, potentially colluding with the patient's illusions (Gabbard, 1994a, 1994b). Mismanagement

may lead to premature appeals to the patient's ego, inadvertent push-back, or analytic rupture, underscoring the need for careful containment, reflection, and attunement to both transference and countertransference dynamics (Bolognini, 1994).

In child and adolescent populations, erotized transference may appear in those with severe psychopathologies, including narcissistic, borderline, or psychotic structures, or in patients who have experienced overstimulation or sexual abuse (Kohen de Abdala, 2022). These children may repeatedly seek physical closeness, challenging the analyst's capacity to maintain a reflective stance. Early exposure to adult sexuality or seduction, particularly during the oedipal phase, may intensify these dynamics (Blum, 1983). Adult misinterpretation of the child's playful or seductive behaviour risks prematurely sexualising or interrupting the child's capacity for fantasy, symbolisation, and healthy erotic development (Bergmann, 1994).

### *Other types of erotic transference*

Psychoanalytic literature identifies other forms of erotic transference that reflect differing levels of psychological functioning and relational maturity. Bolognini (1994) distinguishes the loving and affectionate transferences as two such types. While both are associated with healthier development, they are not without challenges, as they can evoke defensive reactions in the analyst. Bolognini (1994, 2011) emphasises the importance of recognising defensive erotization and addressing it directly, while simultaneously welcoming and encouraging the genuinely loving aspects as signs of relational vitality. It is essential to differentiate erotic from loving transference, given their distinct developmental and clinical implications. This distinction is particularly important in adolescent work, where developmental vitality and defensive sexuality may closely resemble one another in presentation.

The loving transference is a highly conflictual form of transference in which

the patient's feelings and loving fantasies—(a) predominantly lacking in defensive significance compared with other, negative aspects in the relationship; (b) encouraged naturally and non-seductively by acceptance and valid contact in the analysis; and (c) characterised by a genuine, specific sexual identity based on sufficiently integrated development in the pregenital phases—encounter a complementary series of feelings of danger and destructive fantasies which oppose their appearance, communicability and symbolic experienceability in the psychoanalytic treatment. (Bolognini, 1994, p. 77).

This transference represents a dual process: a healthy capacity to love that struggles to emerge, alongside a neurotic tendency to repress positive relational experiences through defensive repetition of anti-relational attitudes. Shame and fear of rejection, rooted in early disappointments in the oedipal situation, often complicate the expression of loving feelings. Clinically, this places the analyst in a delicate position of supporting emerging love while not collapsing into reassurance or collusion.

The affectionate transference is rarely observed and signals a more advanced developmental resolution, corresponding with a successful negotiation of the depressive position. Its excitement and intensity are attenuated, and it is characterised by relational fertility, growth, and integration. This form of transference emerges either in the later stages of successful analysis or in children who have internalised an admired and loved parental couple that survived oedipal conflict. Bolognini (1994) defines it as

the transposition in the analysis of an ameliorated internal object relationship involving sexual specificity, gratitude and quite free appreciation of the object and of the subject's own relational potential, while at the same time respecting reality and the relevant limits' (Bolognini, 1994, p. 83).

Here, erotic feelings are integrated within a broader relational and developmental context, reflecting a capacity for symbolic thought and mature engagement with internal and

external objects. This form of transference therefore stands in sharp contrast to the coercive immediacy of erotized dynamics described earlier.

While these classifications can illuminate the patient's developmental level and functioning, some contemporary authors caution against rigid typologies. Civitarese (2022) argues that the distinction between erotic and erotized transference is artificial. Rather than reflecting fundamentally different phenomena, the adjectives describe the intensity and containability of the transference, often serving a defensive function for the analyst. By categorising the transference, the analyst can maintain a sense of control and professional distance from the frightening experience of encountering the patient's unconscious desires and primitive affective states.

Cultural, gendered, and unconscious factors further shape the vicissitudes of erotic transference. Earlier views assumed that erotic transference was primarily determined by the analytic couple's configuration, particularly in adult therapy. Lester (1985) and Atkinson and Gabbard (1995) challenge the belief that erotic transference is purely dyad-dependent, highlighting the influence of sociocultural norms. For example, erotic transference may be more readily tolerated or culturally validated in a male-analyst/female-patient dyad, where men in positions of power are unconsciously regarded as sexually desirable. Conversely, in female-analyst/male-patient configurations, societal and unconscious anxieties may inhibit the expression of erotic transference, with maternal transference typically emerging first and erotic or paternal transference developing later (Blum, 1971; Shahrzad, 2000). Atkinson and Gabbard (1995) note the specific risks associated with the female analyst encountering the patient's sexualised projections: "Succumbing to a man's sexual advances, even psychologically, may conjure up a perception of loss of autonomy and authority, or even of a basic sense of safety" (para. 5). Similarly, female analysts may unconsciously rely on their gendered reality to avoid being experienced as a seducer or may collude with the patient by

adopting an asexual maternal stance (Karme, 1993; Shahrzad, 2000). Homoerotic transferences may also be defended against (Lester, 1985). Shahrzad (2000) challenges the primacy of analyst gender, suggesting that cross-gender transferences can sometimes serve adaptive functions by alleviating anxiety surrounding oedipal scenarios that might otherwise be experienced as highly threatening. Taken together, these perspectives underscore the need for careful, nuanced consideration of erotic transference in clinical work. The loving and affectionate transferences highlight the potential for developmentally healthy integration of sexual and relational experiences, whereas erotized or perverse forms signal unresolved oedipal and pre-oedipal conflicts. Cultural, gender, and relational contexts shape how these dynamics are expressed and contained, while defensive responses, by both patient and analyst, can obscure the underlying psychic material. For child and adolescent psychotherapists, recognising the spectrum of erotic transference, and the developmental and relational meaning embedded in each form, is crucial for containment, interpretation, and support of the patient's emerging sense of self, relational capacity, and sexual identity.

### **Working with the erotic transference**

Erotic feelings in the transference relationship can be a disconcerting experience, a possible threat to our capacity to think and psychic equilibrium (Jackson, 2017), and psychoanalysis has given mixed messages on the more appropriate way to approach them (Gabbard, 1994a). These feelings, while sometimes seen as dangerous or disruptive, can also be understood as deeply informative signals about the patient's internal world and unresolved developmental conflicts, particularly those linked to the Oedipal complex and early object relations. This tension between danger and meaning already signals the technical and ethical complexity that characterises clinical work with erotic transference.

Bolognini (1994) believes in the maturational potential of working through the vicissitudes of the erotic transference and countertransference. The patient who experiences

an oedipal transference in their analysis can transfer an entrenched and fixated oedipal love from the parent onto the analyst, and with thoughtfully dosed frustration, begin to disentangle themselves, mourn, and move their attention to more appropriate object choices (Davies, 2003). This process can be understood as a negotiated mourning: the adolescent or adult patient simultaneously confronts the loss of the original object of desire and begins the painful work of redirecting libido toward realistic and developmentally suitable relationships. Davies (2003) suggests that one of the characteristics of oedipal love is that it involves parent/analyst and child/patient alike and that the analyst therefore needs to process their own feelings and mutually mourn the unrealizability and idealisation of the oedipal love. In this sense, working with erotic transference is inseparable from engaging with the symbolic Oedipal triangle and the patient's ongoing work of separation and individuation. An unreachable and imperturbable analytic stance may reinforce idealisation. By contrast, showing a flawed and imperfect self may help free the patient to move toward post-oedipal, imperfect, and more intimate relationships. This is, of course, not necessarily a smooth process and working through an erotic transference can pose risks to the therapeutic relationship and treatment (Bolognini, 1994). The tension between idealisation and reality testing, and between dependency and emerging autonomy, mirrors the central challenges of adolescent development itself.

Gabbard (1994a) argues that love and lustful feelings in the transference are as real as those experienced in external life and that it is crucial to acknowledge their reality. However, this can be a double-edged sword, as they can invite and coerce the analyst in enactments. In contrast to the Kleinian perspective, which would think of the analyst's erotic countertransference only in terms of projective identification (Klein, 1946/1997), Gabbard (1994b) proposes that enactments are a joint creation of both the patient's projections and the analyst's inner conflicts and reality. Countertransference enactments can range from subtle verbal or non-verbal gratifications within analytic boundaries to the extreme of engaging in

sexual relationships with the patient (Gabbard, 1994a; Gabbard, 1994b). The analyst acting on their erotic countertransference can, in fact, have various serious consequences for both the analyst and the patient. The latter, for example, could lose trust not only in their analyst, but also in the process of analysis overall (Bolognini, 1994; Gabbard, 1994a). Here, we see the complex ethical and emotional demands placed on the analyst, whose capacity to contain, think, and reflect becomes central to the therapeutic work, particularly when eroticized material evokes early Oedipal anxieties and unresolved mourning processes. This positions ethical restraint not as suppression, but as an active analytic function. Personal analysis offers the unique possibility for the analyst to handle these feelings in a different way. This will depend on their capacity to recover and regain their bearings after being impacted and coerced by the erotic transference and countertransference, and to notice their pull into enactment (Gabbard, 1994a; Gabbard, 1994b). It is important for both the analyst and the patient to think of the erotic transference as both real feelings towards a new object, and displaced from a past relationship (Gabbard, 1994b). This dual reality underscores the critical interpretive work in psychoanalysis: the analyst must help the patient link present experiences with past relational templates while simultaneously negotiating the eroticized intensity of the transference relationship. This dual positioning is particularly precarious in adolescent work, where concrete sexuality and symbolic meaning easily collapse into one another.

Despite the centrality of sexuality in adolescent development, the literature on the erotic transference with this population is limited (Brady, 2018; Davids, 2022; Jackson, 2017; Lena, 2017). Alvarez (2010) poses the question of whether the distinctions between perverse, eroticized, and normal erotic transferences, between Oedipal and post-Oedipal sexuality, as well as between countertransferences in the analyst of an erotised versus a normal erotic nature, could have any relevance for child patients. Implicitly, the management of adolescent erotic transference requires a nuanced understanding of developmental trajectories, mourning

of early objects, and the re-emergence of Oedipal dynamics. This gap in the literature leaves CAPTs with limited technical guidance for a highly charged clinical domain.

Boschan (1992) highlights some of the additional peculiar difficulties that are related to working with adolescents. He points out that when working with this age range, analysts must “handle not only the patient's transference, but also the transferences of the family” (Boschan, 1992, p. 313). Some of the complex acting out that can take place in the family may be out of reach of the interpretations. He also warns that analysts should be cautious when interpreting erotized transferences with adolescents, which he views as narcissistic efforts to avoid dependency and with which the analyst may inadvertently collude. He notices that attempts to avoid taking up erotized material can often lead to either narcissistic withdrawal or further attempts to sexualize the analytic situation. This underscores the intergenerational complexity of erotic material in adolescent analysis: family dynamics, early relational failures, and emerging sexuality all intersect, demanding heightened analytic sensitivity.

Some recent papers that offer rich clinical examples and convey the challenges of dealing with the erotic transference in adolescent work, have become part of a book edited by Brady in 2022, a few of which are summarised below. For example, Jackson (2017) describes the work with two female late adolescents to illustrate how the erotic transference can present itself in subtle or explicit ways in the work and, in line with Symington's (1996) ideas, quite early in the treatment. He highlights the role that using the couch could have in facilitating the emergence of the erotic transference, but also how this may be accompanied by increased emotional turmoil for both patient and therapist. He acknowledges how anxiety-provoking and persecutory working with the erotic transference can be and stresses the importance of one's own analysis and the support of colleagues in reminding us that the feelings evoked are due to unconscious dynamics and not to one's own charm. Through his clinical examples,

Jackson (2017) conveys the technical challenges the erotic transference poses to CAPTs, who need to reflect carefully on when and how directly to interpret in the transference. Therapists need to consider whether an interpretation may increase the emotional temperature rather than contain the patient's feelings, and whether a decrease in temperature reflects genuine containment or an unconscious defensive flight from intolerable affect. While it is not always possible, or not possible yet to interpret the erotic transference directly, Jackson (2017) believes that it would be helpful to at least notice the presence of thoughts and feelings that for the moment feel impossible to think about, in order not to collude with the patient in turning a blind eye on them (Steiner, 1985). This example demonstrates how adolescent erotic transference can evoke both historical conflicts and contemporary relational anxiety, and how careful analytic containment supports the mourning and symbolic processing of these experiences. Here, timing and emotional temperature emerge as central technical variables.

In her 2018 paper, Brady then conveys her experience of the body being more frequently the subject of analysis with adolescents, due to their need for help to make sense of their changing bodies and overwhelming feelings. She gives a vivid example of her difficulty to think with a 16-year-old patient who, by being constantly in motion on the couch, was conveying to her the experience of commotion she felt in a moment of her life when there was the possibility of having her first sexual intercourse. This highlights the embodied nature of adolescent erotic transference, where both psychic and somatic experiences must be considered. Adolescents may struggle to mentalize or symbolize sexual feelings, and their enactments or movements often become expressions of the tension between the infantile, dependent self and emerging sexual identity.

Brady (2018) uses the term "erotic insufficiency" to describe the timid avoidance of the erotic in the work with adolescents, not linked with a lack of capacity of the therapists to work with the erotic, but due to anxiety. For example, the catastrophic possibility of boundary

violation. Therapists can worry about manipulating the child, introducing them to the world of adult sexuality, breaching incest taboos, or of retaliation from the parents and/or society (Atkinson & Gabbard, 1995) and their own parental superego (Brady, 2018). While much attention has been posed to the damage that excessive erotizing may have on adolescents' development, she warns that insufficient attention to the erotic can also be damaging. When helping adolescents with sexuality, the message that is conveyed is that sexuality is part of us and that even intense feelings can be shared. The possible impact of erotic insufficiency can therefore be to pass on the message that these intense feelings cannot be thought about.

If the analyst can feel some ease with sexual feelings alive in the field, then his or her own, as well as the patient's capacity to think about sensual/bodily/sexual feelings can develop in both patient and analyst (Brady, 2018, p. 114).

Critically, this stresses the interrelation between analyst containment and the adolescent's ability to integrate bodily and emotional experiences, highlighting how the analytic frame functions as a site for mourning, negotiation, and symbolic work. Nonetheless, it is also important to consider whether direct commentary may be helpful and how patients would receive it, as without sufficient groundwork, or with abused or over-concrete children (e.g., those on the autistic spectrum), this may be particularly difficult.

In a second clinical example, Brady (2018) describes encountering erotic feelings with a 12-year-old boy, which coincided with him entering puberty and the increase of session frequency. Differently from Jackson's (2017) examples, the erotic transference emerged two years into treatment. Brady (2018) notes that this increase in sessions affected not only her patient but also his family, who began to question her interest in the boy, consequently influencing his fantasies about their relationship. With the use of this example, Brady (2018) argues that the terms transference and countertransference do not fully describe the complexity of the dynamic in action and that the term "erotic field" better conveys the

intensity of the interaction between the two and the confusion that can at times arise about whose feelings are present in the room. The erotic field becomes for her patient an opportunity to try on feelings and fantasies and be able to name them with a containing other, enabling the patient to then use the experience in relationships with his peers. This concept underscores the relational and somatic intensity of the transference–countertransference interaction and highlights the adolescent’s need to mourn omnipotent fantasies while negotiating emerging sexuality in a safe relational context. It also raises critical technical considerations: the analyst must carefully calibrate their interventions to neither overstep boundaries nor collude with avoidance, while supporting the patient’s symbolic processing and emotional integration. Brady (2018) suggests that dyad gender configuration may facilitate or hinder the management of these dynamics, particularly during puberty when the adolescent is negotiating new sexual and relational identities.

Like Brady, Davids (2022) highlights the importance of Lemma’s (2015) concept of the embodied setting, where the analyst’s body is an embodied form of the setting, and clinicians should not only be open-minded and open-hearted, but also “open-bodied”. Therapists should pay attention to the way their bodies speak to them and to the way the two bodies of clinician and patient speak to one another somatically in the sexual field. Davids (2022) states that the somatic countertransference can put the therapist in touch with the intensity that the adolescent is experiencing, and the necessity to respond to it rather than react. A positive attitude towards one’s sexual self and the support of a more equipped adult mind, may contain and help the adolescent to make sense of their feelings and to facilitate sexual development through spoken and unspoken identification. This, critically, reinforces the importance of mourning and symbolization: adolescents must navigate the loss of infantile omnipotence and dependency, while the therapist’s containing presence provides a scaffold for the integration of emerging sexual and relational capacities. This however could be

particularly challenging as working with adolescents may evoke painful experiences from one's own adolescence, not to mention the difficulty of dealing with countertransference feelings of lust and arousal. Adolescents tend to act out and can be powerfully seductive and difficult to contain. Further self-analysis may be needed, but if well used, being in touch with one's own adolescent experiences can deepen one's capacity to empathise with patients.

Dauids (2022) highlights the importance of being impacted to avoid the risk of conveying the message that erotic feelings cannot be thought about and integrated. Nonetheless, clinicians who find themselves under sexual fire may feel harassed and coerced, left with no space to think, and may therefore become rigid, defensive, and controlling rather than containing. Supervision and peer discussions, as well as writing, can support analysts in dealing with these difficult dynamics, to maintain effective thinking which would provide a third position (Britton, 1989, 2000) and create a space to stand back, think and maintain the analytic frame. To make use of this support, however, the analyst needs to work on their own self-judgement and acknowledge their feelings of shame and discomfort. In Dauids (2022) clinical examples with two teenage boys, the absent father and the enmeshed relationship with the mother seemed to be repeated in the transference relationship. She conveys the feeling of guilt that these dynamics can be evoked in the analyst due to the age difference, feeling like the incestuous mother. She points out that some believe that it may be too stimulating for male adolescents to work with female analysts, but the literature on this is limited. Dauids (2022) describes her own experience of publication anxiety and how contained she felt by reading about other colleagues' experiences. Despite this, the general lack of publications on the matter conveys that the erotic transference in the work of adolescents can get consciously or unconsciously collusively sidestepped, recognised but not discussed out of shame or embarrassment, or completely ignored. This silence itself becomes a powerful determinant of clinical risk.

Lena (2017) conveys in her work with a depressed 16-year-old boy, developmentally stuck and unable to integrate genital sexuality, the difficulty of finding a language able to capture both the maternal and the sexual, the need and the desire. Instead, the sexually exciting emotional containment, communicated through his use of gaze, linked to Atkinson and Gabbard's (1995) idea that voyeuristic looking is part of ordinary sexual development of adolescent boys, was used to overcome boundaries and negate separateness. As Steiner (2011) points out, narcissistic patients are unable to see, as seeing implies a level of separateness; vision can be used as a medium for projective and introjective mechanisms. Lena (2017) reflects that her initial difficulty in addressing the erotic transference may have been linked with the boy's objects' incapacity to make space for his sexuality and stresses the importance of supervision to enable her not to collude with this by focusing on the maternal. She suggests that he needed to access both maternal and paternal aspects of her mind, to introject an experience of a creative couple, to relinquish his phantasies of intrusion and come to terms with the facts of life (Money-Kyrle, 1968) while also establishing a more realistic sense of potency and capacity to think. This shows how erotic transference may require integration of both maternal containment and paternal symbolic function.

Moreover, Paton (2017) describes a 16-year-old boy's difficulty in managing separation and loss and attempts to avoid feelings of depression and vulnerability by trying to intrude upon his object and control it from within. Sexualizing the atmosphere in the consulting room was one of the ways his patient found to defend himself from these feelings. Paton (2017) emphasises the importance of tracking how and when his patient used sexual talk in sessions, to discern the times when it was used as a distraction from those that represented a more ordinary adolescent experimentation. The evolution of the transference/countertransference relationship was his main tool to make sense of his patient's predicament. He names the sense of fascination and excitement stirred up in him, the feeling

of being special, and at times being swept away in a sense of symbiosis with his patient. He conveys his patient's struggle to find the right distance between himself and his object, feeling either entirely separate or fused, and writes:

I understand this temporarily fused state between subject and object to be a defence against Oedipal anxieties, as the potential third point in the Oedipal triangle is repeatedly assaulted. Most of the attempts that I made to bring understanding, relief and containment were attacked, because this very help was simultaneously experienced as a hostile and humiliating reminder of separation and an exclusion from the parental couple. (Paton, 2017, p. 36)

He references Britton (2003), who describes how in the erotic countertransference the dyadic transference relationship obliterates the primal couple, leading to a collapse of the Oedipal triangle. In line with this, Paton (2017) notices how at times he found himself resisting his supervisor's encouragement to take a more paternal stance, perceiving her as a third intruding upon the exclusivity of the therapeutic couple. He reflects on his difficulty in being in touch with the overwhelming feelings of loss and sadness that emerged as the treatment progressed, and on how, when he became able to recognise and begin to work through these feelings and tolerate the triangular relationship, his patient became more able to progress himself in these areas. This demonstrates that navigating erotic transference with adolescents is inseparable from facilitating mourning, negotiating Oedipal anxieties, and supporting the emergence of differentiated yet connected relational experiences.

### **The Erotic Transference in Research**

While the theoretical literature on erotic transference provides a rich psychoanalytic framework, empirical research remains limited and fragmented, often reliant on self-report questionnaires or small qualitative samples. Importantly, all existing studies focus exclusively on adult populations, leaving a critical gap in relation to adolescents. Nonetheless, these

empirical accounts highlight recurring themes: the prevalence of sexual feelings in therapy, the shame and silence surrounding them, the centrality of supervision, and the consequences of inadequate training.

The absence of empirical studies with adolescents is particularly striking given that adolescence is a developmental stage characterised by rapid psychosexual maturation, identity formation, and boundary testing. To explore how CAPTs might engage with erotic transference, it is therefore necessary to draw on studies of adult practice, focusing on therapists' experiences, attitudes, and training in managing sexual and erotic dynamics. However, this methodological necessity also introduces important questions about transferability and developmental specificity.

The earliest large-scale survey, Pope et al. (1986), established the prevalence of sexual attraction in therapeutic relationships. The majority of their 585 psychologist participants reported finding at least one client attractive, yet most had not seriously contemplated acting upon these feelings. Importantly, the study revealed that therapists rarely received formal education on managing sexual or erotic attraction, leading many, particularly younger clinicians, to seek supervision when confronted with these experiences. Sexual feelings were largely considered antitherapeutic, perhaps explaining their exclusion from training curricula. Yet, Pope et al. (1986) highlighted that concern for patient welfare, more than fear of disciplinary consequences, was central in preventing boundary violations, underscoring the need for safe educational spaces where trainees can acknowledge and discuss erotic feelings without fear of judgement or intrusion. This early study already established the foundational tension between ethical responsibility, professional anxiety, and institutional silence.

Giovazolias and Davis (2001) extended this line of inquiry, finding that nearly half of their 122 counselling psychologists normalised feelings of attraction towards clients, while others experienced guilt or shock. Their study suggested a shift away from absolute taboo,

with some therapists viewing erotic feelings as potentially beneficial for the therapeutic process, particularly when acknowledged in supervision or personal therapy. However, a substantial proportion of participants disclosed their feelings to no one, raising concerns about the isolation and risk that secrecy can bring.

Luca (2018) provided a trainee perspective, showing how internalised social taboos, moralistic reactions, and fear of professional censure foster defensive responses to client attraction. Trainees often anticipated punitive reactions from supervisors or institutions, leaving them ill-equipped to address sexual desire in the therapeutic encounter. This points to the centrality of training and supervisory cultures in shaping how erotic material is managed.

Using an Interpretative Phenomenological Analysis (IPA), Rodgers (2011) explored the experiences of six therapists from diverse theoretical orientations and illuminated the blurred and often confusing distinction between erotic and loving feelings. Participants differed in their views of whether engaging with these phenomena could enhance therapeutic work, but all highlighted the shame and embarrassment associated with the topic, and the critical role of supervision in navigating it. Rodgers' study also drew on Kearnes' (2007) warning that therapists lacking psychosexual training may mishandle erotic transference, a risk heightened in the current climate of professional scrutiny around sexual misconduct. This highlights how fear of error may paradoxically increase clinical risk through avoidance.

Similarly, Spilly (2008) emphasised the variability of therapists' responses, noting that more affectionate or loving erotic transferences tended to elicit empathy and openness, while more overtly sexualised or "erotised" transferences provoked disgust, violation, or avoidance. Therapies often reached impasse when erotic dynamics were ignored, with rupture or derailment as potential consequences. Spilly's participants stressed the need for a middle ground between seduction and denial, but identified significant obstacles, including shame, anxiety, and a lack of training. Countertransference responses were often intensified when

therapists themselves were struggling in personal relationships or experiencing loneliness, suggesting that the therapist's own subjectivity and developmental history powerfully shape their capacity to work with erotic material.

Barnewall (2016), interviewing three female humanistic and integrative psychotherapists, further explored the intersection of gender, sexual identity, and erotic transference. Female therapists' lack of awareness or confidence in engaging with erotic dynamics suggested resistance or discomfort, while boundary negotiation emerged as a central theme. Unlike other studies, participants did not find personal therapy a useful resource for addressing erotic issues, but emphasised supervision and self-awareness as essential for developing skills in this area.

Recent work by Lans et al. (2024) offers a more nuanced mapping of therapists' understandings of erotic transference, using thematic analysis of 116 practitioners' responses. Three themes emerged: threat, where erotic dynamics undermined the therapist's professional identity or the therapeutic relationship; boundaries, where erotic transference required careful negotiation and carried risks of rejection or rupture; and growth, where working through erotic material fostered therapist development and patient insight. Interestingly, most participants aligned with only one theme, with little overlap, suggesting polarised perspectives. Demographic variables influenced responses, with male therapists focusing more on boundaries, and more religious therapists being less likely to see erotic transference as growth-promoting. This highlights the influence of personal values and beliefs in shaping professional practice.

Complementing this, Gewirtz-Meydan et al. (2024) developed the Therapists' Attitude towards Sexual and Erotic Feelings (TASEF) scale, identifying four dimensions (gratification, fear, threat, and aversion) that structure therapists' responses to erotic dynamics. Findings suggested meaningful differences across gender, sexual orientation, therapeutic experience,

and income. This psychometric work offers a tool for future research and clinical training, enabling therapists to monitor their responses and to develop greater reflexivity. However, such tools cannot substitute for sustained relational and supervisory containment.

Across the literature, a consistent finding is the absence of formal training in recognising and working with erotic transference (Luca, 2018; Pope et al., 1986; Spilly, 2008). When erotic feelings arise, therapists frequently rely on supervision or consultation, though shame and fear of judgement can inhibit disclosure (Spilly, 2008). For trainees especially, professional cultures that moralise or pathologise sexual attraction risk leaving them isolated (Luca, 2018). Educational programmes that normalise discussion of sexual and erotic feelings and provide clear ethical frameworks and safe supervisory spaces appear essential for protecting both patients and therapists (Giovazolias & Davis, 2001). Training thus emerges as a central ethical safeguard rather than a peripheral skill.

Although the above studies focus on adult therapy, their findings resonate strongly with the challenges of adolescent work. Adolescents' emerging sexuality and identity formation may make erotic dynamics both more likely and more developmentally salient, yet therapists may feel even less prepared to address them given societal anxieties around sexuality and safeguarding. The themes of shame, silence, inadequate training, and supervision identified across the adult literature point to significant risks if adolescent psychotherapists remain unsupported in this domain. Conversely, the potential for growth and therapeutic deepening, as highlighted in Lans et al. (2024), suggests that careful engagement with erotic transference within firm ethical and developmental boundaries may represent an important and underexplored avenue in adolescent psychotherapy. Methodologically, most studies rely on self-report and heterogeneous samples, often collapsing attraction, erotic feelings, and erotic transference, with little attention to developmental stage, analytic school, or setting. Crucially, no study examines psychoanalytically trained CAPTs working with

adolescents, leaving unanswered how clinicians recognise, think about, and technically manage erotic dynamics. It is precisely this methodological and clinical gap that the present study seeks to address.

## **Conclusion**

The literature demonstrates that sexuality is a central yet complex aspect of adolescent development, intimately tied to identity formation, mourning of the infantile self, and the negotiation of Oedipal conflicts. Adolescents navigate intense bodily, sexual, and relational changes that can overwhelm emerging ego capacities, particularly for those with disrupted early attachments. Clinical findings indicate that these dynamics often manifest in transference and countertransference phenomena, including erotic and erotized transferences, which can range from developmentally adaptive expressions of desire to perverse or defensive enactments.

Empirical and clinical studies highlight the nuanced ways these dynamics appear in therapy. Adolescents may act out or withdraw, rely on narcissistic defences, or attempt to sexualise the analytic space to manage overwhelming feelings. Therapists' countertransference, particularly erotic countertransference, plays a critical role in shaping the therapeutic encounter, and reflective supervision and embodied awareness are essential for containing these interactions. Importantly, participants in existing empirical studies are often clinicians from other disciplines and theoretical orientations, which may limit how their findings can be generalised to the work of child and adolescent psychotherapists. This further underscores the need for discipline-specific investigation.

The literature focused on adult patients further shows that erotic transference is widely experienced yet insufficiently conceptualised in training and practice. While some clinicians view erotic dynamics as antitherapeutic or taboo, others recognise their potential to deepen analytic work when approached ethically and reflexively. This ambivalence underscores a

broader tension between safeguarding anxieties and the developmental need to think about sexuality as a meaningful aspect of the therapeutic field. Supervision, institutional support, and spaces for open discussion emerge as central in mediating this tension. Without such spaces, avoidance itself becomes a clinical risk.

Finally, the absence of systematic empirical research on adolescent populations represents a significant gap, given the developmental centrality of sexuality during this stage and the heightened ethical sensitivities it entails. By drawing on and extending adult-focused studies, this thesis explores how CAPTs currently understand and work with erotic transference in adolescence. The findings aim to inform clinical practice, contribute to training and supervision frameworks, and identify directions for future research that can bridge the persistent divide between psychoanalytic theory and empirical inquiry.

## Empirical Study

### Introduction

The literature review highlighted that while the erotic transference has been extensively explored in psychoanalytic work with adults, empirical research focusing on its manifestation and clinical management in adolescent psychotherapy remains virtually absent. This gap is striking given that sexuality and the negotiation of erotic feelings are central to adolescent development, and that the therapeutic relationship often becomes a crucial space where these experiences are expressed and understood. Existing studies (e.g., Lans et al., 2024; Luca, 2018; Spilly, 2008) have primarily examined adult clinical work, leaving limited understanding of how CAPTs engage with and conceptualise erotic dynamics in this younger population.

The present study aims to begin addressing this gap by exploring how CAPTs understand and work with the erotic transference in adolescents. This study addresses the following research question: *How do Child and Adolescent Psychotherapists work with the erotic transference with adolescents?* In doing so, it also examines how therapists conceptualise this phenomenon and navigate its clinical, emotional, and theoretical complexities.

A qualitative design was chosen to enable a nuanced exploration of participants' subjective experiences and meaning-making processes. Reflexive Thematic Analysis (Braun & Clarke, 2006, 2019, 2022) was deemed particularly suitable, as it allows attention to both the latent and manifest meanings within participants' accounts and acknowledges the active interpretative role of the researcher. Other qualitative approaches were considered but found less suitable. Interpretative Phenomenological Analysis (IPA), though valuable for exploring lived experience, adopts a highly idiographic and phenomenological focus that was not compatible with this study's broader interest in professional discourse and shared meaning-

making across participants (Smith et al., 2009). Grounded Theory, particularly in its classical and Straussian forms, seeks to build explanatory theory through iterative comparison (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Its realist assumptions and goal of theoretical saturation were inconsistent with the study's constructivist stance and exploratory intent.

RTA therefore offered the most coherent and methodologically rigorous framework through which to explore how CAPTs navigate erotic transference. Its adaptability, reflexivity, and capacity to engage with latent and contextual meaning made it particularly well suited to investigating a topic characterised by ethical complexity, professional ambiguity, and emotional intensity.

This study is grounded in a Kleinian and post-Kleinian understanding of the analytic relationship. Following Heimann's (1950) view of countertransference as a means of understanding the patient's unconscious communications, and Joseph's (1985) concept of the "total transference situation", transference and countertransference are regarded as interdependent aspects of a shared emotional field. Within this perspective, all communications, whether verbal, non-verbal, or enacted, are understood as expressions of the transference. Consequently, even subtle or indirect references to the erotic are considered manifestations of the erotic transference, reflecting the patient's internal world and their relationship to sexuality, dependency, and separation. Although participants were not selected based on their theoretical orientation, all identified as working within the Kleinian tradition, which shaped how they conceptualised and described these dynamics. This framework also informed the author's interpretative stance in the analysis.

## Methodology

### Aims

This qualitative study aimed to explore how CAPTs understand and work with erotic transference in their clinical practice with adolescents. To investigate how clinicians recognise, think about, and respond to erotic transference phenomena within the therapeutic relationship, the following overarching research question was designed to guide a focused and in-depth exploration:

*How do Child and Adolescent Psychotherapists work with the erotic transference with adolescents?*

### Recruitment

CAPTs were recruited using a purposeful sampling approach, which allows for the selection of information-rich cases relevant to the focus of the study (Patton, 2014). Recruitment initially targeted clinicians who had shown a particular professional interest in the topic of erotic transference in adolescent work, such as through publications, conference presentations, or public discussions. Given the sensitivity of the subject, these clinicians were considered more likely to engage openly and offer theoretically informed reflections on their clinical experience. Because explicit discussions of this phenomenon are scarce in both training and the literature, participants who had previously reflected on the topic were considered best positioned to provide rich and thoughtful accounts of how erotic dynamics are experienced, conceptualised, and worked with in adolescent psychotherapy.

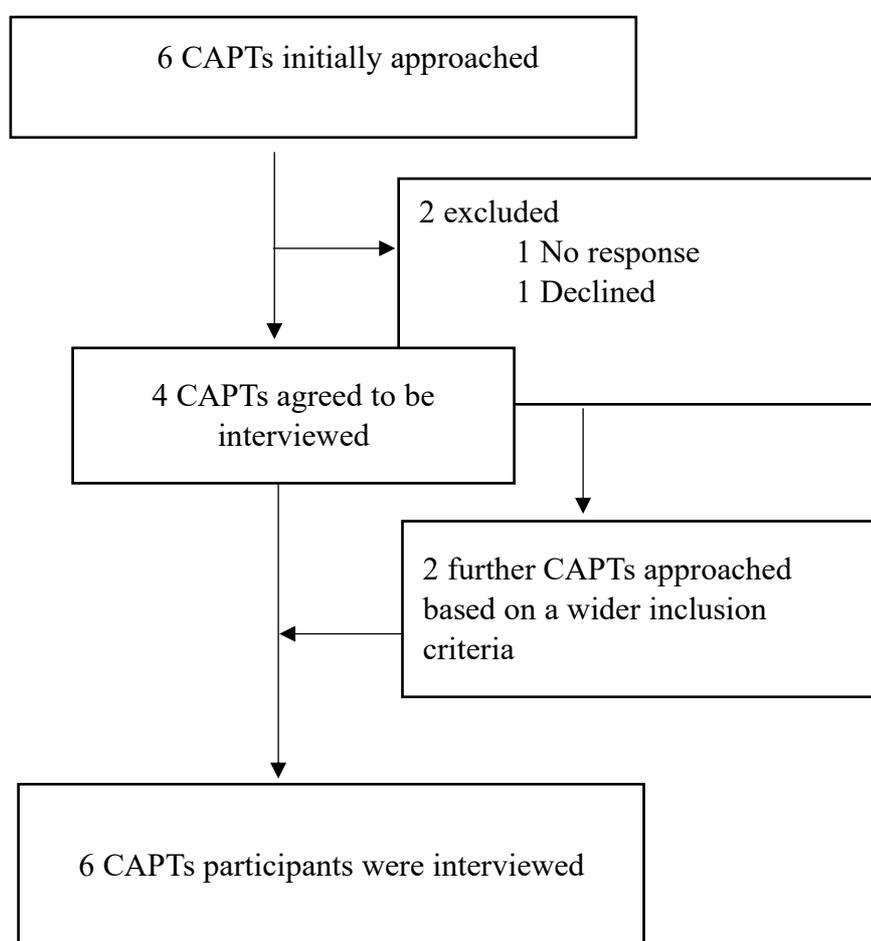
Six clinicians were initially approached: four expressed interest, one declined, and one did not respond. To ensure sufficient diversity of perspectives, the inclusion criteria were subsequently expanded to include CAPTs with extensive clinical experience in adolescent psychotherapy and an interest in topics related to the erotic transference. Two additional

participants were recruited under these broader criteria, resulting in a final sample of six participants (see Figure 2 for the recruitment process).

Recruitment took place via direct email contact and the distribution of a Participant Information Sheet (Appendix A). Follow-up exchanges via email or in person were used to discuss the study aims and address any questions prior to obtaining informed consent.

## Figure 2

### *Recruitment process*



### **Participants**

Six qualified Child and Adolescent Psychotherapists took part in the study. To preserve anonymity, demographic information is presented in aggregate form. Approximately half of the participants identified as male and half as female. The majority (around 80%) identified as heterosexual, with 20% identifying as LGBTQ+. All participants were cisgender

and worked across a range of professional settings, including private practice, NHS, and third-sector contexts. All participants were trained within a Kleinian or post-Kleinian framework. This was not a deliberate sampling decision but rather a reflection of those who chose to participate, as clinicians from other psychoanalytic schools either declined or did not respond. The sample composition and its implications for transferability are further reflected upon in the Discussion section.

Some of the participants were previously known to the researcher in a professional capacity, while others were known by reputation but not personally. These relationships are discussed reflexively in the Discussion section in relation to the researcher's positionality.

### **Study design**

Given the exploratory and under-researched nature of the topic, a qualitative design was chosen to capture the complexity, nuance, and subjectivity of therapists' experiences. The study sought depth of understanding rather than generalisation and therefore adopted Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2006, 2019, 2022) as the analytic framework. RTA's critical-constructivist flexibility, together with its emphasis on researcher reflexivity and engagement with complex and sensitive material, made it particularly suited to a topic characterised by sensitivity, taboo, and emotional intensity.

RTA is best understood as a method of data analysis rather than a full methodology, offering a structured yet adaptable framework to organise, interpret, and theorise qualitative data (Braun & Clarke, 2022). Its reflexive orientation positions the researcher's subjectivity as an analytic resource rather than a source of bias; meaning is viewed as co-constructed between researcher, participant, and context. Throughout the analytic process, a reflexive journal was maintained to record thoughts, reactions, and emerging insights, helping to trace how interpretative choices and disciplinary assumptions shaped meaning-making (Braun & Clarke, 2022).

The research was approached within a psychoanalytic epistemology, informed by Kleinian and post-Kleinian perspectives of the transference as the “total situation” (Joseph, 1985) and Heimann’s (1950) definition of countertransference. This view recognises that all communications, verbal, behavioural, or affective, are part of the transference and thus relevant to understanding erotic dynamics. This theoretical grounding informed both the research question and the analytic process, shaping how meanings in participants’ accounts were interpreted and contextualised. While RTA is itself a-theoretical, this study was informed by a psychoanalytic epistemology, particularly the assumption that latent meanings underlie manifest communications. Coding therefore combined inductive engagement with participants’ language and deductive sensitivity to psychoanalytic concepts, consistent with RTA’s flexibility and openness to multiple interpretative lenses.

### **Data collection**

A semi-structured interview was used, with the interview schedule (Appendix C) sent to participants ahead of the interview. Although this limited spontaneous data collection, given the sensitivity of the topic it was important to ensure that interviews were less distressing by allowing participants to know what to expect.

Supporting prompts were used in interviews to facilitate discussion on participants’ thoughts on how the erotic transference may present in adolescent work, what risks or dilemmas clinicians encounter, and what facilitates or hinders engagement with erotic dynamics, but these were intended as avenues of exploration within the main question rather than additional research questions. The interview questions were informed by the literature and, due to the sensitivity of the topic, were carefully selected following discussions with peers in the author’s research workshop and in supervision. Interviews lasted around an hour.

The following three areas were explored:

- The participants' thoughts on how erotic transference can present itself in the work with adolescents (e.g. explicit towards the therapist or implicit towards other people in the patient's life)
- The participants' ideas and opinions on how Child and Adolescent Psychotherapists currently work with the erotic transference, referring both to their own experience as clinicians and as supervisors
- The participants' sense of whether and why erotic transference has become a taboo, and what the risks and gains of thinking more about it might be.

In line with a semi-structured interview, a flexible approach was maintained in which participants largely led the discussion, speaking freely about their thoughts and experiences and using clinical examples to explore the topic, allowing themes and associations to emerge. When needed, the interviewer encouraged further exploration of the themes by asking questions and facilitated a conversational reflection on the participants' thoughts and ideas.

Interviews were arranged at times and in places that were most convenient to participants. Two of the interviews took place in person at the participant's place of work, while four took place on Zoom, either because of time restrictions or because the participant was out of London. Interviews were audio-recorded using either a portable recorder or a phone. Recordings of the interviews were stored in a password-protected computer. Interviews were then transcribed verbatim using a dictation software. The transcription was reviewed while listening to the recording to correct for any mistakes.

### **Data analysis**

Data were analysed following the steps outlined by Braun and Clarke (2022), as summarised in Table 2. However, Reflexive Thematic Analysis (RTA) is not a strictly linear process. The analytic work involved continuous movement between immersion in the data and periods of reflection, allowing interpretative depth to develop over time. As familiarity

with the data and confidence in the coding process grew, stepping back from the material periodically helped to refine and clarify the emerging thematic structure. The focus was on deepening interpretation rather than seeking a definitive answer to the research question. RTA is “a subjective, situated engagement with data” (Braun & Clarke, 2022, p. 92), and analysis is therefore never fully complete. Data analysis was concluded when the author judged that the themes sufficiently captured meaningful patterns relevant to the research question.

## **Table 2**

*Data analysis steps (guided by Braun & Clarke, 2022)*

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### **1. Familiarisation with the dataset**

- a. Proofread the interview transcripts while listening to the recording, amending any details that would have made the participants recognisable.
- b. Once all interviews were transcribed, continue to familiarise oneself with the dataset by reading the transcripts again.

### **2. Coding**

- a. Assign initial codes to salient sections of the transcript. Importantly, focus on capturing single meanings or concepts rather than just summarising the content of the section. Code both at a semantic, more explicit and surface-meaning level, and a more latent, implicit level. Assigning more than one code to each section captures a mixture of semantic and latent codes, reflecting broader meanings and more detailed aspects of the data.
- b. Once all interviews were coded, a second round of coding clusters the codes across all different transcripts.

### **3. Generating initial themes**

- a. Combining codes obtained to identify patterns of meaning that become provisional preliminary themes, with broader and specific themes emerging.
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- b. A visual mapping process helps make sense of the connections between the different themes.

#### **4. Refining and naming themes**

- a. Avoiding creating too many themes, resulting in a fragmented analysis, while also capturing the essence of the themes. Thus, some of the preliminary themes were reviewed to determine whether they were sub-themes, or aspects of a theme.
- b. To aid the refining process, reviewing the emerging themes with peers and in supervision allowed the author to identify discrepancies and repetitions and to refine connections between themes and sub-themes..

#### **5. Writing up**

- a. The process of writing up findings further aided the refining process.
  - b. The selection of quotes to represent the themes aided this.
- 

### **Ethical considerations**

This project was approved by the Tavistock Research Ethics Committee (TREC) in July 2023 (Appendix D). The nature of the study did not require any enhanced ethical considerations. Participation was not anticipated to raise issues for the participants, as they were qualified CAPTs with access to supervision, personal analysis, and collegial support. Nonetheless, following the interviews, each participant was provided with a debrief email (Appendix E), which included information about the Trust's confidential counselling service, the author's and their supervisor's contact details, and the Head of Academic Governance and Quality Assurance.

Informed consent was acquired from all participants (Appendix F). The different relationships the author had in relation to the participants are accounted for in the discussion

section. Of note, “previous personal experience of a topic may sensitise the researcher to the deeper significance of that topic in the lives of informants, and may make the researcher more credible and trustworthy to informants (McLeod, 2015, p. 105).

Participants were informed that interviews were recorded and transcribed verbatim and that direct quotes might be used, meaning they could potentially identify themselves in the final report. However, they were aware that to ensure confidentiality any identifiable information would be excluded/disguised about them and their patients. As Smith et al. (2009), state researchers can guarantee that the interviews will remain anonymous, but they will not be confidential. Given the small pool of authors in this area of research, careful consideration was given to avoid involuntarily identify participants based on chosen data extracts quoted.

## Findings

To answer the research question *How do CAPTs work with the erotic transference with adolescents?*, semi-structured interviews investigated participants' views and thoughts in the following areas, with the aid of examples of direct or indirect clinical work: how adolescent patients bring the erotic transference into the work, how CAPTs work with the erotic transference with adolescents, and the possible risks and gains of working with the erotic transference.

Through the data analysis, five themes were identified, one of which had subthemes presented in turn.

- 1. Navigating ambivalence**
- 2. Making sense of the erotic transference**
- 3. Working with external influences**
  - 3.1. Therapist-patient match**
  - 3.2. Gendered societal expectations**
- 4. Risks in the erotic transference**
- 5. Finding the right level**

### **Theme 1 - Navigating ambivalence**

This theme captures the tensions and oscillations therapists experience when erotic transference emerges in adolescent psychotherapy. Participants described struggling between avoiding uncomfortable feelings and engaging with material that can illuminate the patient's inner world, highlighting both the challenges and psychoanalytic potential of working with erotic material. Erotic feelings were frequently experienced as taboo, unsettling, or difficult to acknowledge not only within the therapeutic relationship but also in the wider professional context. As one participant observed:

*One of the easiest areas of work not to get discussed because it's uncomfortable, you know. And within the countertransference, the transference and countertransference relationship is one of the most uncomfortable areas. (P6)*

Participants highlighted how the emergence of erotic transference can provoke confusion and defensive reactions in therapists. Explicit erotic feelings were described as particularly powerful and sometimes shocking, making it difficult for clinicians to think clearly and respond appropriately. For example:

*She was like so shocked. She was like "I don't know what to do! What's going on? What do I do?". She was like a rabbit in the headlights, and she was you know... she just felt so not surprisingly really challenged by this. (P4)*

However, erotic transference often manifests in subtle or indirect ways, such as through non-verbal communication, attire, or accounts of external relationships, which may be less immediately alarming but equally significant:

*With adolescents, it's so powerful, I mean, it may be the way they dress, it may be, I mean, sometimes much more openly, I've heard of older adolescents just saying I really want to fuck you. And therapists having to hold the fort as it were. (P3)*

Implicit erotic transferences can be easier to defend against and therefore more likely to be overlooked, potentially missing important developmental or relational communications.

*There is something that feels perhaps, in my experience, more intrusive or even more uncomfortably when in the countertransference the therapist notices some sexual feelings towards a patient. And that may be something that is very difficult to acknowledge and reflect upon. (P1)*

Participants noted that less experienced therapists, in particular, may struggle to acknowledge these feelings in supervision or discuss them openly with colleagues:

*Those kinds of more intense erotic feelings that are aroused in clinicians are really perhaps not, were not discussed certainly on my training, but also in a way, those kinds of feelings weren't sort of discussed openly in the groups. (P5)*

Consequently, limited use of supervision can leave clinicians feeling even more confused about how to work with these dynamics therapeutically.

*And then because we tend to talk about it less in supervisions and with colleagues, we then also think less about A) how we might take things up and B) the potential risks of not taking things up. (P6)*

This avoidance may lead therapists to interpret erotic material defensively, such as focusing on infantile expressions of desire rather than adult, contemporary erotic dynamics:

*I think they respond defensively to something that's more adult erotic transference, more genital, rather than oral. And instead, they're interpreting things as an oral level, the wish for the baby to kind of consume mummy sort of thing. And so, I think that's done defensively. (P2)*

Participants emphasized that ambivalence may be heightened in adolescent work compared to adult psychotherapy due to societal taboos around adolescent sexuality and the perceived inappropriateness of erotic feelings. Yet alongside avoidance, therapists expressed a clear wish to understand and make sense of these dynamics, either through supervision, literature, or direct clinical exploration. This oscillation between defensive retreat and reflective engagement highlights the complexity of navigating ambivalence in adolescent erotic transference:

*It was something that I found so puzzling and so disconcerting that I felt the need to go and read papers about and put my mind to it. (P1)*

*On one hand, I thought, gosh, this feels very hard to weather and kind of sustain this or withstand it rather. And then another part of me thought, oh gosh, how exciting this is. This is so, there's so much rich psychoanalytic potential here. (P2)*

## **Theme 2 - Making sense of the erotic transference**

This theme explores how CAPTs make sense of erotic transference to distinguish defensive manoeuvres from expressions of developmental striving. Participants highlighted the importance of understanding the function of erotic material as a guide for therapeutic technique and as a window into the adolescent's internal world and relational needs. Working with the erotic transference required therapists to tolerate confusion and uncertainty while remaining curious about what was being communicated through these complex dynamics.

Participants emphasised the centrality of supervision and personal analysis in helping them make sense of these experiences. As Participant 4 noted:

*And then the need for supervision, the need for the third position and all of that... you know... The importance of that third to go in and to think about... to help the therapist think about what's going on in the transference relationship and the erotic transference or whatever transference it is... I think that's particularly important with these cases. (P4)*

Several participants suggested that there may be times when it is neither appropriate nor necessary to address erotic transference directly with the patient. What mattered, they felt, was that the therapist understood its meaning and function within the therapeutic process. As Participant 1 described:

*As any information that comes through the transference and countertransference, it's so useful to achieve some sort of coherent and informative formulation. In less extreme cases, it may not be again, as I said earlier, something that needs to be taken up very directly with the patient. But it's so useful to be able to learn from it in supervision or*

*even if it's not taken to supervision, but within yourself when you think about a case.*

(P1)

Across interviews, participants described a general tendency within child psychotherapy to conceptualise erotic transference primarily as a defence against dependency, vulnerability, and separation. As Participant 4 reflected:

*I don't know what your thoughts are about the erotic transference, but we do see it as a defence, don't we, against dependence and against you know sort of feelings of the iniquity of the kind of the power relationship in therapy against the feelings of dependence (P4)*

However, participants also offered examples where erotic transference seemed less defensive and more linked to ordinary developmental processes. Participant 4 illustrated this through reference to common adolescent experiences:

*We've all had crushes on teachers... I'm sure, I mean I certainly did, you know. There's a certain teacher you absolutely hate and there are teachers you really want to be your best mate, there's teachers you fall in love with, there's all of that... (P4)*

These accounts suggest that erotic feelings in adolescence can represent a natural, if unsettling, part of development. Yet, as Participant 6 noted, such experiences often evoke confusion and anxiety in both adolescents and adults:

*When children start hitting puberty and adolescence, they might have a dream with sexual content around a family member which would be very disturbing for them, you know... that... and then there might be a kind of... and then there's often a need to kind of create some distance with family members, just because the sort of clarification in their minds between intimacy and sexuality is so much more fragile. So that the kind of crossing over and the blurring happens much more easily. (P6)*

Participants emphasised that CAPTs need to distinguish between discomfort arising from developmental struggle and that reflecting psychopathology. As Participant 6 further explained:

*And adolescents are much less able also to differentiate between intimacy and sexuality, so you know... Adolescents feel a lot... Children and adolescents feel a lot through the body so I think that you know intimacy for a young person, especially if they haven't really had a quality of intimacy and attention in their life, is a very... that on its own is a hot experience. (P6)*

The intimate and containing nature of therapy may thus become a fertile space for such feelings to emerge. Recognising this allows CAPTs to understand the erotic transference not merely as resistance but also as an attempt at connection, exploration, or vitality.

Participant 4 described how assessing an adolescent's stage of sexual development is integral to clinical formulation and understanding the meaning of the transference:

*When we are assessing, we always sort of make an assessment, don't we, where they are in their sexual development let's say as well, and their relationships, you know, their intimate relationships and all the rest of it. So, you know you do, you know, we do work with young people where you feel it should be there, you know what I mean? There's this... there seems to be a stuck in latency type... that's where they are in their development. There's a sort of sexual development that hasn't... Isn't progressing (P4)*

Participants shared experiences illustrating both defensive and developmental expressions of erotic transference. Participant 1 reflected on an adolescent whose erotic expression was more exploratory:

*Sexual transference is also a lot less heavy and disturbing than in the initial case that I mentioned. More of a playful developmental exercise, you know, that can happen in the room with a therapist where actually you're just trying on, you know, how would*

*you feel in an intimate relationship as an adolescent. So I think with that case, I have in mind that there was a sense that a part of her was maybe interested in, you know, experimenting that, but then a bigger part of her was very defended and, you know, really holding on to this fantastic label of asexuality, which I didn't believe was relevant for her. (P1)*

Participant 2 contrasted two patients to illustrate the difference between developmental and defensive erotic transference:

*With the first one, it felt like it was so defensive. It was hard to get to a more ordinary adolescent, figuring out his sexuality, trying to figure out my sexuality, trying to figure out different ways that he could relate to me in the room, exploring all sorts of different feelings that came up in the transference. It was less like that. It was more to do with utilizing, unconsciously again, but utilizing something erotic as a way of kind of getting inside me in an intrusive way to kind of control me. With this other boy, he's much less like that. It is much more ordinary. He wouldn't talk about it in relation to me (P2)*

Participants therefore underlined the importance of distinguishing when erotic feelings represent a developmental striving for recognition and potency, and when they function defensively to manage anxiety, control, or separation. Participant 5 articulated this developmental aspect well:

*It's somehow important that the patient needs to know that they have an impact on you. And what that impact is, and that might be an actual erotic level. And so how do you talk about that, in a way, this is, you know, safe or feels appropriate, because they might want to know that they have, you know, done something to you, that they have provoked something in you. In a way, you know, adolescent, children, want to feel that they're attractive, you know, the parents, so, I mean... I remember a male supervisor*

*saying to me, you know, that's what she really wants to notice if you think she's the kind of girl that boys would like, which I thought was a really interesting phrase. (P5)*

In contrast, defensive erotic transference often involved feelings of intrusion and entrapment, both for the patient and the therapist. Participant 4 described this “bubble” of seductiveness:

*The violence and all of the more difficult feelings were being kept outside the room. There was this real attempt I think just to... just to make us this sort of perfect fit, you know, dyadic no separation. We're just in there the two of us against the world. (P4)*

Similarly, Participant 2 conveyed the claustrophobic intensity of such dynamics:

*This is the bit that was the most uncomfortable, but it kind of found a place in me that where I could kind of get, I could get a bit lost there with him. And that he and I could be like this. So, we could be very, very kind of undifferentiated, very, very close and intimate, but too... like in a claustrophobic way. (P2)*

These examples highlight the importance of understanding what the erotic transference might be defending against. Participant 6 described how for some adolescents, seductiveness becomes a means to secure the therapist’s attention in the absence of earlier experiences of emotional attunement:

*It was as if she couldn't believe that I could actually hold her in my mind in any meaningful way if I wasn't actually sleeping with her, if we weren't sleeping together she couldn't actually trust that she really had my attention because she was so used to using her body as the means to get people's attention and that she just didn't have any faith in any other way. (P6)*

Similarly, Participant 5 viewed erotic transference as a defence against dependency and separation:

*I think there is something about her that wants to be seen as a sort of exciting sexual girl, rather than more thinking about her sorts of littleness and her dependency and her feelings of being left out. And... so... I think she... she can feel terribly left out all the time. And I think there's a real difficulty with separation. (P5)*

In this way, the iniquity of power in the therapeutic relationship can be denied in an omnipotent way.

Participants also suggested that not only the presence, but the absence of erotic feelings could be clinically significant. A total absence of sexuality, both within and outside therapy, might indicate developmental arrest or retreat. As Participant 1 explained:

*It was something to do with this boy maybe coming also quite in a rushed way to experience his sexuality without having experimented. So this was a boy who hadn't been out and about acting out his sexual feelings. It was something, the context of his development was a lot more in a retreat. So it was as if he found himself for the first time in a relationship that felt quite emotionally intimate. And suddenly this wave of sexual feelings just came upon him and took everything over (P1)*

Participant 2 echoed this, noting that an absence of erotic transference could signal avoidance of closeness or fear of reciprocation:

*I think it's so central to adolescence in particular, that I think that if it doesn't come up, and if it doesn't come up in the transference to an extent, I think probably there's something a bit missing. (P2)*

*it's an anxiety then of, of a fear of actually getting too close, of an actual boundary being broken, being with someone that could reciprocate. I guess that must be part of what their anxiety is about keeping it at bay. Something to do with the reality of their struggle, trying to keep that further away perhaps. (P2)*

Taken together, these accounts suggest that a certain level of erotic feeling within the therapeutic relationship and the capacity to reflect on it are a marker of vitality and developmental movement. For CAPTs, the task lies in recognising the meaning of the erotic transference, neither pathologizing nor idealising it, but using it to understand the adolescent's psychic reality and promote growth.

### **Theme 3 - Working with external influences**

This theme explores how contextual factors ranging from societal and cultural norms to the characteristics of the therapeutic dyad shape CAPTs' capacity to notice, think about, and work with erotic transference. Participants reflected on how the broader cultural environment, organisational context, and prevailing gender expectations can either facilitate or hinder the exploration of erotic dynamics in therapy. They also highlighted how the therapist–patient match, including factors such as gender, sexual orientation, and age, can influence both the recognition and management of erotic transference and countertransference, thereby affecting clinical decision-making and the overall therapeutic process.

Participants wondered whether psychoanalysis itself has, over time, closed itself off to thinking about sexuality. Several referred to the tendency within the object relations approach to focus primarily on early mother–infant relationships, which may risk neglecting the place of sexuality in psychic life. As Participant 2 observed:

*In child psychotherapy, we have such a tendency to focus on the baby and the mother, or the nipple in the mouth. We really struggle to get past that. (P2)*

Such reflections suggest that one's theoretical training and analytic background can deeply influence how one perceives, conceptualises, and works with erotic transference.

At a broader level, participants reflected on the role of culture in shaping openness or defensiveness towards sexuality. A closed, persecutory culture can restrict thinking and

generate fear, influencing not only how CAPTs approach sexuality in the consulting room but also how free they feel to think and speak about it with colleagues. Since psychotherapy concerns itself with exploring thoughts and feelings that are difficult to think, a cultural climate of anxiety and persecution may threaten the very conditions required for therapeutic reflection. As Participants 2 and 4 described:

*I think culture is becoming more fearful, I think there's also becoming more sensitive, what it should do. But I think there's also the other side of it is that people become very frightened and talking openly about anything, they worry about, there's a lot of worry about offending people. And I think that we need to be careful that that doesn't get into psychoanalysis too much, or child psychotherapy too much, because we need to be able to call a spade a spade and to talk straightforward with patients (P2)*

*Culturally we don't talk openly and that's what all this thrust in schools in terms of safe relationships and sexual... sex and relationship education and all of that's very very important. Isn't it? Culturally, we need to be able to... Talk more openly about... about sex and sexual development. And I think we take that into the consulting room with us. (P4)*

Alongside this, participants reflected on the current social climate in which clinicians often feel scrutinised and fearful of potential allegations. This heightened vigilance may lead CAPTs to avoid acknowledging or discussing erotic transferences and countertransferences out of anxiety about professional risk:

*He said "If I went home and said that I'd had these feelings for this girl dancing like the Spice Girl, I'd be fired!". And he would with this all this stuff about child abuse nowadays. (P3)*

Participants also discussed how cultural factors influence adolescents' experience and expression of sexuality. CAPTs emphasised the importance of remaining sensitive to the

cultural contexts that shape patients' attitudes towards erotic and relational life. As Participant 4 reflected:

*The moment I just think one has to remain open to it and curious and sensitive to culture. I mean, it's whether you're working with a Jehovah Witness or a, you know, a gang member, you know for whose... relationship to sex and so on is... is very culturally determined... Socioeconomically as well... (P4)*

Participant 2 raised the issue of how freely LGBTQ+ adolescents are able to explore their sexuality, compared to heterosexual peers, within a culture that continues to carry implicit and explicit biases:

*I don't have an answer, but I'm curious about the need really for adolescent, gay adolescents, or LGBT in any way... adolescents.... the kind of the... the lack of their options to flirt, to play, to experiment, to try to seduce that with straight young people, it's kind of unconsciously allowed and encouraged, and it's played with and it's seen everywhere in culture. But I think that if you're LGBT, it's not, I think it's the opposite, I think that it is consciously or unconsciously, it is discouraged (P2)*

Participants also highlighted the impact of institutional context, particularly differences between public and private sectors, on their capacity to engage with erotic dynamics. Several noted that NHS and third-sector environments often felt more restrictive, governed by anxieties about risk, safeguarding, and reputation. In contrast, private practice was experienced as affording more autonomy and emotional freedom to think:

*I don't know whether it's my confidence, or I don't know if it's because I'm working privately, I hear much more about it now from adolescents, and much younger than I did. But then beforehand I was working at the [service], or I was at [service], or in a school, and I think I didn't feel I had enough permission there to be as interested, because I was so aware of the organisation, of supervisors, of the teachers outside,*

*of... so it's somehow, maybe it feels a bit different, I feel a bit more permission here to work more autonomously perhaps, so maybe I take more risks (P2)*

However, participants also acknowledged that some adolescent-specific services, both within the NHS and the third sector, have developed cultures that are more open to thinking about sexuality:

*I imagine maybe, you know, maybe we do it a bit more in some ways than it used to be done now. I think there may be more of an interest in this topic, especially in places like the [service] or adolescent specific services in the third sector. I think there has been, and I think in some of these contexts, there has always been a careful thinking about sexuality and how it manifests from a psychoanalytic point of view. (P1)*

The supervisory environment was described as another crucial contextual influence. Participants consistently noted that the supervisor's attitude plays a determining role in shaping how safe and thinkable erotic material feels. An open, curious, and non-judgmental stance was seen as enabling reflection, while persecutory or overly critical atmospheres discouraged disclosure. Views differed on whether group or individual supervision was better suited for such exploration. Some found groups too exposing, while others felt individual supervision could feel too intimate. As Participant 6 observed:

*A lot will depend on how contained and comfortable and clear the supervisor is. Because they're going to be setting the atmosphere for what gets brought and what feels possible to discuss and how helpful and contained and sense making the discussions are, as against how uncomfortable or felt to be critical or judgmental it might be (P6)*

The ability to reflect on erotic material in supervision was seen as directly influencing the therapist's capacity to hold and think about such dynamics in the room with the patient.

When supervision felt closed, participants described struggling to integrate these experiences, leaving both therapist and patient feeling confused or isolated.

Participant 4 described the importance of cultivating an atmosphere of curiosity, both in supervision and with patients, to enable adolescents to feel that sexuality can be thought about safely:

*I think it's part of one's general curiosity to be... about a young person, you know. And then that, you know... In assessment we ask things like are you in a relationship? Are you interested in relationships? You know, I think it kind of goes... it often doesn't go much further than. I'm not saying you know, sitting down and say like 'hey, tell me that you know, how many times you are masturbating' you know, all of that and but... but... I just think enabling our patients to perhaps feel a little bit more at ease... (P4)*

An open, containing environment is therefore essential for the adolescent's development. As Participant 3 remarked, parents must face their own anxieties about their child's sexuality to allow them to mature; CAPTs must perform a parallel function in the consulting room:

*Every parent has to face in a way the reverse Oedipal complex, which is you have to let your children grow to be sexual beings. (P3)*

Finally, participants reflected on how the online setting may alter the dynamic of erotic transference. Some felt that the absence of bodily presence limited the possibility of recognising and working with erotic feelings. Others suggested that blurred physical boundaries such as meeting adolescents through screens associated with their personal and social lives might intensify erotic undercurrents in more confusing ways. As Participant 1 reflected:

*What does it then feel like to see a therapist on the same screen where they may see other things and being in the room and the intimacy of the room and how that way of*

*interacting with a therapist may stir up other parts of themselves that are engaged in exploring their sexuality. So, in some ways it may make it even more amplified. (P1)*

In sum, this theme highlights the multiplicity of external influences, cultural, institutional, and interpersonal, that shape how CAPTs can recognise and work with erotic transference. A reflective institutional culture, supportive supervision, and cultural openness appear essential for allowing clinicians to think about sexuality without fear, thereby enabling adolescents to do the same.

### ***Sub-theme 3.1 - Therapist-patient match***

This sub-theme explores how the match between therapist and patient, particularly in terms of gender, sexual orientation, and age, can shape the emergence and recognition of erotic transference. Participants described how alignment or difference in these characteristics may influence both the therapist's comfort and their capacity to interpret erotic material, affecting clinical understanding and the therapeutic process.

Participant 5 captured this sense of individuality and variability succinctly:

*I think obviously the biggest impact is the fit between you and the patient... with each person. So, I think it's always different with whoever you have, because it is very individualized in the way. (P5)*

Participants reflected on how both gender and sexual orientation play a role in shaping awareness of erotic dynamics. They generally felt that the difficulties associated with erotic transference are not exclusive to one gender, but that the therapist's and the patient's sexual orientation may either heighten or obscure awareness of erotic material. As Participant 6 noted:

*This is not necessarily different to any other area of our work, I just think it's a less comfortable and less familiar area. So I don't think gender actually makes a whole lot of difference, but... when the gender of patient and therapist matches the sexuality of*

*patient and therapist, I think things are that much more consciously felt and visible to both, whereas there might be more blind spots when there are different sexualities and genders. And/or you might have you know that either patient or therapist might be more defended against, or unaware of... (P6)*

This suggests that therapists and patients may find it more difficult to recognise or acknowledge erotic transference that does not align with their own sexual orientation, creating potential blind spots in the work. Yet, one participant described how erotic transference can still emerge meaningfully in therapeutic dyads with differing sexual orientations:

*There were at times an erotic transference, it kind of drifted in and out. And I felt very engaged with it in a way that felt very unusual to me as a gay man, to have a female, I mean she was in her early 20s, who was, I was in a very intimate kind of, an intimate kind of relationship with, and at times that there was a kind of a blurring in a way. And I felt it. And I remember thinking at the time, gosh, it doesn't make a difference, the sexuality of the therapist, because you feel it either way. So, I think that must be true to an extent. But I also wonder whether it's harder to get going. (P2)*

Participants also speculated that heterosexual therapists and patients might experience same-sex (homoerotic) transferences as more disturbing or difficult to think about. As Participant 5 reflected:

*I suppose this is more of an ordinary heterosexual... transference, you know, at an erotic level, maybe being heterosexual myself, I wasn't aware of necessarily, you know, more homosexual transference between other men, I don't think that I'm necessary... it might be... might be a blind spot for me, perhaps, I don't know. (P5)*

Participant 2 added that erotic feelings between same-sex dyads might be more readily pathologised than understood as developmental or exploratory:

*What I've noticed is that there are times when I have understood an aspect, if it's LGBT, that I think is more ordinary, healthy, inverted commas, sexual exploration. Sometimes I think heterosexual supervisors or colleagues, you know, going back years, I think they can at times see it as something more pathological if it's an LGBT transference, erotic transference. I think it can more easily be seen as pathological rather than something more ordinarily developmental and adolescent reaching out playing, experimenting. (P2)*

These reflections suggest that unconscious biases, both cultural and personal, can shape how erotic material is recognised and conceptualised, reinforcing the importance of reflective practice and supervision that address sexuality openly and non-judgementally.

Age also emerged as a relevant factor, particularly the age gap between therapist and patient. Participants observed that a larger age difference may heighten the sense of taboo and stir up incestuous anxieties, making it harder to address erotic material directly. Conversely, with older adolescent patients, naming and working with erotic dynamics was often felt to be easier and more permissible. A greater age distance could also provide protective emotional space for the therapist, helping them manage their own reactions.

Trainee CAPTs, being younger and closer in age to adolescent patients, were seen as particularly vulnerable to the intensity of these dynamics. The proximity in age could make the erotic transference feel more real or “possible”, leading to heightened anxiety about acting on or being overwhelmed by such feelings. Participant 5 recalled:

*I think maybe as a young man, when I was in my 20s, seeing adolescents, some adolescents, I found it really difficult because I was... I think maybe I was scared myself, what would happen if I did? (P5)*

Overall, this sub-theme highlights how the therapist–patient match can amplify or obscure awareness of erotic transference. Variables such as gender, sexual orientation, and age

interact with individual histories and social meanings, creating unique constellations in each therapeutic pair. The findings suggest that awareness of these dynamics, alongside reflective supervision, is essential to prevent blind spots and to enable the therapist to understand erotic material as a potential form of communication rather than a threat to boundaries or professional safety.

### ***Sub-theme 3.2 - Gendered societal expectations***

This sub-theme explores how social and cultural constructions of gender influence CAPTs' capacity to engage with and think about erotic transference. Participants described how societal messages about masculinity and femininity shape therapists' comfort, caution, and perceived permission when encountering erotic material, with implications for clinical work, supervision, and professional dynamics.

Several participants reflected that men may be granted greater social licence to explore sexuality and erotic curiosity, while women are implicitly discouraged from doing so.

Participant 2 captured this imbalance:

*I don't know if "allows" the right word, but I think society sets men up somehow to be the ones that can ask the questions. I think it's sexism. But they're somehow the ones that are given permission. That's maybe the right way of saying it. To go off and do those things. And my suspicion is that women are kind of given a different message. They're not to do that. I could be wrong, but that's what I would guess. (P2)*

From this perspective, male therapists might feel more permitted to recognise and engage with erotic dynamics, while female therapists may internalise greater inhibition. Yet, an opposing tension also emerged: several participants felt that male therapists face heightened scrutiny and risk of misinterpretation, particularly when working with female adolescents, which may lead to excessive caution or defensive withdrawal. As Participant 6 explained:

*I would say that socially men are trained to be a bit more cautious about themselves and their impact archetypally with female patients... um... but I would say that men might be a little bit more worried about how they might be experienced... (P6)*

In contrast, women were sometimes described as feeling more at ease acknowledging erotic feelings, perhaps because society positions them as less threatening. However, this apparent comfort may carry its own clinical risks if it leads therapists to underestimate how intense or disturbing erotic material can feel for the adolescent. As Participant 6 observed:

*Somehow I think women are just that more potentially comfortable with it, because they're a little bit less trained to be worried about the way in which they might be experienced and perceived and that much less training to be thought of as a threat socially growing up... um... that doesn't mean they're right to be thinking like that because from a patient's point of view the sort of sense of disturbance and intensity might be just the same... (P6)*

Participants also highlighted that gendered assumptions influence not only clinical work but professional relationships within training and institutional contexts. Gender imbalances within clinics or supervision groups can reproduce societal power dynamics and shape how freely erotic material is discussed. Participant 5 reflected on this complexity:

*I think it's at the heterosexual level... what's difficult is that there's such an imbalance between genders in the clinic, really. And I think there are, you know, in a way, I think that also plays into a kind of complex dynamic between men and women on the, on the training. I mean, I think that's probably with any sort of group which becomes a minority and feels itself to be a minority in a group. But there's obviously something more complicated with men because men have all the sorts of positions of power, you know, outside the [service]. (P5)*

Such dynamics may unconsciously shape how supervision groups function, how openly erotic countertransference is shared, and how therapists experience their own gendered identities within the institutional frame. The findings therefore suggest that gendered societal expectations operate not only intrapsychically and interpersonally but also organisationally, influencing the degree to which erotic transference can be thought about, verbalised, and worked with in child and adolescent psychotherapy.

#### **Theme 4 - Navigating risks in erotic transference**

This theme explores the multiple risks and anxieties CAPTs encounter when working with erotic transference in adolescents. Participants described the delicate balance between engaging with this material and maintaining appropriate boundaries, alongside the personal and professional risks of being misinterpreted or overexposed. The complexity of managing erotic feelings, both in the patient and in the therapist, highlights the importance of supervision, self-awareness, and clinical experience in navigating this terrain safely and productively.

Participants reflected that the emergence of erotic transference can stir powerful and conflicting feelings in the therapist. As Participant 1 observed, naming erotic material can feel dangerous, evoking anxieties linked to incest taboos and fears of re-traumatising the patient:

*I think it's the incest taboo, the fear of being, by naming it, becoming this seducing adult. Especially if there is any element in the history of the patient, any sort of traumatic experience in their early lives. (P1)*

For some, the intensity of these feelings led to defensive manoeuvres, a wish to “cool down” the encounter or avoid its exploration. Participant 2 reflected:

*I wonder whether she tried something out early on. And maybe I somehow didn't. I don't know. I wonder why I didn't somehow make more of it then. Or maybe I was too frightened.*

*Maybe it felt too hot. Or it felt too much. I don't know. Maybe I needed to then cool it down straight away and probably went for a different interpretation (P2)*

Fear of judgement or misunderstanding by colleagues, supervisors, or the wider institution was described as a significant obstacle to thinking openly about erotic countertransference. The age range of the patients added to this difficulty, as therapists felt particularly exposed when erotic feelings were evoked in work with adolescents. Such experiences could also awaken memories of the therapists' own adolescence and sexuality, as Participant 5 recognised:

*I can get quite excited by the story, and it might mean that I miss the more infantile parts of her, I think. It probably does remind everyone of their own adolescence a bit when people are talking about, you know, at some level. And of course, people had different adolescence. Maybe some people's were more difficult. (P5)*

While such resonances may offer empathic understanding, they also carry the risk of blurring boundaries between self and patient. Participant 4 highlighted the importance of differentiating projected feelings from one's own internal material:

*The countertransference obviously needs to be... one needs to be very careful working, you know thinking about it... Obviously... because there's a lot of oh, I'm feeling this because it's what's being projected into me. I think... You know, which is why we have the luxury of an analysis whilst we're developing this... as clinicians. And hopefully one does take those maybe if one does feel those things, you know ok it's being projected into one... (P4)*

Because of the intimate nature of this work, therapists described feeling vulnerable to exposure when discussing erotic dynamics in supervision, particularly in groups. As Participant 6 noted:

*In fact with all areas we expose ourselves when they're thinking about our work and when we're talking about and when we're talking in supervision and then supervisees talk to us as supervisors. We're always exposing how we're thinking in a way but... because we never are quite sure what belongs to whom and how we're thinking about things. I think it is a much more kind of complicated, delicate area (P6)*

Participants also acknowledged the seductive potential of erotic transference and the risk of being drawn into collusive enactments. As Participant 4 put it:

*As we do about the sort of you know idealizing transference, you know, which is... it's nice being idealized, isn't it? You know, but we have to be very careful with the getting drawn into something with the patients. We just have to be very careful not to... (P4)*

Such “bubbles of niceness” can blind both therapist and patient to underlying conflicts or aggression. Erotic attention from a patient may also evoke long-dormant desires or needs in the therapist, as Participant 5 candidly reflected:

*It can be quite exciting, I suppose, for me, you know, it's quite exciting. And I mean, in some ways, we all want to be desired at some level... for somebody to sort of act in a provocative way to you, which is sort of probably hasn't happened for 30 years or something, I think that does play into something, you know.... Maybe that makes it more difficult. (P5)*

Therapists therefore emphasised the necessity of supervision and analysis to process such feelings and avoid confusing their own responses with the patient’s communications. As Participant 6 expressed:

*I suppose we've, as therapists, we've just got to try and be as open as we can to what might be going on for the patient as well as what it's evoking in us and I guess we shouldn't underestimate how much we might want to protect and defend ourselves in an uncomfortable areas and again to come back to the importance of supervision and*

*supervision which feels safe where one can kind of try and make sense of this stuff and how it impacts on us. (P6)*

With clinical experience, therapists reported a greater capacity to tolerate and think about such feelings rather than defensively attribute them to the patient. Participant 5 reflected:

*The longer I've been a psychotherapist I'm more able to acknowledge, you know, what I'm finding difficult in this relationship, what I'm struggling with, rather than it's all them. (P5)*

The power of erotic transference to evoke excitement, intimacy, and anxiety made it particularly challenging for trainees, who may lack the experience or analytic containment to manage it. As Participant 4 observed:

*It can feel quite exhilarating at times, you know to have that access, that intimacy, that relationship and the opportunity to really unpick it in such... such detail with all the supervision groups, with the individual supervision and your analysis (P4)*

Some described how the topic itself could stir collective excitement in training or supervision groups, potentially impeding thoughtful reflection. Yet this very excitement also reflected the vitality of the phenomenon and its rich analytic potential. Participant 2 recalled:

*I was a trainee at the time, it was in my second year. So it was... on the one hand, I thought, gosh, this feels very hard to weather and kind of sustain this, or withstand it rather. And then another part of me thought, oh gosh, how exciting this is. This is so, there's so much rich psychoanalytic potential here. And so I also thought, wow, we can really get into something. (P2)*

Participant 3 echoed this view, noting that erotic countertransferences “can be so dangerous, but they can be so productive too and mustn't be evaded... They must be contained, transformed and used.”

Alongside the personal and ethical risks, participants also spoke of clinical misunderstandings that can arise from misreading erotic material. Erotic expressions may be prematurely pathologised rather than viewed as developmental, or conversely, patients may misinterpret the therapist's interventions as seductive or questioning rather than exploratory. Participant 2 explained:

*It feels riskier somehow, that they might feel more... I wouldn't want them to feel seduced by me. (P2)*

Participant 1 added that misattuned interpretations could damage trust:

*Sometimes we might as therapists find ourselves getting quite worried that if we do challenge, you know, something like that, or, you know, show the patient that something is happening in the room, in the relationship with the therapist that doesn't quite fit with their narrative about themselves, that that could be met with, you know 'you're not understanding me, you're not respecting my, my definition of myself and therefore I can't trust you'. (P1)*

Adolescents' developmental stage may compound this risk, as Participant 6 observed:

*It might be just much less in touch with what might be going on in the transference or how they think about it and they'll be less equipped with adult faculties and resources to be able to make sense of it. So their sense of sort of internal safety and then internal sort of the development of their ability to kind of reflect on things will just be less be likely to be that much less established (P6)*

However, the opposite risk lies in avoidance. Not addressing erotic material can convey moralistic or shaming messages about sexuality, as Participant 3 warned:

*If you neglect it, it can look like you're saying all sex is dirty. You know, like some of the Victorians. And that's a terrible message to give to a child who's trying to emerge*

*from, say, being sexually abused to understand there might be clean, loving sex out there somewhere. You know, you've got to leave a channel open for that. (P3)*

Participant 1 similarly noted that avoidance risks misunderstanding the patient's communication altogether:

*Unless I did talk about these feelings and this intensity of the relationship which was becoming more obviously charged with sexual feelings as well, we wouldn't have gone anywhere with the work. The work would have actually funded itself on a misunderstanding and that would have potentially left the patient feeling neglected (P1)*

Taken together, participants' reflections suggest that managing erotic transference involves negotiating multiple, intersecting ethical, emotional, and developmental risks. Through containment, supervision, and reflective awareness, these risks can be transformed into opportunities for deeper understanding and therapeutic growth.

### **Theme 5 - Finding the right level**

This theme explores the clinical challenge of calibrating therapeutic responses to the erotic transference in adolescent psychotherapy. Participants described the importance of balancing proximity and distance, containment and attunement, and the "temperature" of interpretations. Finding the right level involves discerning when to explore, when to hold back, and how to manage erotic material in ways that facilitate thought rather than enactment. This careful navigation allows therapists to support emotional and sexual development while avoiding overstimulation, intrusion, or defensive retreat.

Participants emphasised that therapeutic technique must remain flexible and responsive to the form the erotic transference takes. When erotic feelings are conveyed subtly, through gesture, non-verbal communication, or the therapist's countertransference, the initial

task may be to register and think about these impressions before attempting to name them.

Participant 1 observed:

*It's this very subtle, nonverbal, intense transference rather than a teenager overtly letting the therapist know that they have sexual fantasies about the therapist. I think that may come up later in the work or it may only come up when the therapist's names something about these feelings in my experience. (P1)*

Several participants described the ongoing effort required to acknowledge erotic feelings in a way that supports sexual and emotional development without either ignoring or overstimulating it. Participant 4 captured this dilemma:

*How to get that balance right? I think that's particularly challenging with adolescent work because you're trying to support them in that forward movement and their sexual development and identity and all the rest of it without crushing it and not allowing it in... or saying it's not appropriate (P4)*

The incest taboo and fear of allegations were noted as powerful inhibitors, particularly with younger patients. While caution was viewed as necessary, excessive defensiveness risked missing opportunities for developmental growth. Participant 2 described the instinct to tread lightly with fragile adolescents:

*Because adolescents are so fragile in a way, aren't they? We really have to respect their limits. I mean, there are times with patients, with adolescent patients, whereas it doesn't, I don't know if, perhaps erotic transference is the right word for it, but it's at a very minimal level, like a hint of it. And I don't mention it because it feels like it would be like I was stomping with big heavy boots all over something in a messy way (P2)*

Participants gave examples illustrating both helpful and unhelpful interventions.

Direct interpretations could sometimes be containing and clarifying, but at other times too

intrusive or stimulating. Participant 6 recounted a case in which the therapist's attempt to explore a patient's dream was experienced as overwhelming:

*The therapist tried to explore it with her and he had some thoughts about the possible meaning of the dream but trying to think about it actually made the patient feel more disturbed it, you know... She was the one that brought it and he didn't even actually go as far as venturing an interpretation, but just having brought it and trying to think about it in that moment was actually too much. So, I don't think one could have necessarily known about it known that she would have had that reaction in advance, because she was the one that brought the dream in quite an explicit way if you like... um... retrospectively she might have needed something like that must have been a very disturbing dream for you to have had, without opening it up or exploring it further.*

(P6)

Participants therefore stressed the need to modulate the “temperature” of interpretations, to think about erotic feelings without “heating things up” beyond what the patient can tolerate. As Participant 6 described:

*How does one help it lead in a direction of thought and understanding in a way which is helpful to the patient primarily and the therapist rather than do something which feels like it's heating things up unhelpfully or exciting things or making either patient or therapist feel like it's too hot and they need to get out especially if the patient wouldn't sort of risk breaking off because they're getting.. they're feeling disturbed by what's coming up or they're worried that they're hearing things in a concrete and literal way rather than something more symbolic and metaphorical (P6)*

Conversely, there were instances where direct engagement had a stabilising effect. Participant 1 recalled fearing that addressing erotic feelings might overexcite the patient but later found the opposite:

*I think even with the patient where I had to take it, where I thought I had to take it up, I did question and I did talk about it when I wrote about the case, that I feared that taking it up would have been perceived as exciting because I think his state of mind was so, I guess, narcissistic and sort of undeveloped that I wasn't sure. I thought that that was a risk. It wasn't the case, I don't think it was the case, I think we found a way just to calm things down and ground and make him feel more grounded, but it was on my mind. (P1)*

Participant 3 offered a model for addressing erotic material “at a safe distance”, leaving room for symbolic rather than concrete exploration:

*It's leaving it in the middle somewhere or maybe the field, I don't know, but it's putting it out there. You can take it as belonging to you and her or you can take it as belonging to them and you can keep your distance from it if you need to (P3)*

Language and tone emerged as key technical tools. Participants discussed how word choice can either soothe or intensify the material. Using age-appropriate or colloquial language was seen as helpful for adolescent patients. As Participant 5 explained:

*Let's use the language of the teenagers that we're working with, rather than using sorts of more adult language that might feel more, I think it can feel like a bit too disturbing in a way, that you're, you know, that they are sort of just embarking on a sort of sexual life in a way that is very different from being an adult and having a sexual life. (P5)*

Similarly, tone of voice could regulate the emotional temperature of the session.

Participant 6 noted:

*If we can find a way to speak to what's going on or to speak to some of the fantasies, but we keep our tone a little bit more pragmatic, so we don't have too much intensity in our tone. A sort of almost slightly more normal, normalising, pragmatic and not a*

*kind of too feeling-full tone, then I think it can... it's... also can be quite helpful and important, that the tone doesn't help heat inadvertently also heat things up combined with the words. (P6)*

Working with adolescents who had experienced sexual abuse was seen as particularly delicate. Participants described the heightened anxiety both their own and the patient's about repeating an abusive dynamic. As Participant 5 cautioned:

*I think, particularly when there's been abuse, that one has to be really careful about how one acknowledges that, because I think the level of anxiety in... probably in you, as well as the patient about becoming and turning into something abusive in the relationship can be really enormous. (P5)*

However, when handled thoughtfully, naming confusion between love and abuse could be therapeutic. Participant 4 illustrated:

*Her fear was that our relationship was going to turn into a highly sexual abusive relationship where I'd become an abuser. [...] But again, so that was very helpful. I mean, in terms of being able then to talk very openly with this very open patient about the confusion of love and abuse. (P4)*

Participants also reflected on a tendency in child psychotherapy to retreat into infantile interpretations as a defence against the discomfort of adolescent sexuality. Participant 6 warned:

*One of the things which happens is it can be easier for therapists to go to quite quickly areas of infantile sexuality or, you know, sort of adolescent sexuality as a sort of vehicle for more infantile feelings. And it's not that it's wrong, it's just that that keeps us slightly safe and it's... might be intellectually true for the adolescent but it might not be... it might not be what they're in touch with. (P6)*

The challenge, therefore, is to hold both the adolescent and infantile dimensions in mind, to acknowledge the bodily and sexual realities of adolescence without losing sight of underlying dependency needs. As Participant 2 summarised:

*It is important to talk about it in relation to, on two levels, I think, that it's not only the adolescent with the adult body, but it's also to talk about the infantile, and I guess one of the risks potentially, I try not to do this, but one of the risks would be that it would only be seen with the adolescent body or the young adult body, and you would lose the infantile stuff when I thought, you need to do both, because that's what they're figuring, working out anyways (P2)*

Failing to maintain this dual awareness risks slipping into enactment or collusion. Participant 5 described this danger:

*You do also have been pulled into something more flirtatious, which then also does ignore everything else. How do you draw on something which might be about eroticism and their sexuality, but also on the more sort of infantile dependent feelings that they have as well? How do you acknowledge all of that? And, you know, if you just flirt with them, are you becoming something else as well? (P5)*

Taken together, these reflections highlight the subtlety required in finding the right level of engagement with erotic material. CAPTs must continuously calibrate language, tone, and interpretive depth, guided by sensitivity to the adolescent's developmental position and the dynamics of the transference. In doing so, the erotic can become a space for thinking and growth rather than enactment or avoidance.

## Discussion

This research project aimed to explore how CAPTs work with erotic transference with adolescents. Both the literature and the findings indicate that erotic transference remains a complex and under-explored topic in child psychotherapy, despite the existence of relevant clinical papers. The paucity of research is striking given the centrality of sexuality in adolescence, where emerging sexuality, intimacy, and attachment form core developmental tasks (Brady, 2022). The erotic transference is one of the most complex dynamics encountered in clinical work, requiring careful thinking and understanding.

The findings show that CAPTs engage with erotic transference in conflicted and inconsistent ways, reflecting both the complexity of the phenomenon and the influence of personal, relational, and systemic factors. This aligns with Lans et al.'s (2024) observation that clinicians tend to hold conflicting or polarised views of erotic transference rather than sustaining its complexity. When clinicians were able to tolerate and think about erotic transference either in the consulting room or in supervision this could generate movement in the treatment. In other cases, CAPTs responded with defensive avoidance and a retreat from thinking. Defensive closure and reflective engagement thus coexisted within the same clinicians, not as fixed positions but as oscillating responses shaped by context, supervision, and the meanings attributed to the erotic communication.

A defensive response accords with Lans et al. (2024) finding that erotic transference is often experienced as a threat rather than an opportunity for growth and development. Celenza (2024) similarly argues that clinicians resist erotic transferences and countertransferences not only because of the fear of incest but because such material risks exposing narcissistic and oedipal vulnerabilities in both patient and therapist. As a result, CAPTs may struggle to acknowledge erotic feelings or to discuss them openly with colleagues and supervisors. One defensive manoeuvre identified in the data was a tendency to interpret erotic material at an

infantile level. This is consistent with Celenza's (2024) observation that clinicians often interpret away from oedipal erotics towards a desexualised maternal transference to avoid the intensity of both oedipal and maternal erotic transferences.

These findings mirror research in adult psychotherapy, where shame, taboo, and fear of professional censure inhibit open recognition of sexual feelings (Luca, 2018; Pope, Keith-Spiegel, & Tabachnick, 1986; Spilly, 2008). This continuity contradicts participants' impression that erotic material is "more thinkable" in adult work. While adult psychoanalysis has shown renewed theoretical interest in sexuality (Celenza, 2024), it may be overestimated how easily clinicians actually work with erotic transference in practice.

Participants highlighted a tendency in Child Psychotherapy to understand erotic transference as a defence against dependency and separation. While this may be true in some cases, this framing may also be used defensively to avoid acknowledging more contemporary and developmental aspects of the transference relationship.

Acknowledging erotic transference appeared especially difficult when it emerged in subtle or indirect forms and had to be apprehended primarily through countertransference. Given that participants were trained within a Kleinian/post-Kleinian framework where transference is understood as the total situation (Joseph, 1985) and countertransference encompasses "all the feelings the analyst experiences towards his patient" (Heimann, 1950, p. 81) even such indirect communications were theoretically thinkable. However, it is important to notice that therapists trained outside this tradition may not conceptualise such enactments as signifying erotic transference.

Being in touch with erotic countertransference remains a complex experience across modalities. Pope et al. (1986) found that despite its prevalence, sexual feeling was largely considered antitherapeutic; later research (Giovazolias & Davis, 2001) confirmed ongoing experiences of shock, guilt, and non-disclosure. For CAPTs this complexity is amplified by

developmental asymmetry: the age gap and parental transference may render the experience “as if” incestuous, compromising clinicians’ capacity to hold the erotic transference in mind as symbolic rather than literal. Despite CAPTs being trained to work within the transference relationship, there is a parallelism between their experiences and those described by participants in Giovazolias and Davis’ (2001) study.

Participants reported that this difficulty was particularly acute when working with adolescents with histories of sexual abuse, where both therapist and patient risk experiencing erotic communication as a traumatic re-enactment rather than as a representation. It is important to consider whether adolescents can tolerate or metabolise transference interpretations without further injury. Such caution resonated with Pope et al.’s (1986) finding that clinicians’ restraint is motivated primarily by concern for the patient’s welfare rather than by fear of professional sanction.

Recognising the potential for ambivalent responses is therefore crucial for CAPTs, enabling them to attend to the adolescent’s communications. This requires finding a balance in working with the erotic transference, avoiding both seduction and denial (Spilly, 2008). While defensive responses may serve a protective function for the therapist, they can inadvertently obscure important developmental communications from the patient and risk invalidating central aspects of the adolescent’s emerging identity. Spilly (2008) highlighted that ignoring erotic dynamics can lead to ruptures or derailments in therapy. Similarly, taking a polarised view of erotic transference as solely threatening, without recognising its potential for exploration and development (Lans et al., 2024) may limit its therapeutic utility (Giovazolias & Davis, 2001; Rodgers, 2011).

A notable distinction in the current study is that CAPTs did not appear to hold rigidly polarised views of erotic transference. Instead, they were able to reflect on the ambivalence within their own responses, questioning and considering their reactions in the clinical

encounter. Where polarised positions were observed, they often appeared as defensive reactions to specific interactions rather than fixed attitudes toward erotic transference.

Working with erotic transference can serve as a valuable tool for exploring the patient's inner world. However, findings indicate that such engagement requires careful attention, thoughtfulness, and sensitivity. Participants highlighted the importance of distinguishing between erotic transference as a developmental expression and as a defensive manoeuvre, emphasising that understanding its function is essential to guiding the therapeutic approach. Recognising this functional variability allows CAPTs to respond in ways that support adolescent development while maintaining ethical and professional boundaries, reflecting the psychoanalytic principle that countertransference can be both a diagnostic and relational instrument (Rodgers, 2011; Spilly, 2008).

CAPTs need to be attuned to the developmental stage of the adolescent to avoid missing opportunities for growth or being drawn into confusing or potentially seductive dynamics. In some cases, erotic material functioned as a way for adolescents to explore emerging sexuality and relational capacities, supporting identity formation and individuation. As Bolognini (1994) noted, healthy signs of vitality and genuine loving aspects should be welcomed and encouraged.

In other instances, erotic transference served defensive purposes, such as testing boundaries, asserting control, or managing separation anxiety. This aligns with Blum's (1973) concept of erotized transference, a protoerotic, primitive, and often aggressive phenomenon aimed at denying the reality of the therapeutic relationship and any sense of separation (Davies, 2001). Intimacy in these cases can feel threatening, associated with vulnerability, and may lead the patient to attempt to pull the therapist into an enmeshed, claustrophobic, or even sadomasochistic dynamic, as Participant 2 described. Sexualising the therapeutic relationship may serve as a way for the adolescent to manage experiences that feel frightening or

overwhelming, functioning as a defence against infantile anxiety (Harding, 2001; Royston, 2001).

The adolescent's task of separating from parental objects, establishing an independent identity, and forming intimate relationships is inherently anxiety-provoking, particularly when this process conflicts with internal desires for constancy and security (Anderson & Dartington, 1998). Developing the capacity for intimate relationships requires acknowledging the sexual relationship of the parental couple and the child's exclusion from it. Difficulty accepting this reality may lead some adolescents to adopt sexualized behaviours as defensive manoeuvres. These presentations reflect more primitive and infantile functioning rather than developmental exploration. They therefore require CAPTs to maintain strong boundaries while sensitively reintroducing reality into the therapeutic relationship. Clinical examples and the literature (Bolognini, 1994; Davies, 2001; Gabbard, 1994b) suggest that these presentations rarely feel seductive to therapists; instead, they often elicit feelings of hostility, annoyance, rigidity, or formal distance, as therapists respond to perceived attacks on the analytic frame and boundaries. Consistent with Spilly (2008), therapists are more likely to react with contempt, disgust, or avoidance than to feel genuinely seduced. The erotized transference can feel easier to manage because it can be attributed to the patient's difficulties rather than reflecting on the therapist. Nonetheless, CAPTs need to remain aware of these defensive responses, as they may unintentionally hinder the adolescent's process of separation and emotional growth.

Participants highlighted that positive feelings, particularly those with an erotic connotation, may feel threatening and challenging for CAPTs to manage. More affectionate or loving erotic transferences often elicit empathy and openness (Spilly, 2008). However, genuine feelings of love and affection in the therapist can create management challenges (Davies, 2001), increasing the risk of being seduced or colluding with the patient's defences

when the therapist feels liked, wanted, or idealized. As Participant 4 described, therapists may wish to remain in a “bubble of niceness” with the patient, keeping difficult feelings at bay and maintaining a romanticized sense of “you and I against the world”. These observations align with the theme of boundaries identified by Lans et al. (2024), highlighting the dual risk of either rejecting the patient or being drawn into anti-therapeutic dynamics.

Findings also emphasised the importance of CAPTs attending to whether the adolescent’s sexuality is active in their private life, limited to the transference relationship, or entirely absent. A complete absence can indicate developmental difficulties. Celenza (2024) describes the absence of erotic countertransference as a “present absence”, signalling a lack of vitality in the patient. CAPTs who feel comfortable with this absence risk colluding with the patient’s defences rather than addressing this crucial aspect of development. Davies (2001) notes that:

in cases in which the patient’s sexuality is disowned, dissociated, or projectively evacuated into the analyst, the analyst’s more active interventions, including partial self-disclosures and/or open recognition and affirmation of the patient’s sexual emergence, may become important aspects of therapeutic change. (pp. 757-758)

The findings suggest that CAPTs should consider the potential developmental and experimental aspects of erotic transference. Adolescents may use the therapeutic relationship to explore parts of their identity safely. Therapists and teachers can function as transitional objects, supporting the adolescent through separation (Healy, 2003). The therapeutic space may feel safer than actual peer relationships, allowing the adolescent to experiment with feelings and relational capacities. As Davies (2001) notes, successful analytic work often witnesses the passage from infantile sexuality to adult genital sexuality. CAPTs must keep in mind both the child’s and adult’s perspectives (Phillips, 2011), as engaging with these

developmental aspects helps avoid defensive responses and deepens understanding of the adolescent's experience.

The complexity of this phenomenon poses a challenge in terms of technique. Participants conveyed that there is no single way to work with erotic transference, but that a better understanding of its function and meaning for each patient, as well as assessing the developmental stage they are at, can help guide the level and timing of interpretations. In some cases, a direct interpretation may be containing for the patient, while in others it may intensify feelings or disturb the adolescent.

Another relevant finding was that CAPTs' personal experiences of sexuality, gender identity, and prior supervisory relationships emerged as significant influences on how erotic transference is perceived and managed. This aligns with Brady's (2018) suggestion that therapists need to feel at ease with sexual feelings in the therapeutic field to help patients develop a capacity to think about them. Some therapists reported feeling relatively comfortable acknowledging erotic material, while others experienced confusion, anxiety, or heightened concern about maintaining boundaries. This mirrors recent findings that therapist characteristics including gender, sexual orientation, and personal values shape responses to erotic dynamics (Gewirtz-Meydan et al., 2024; Lans et al., 2024).

Findings indicated that CAPTs' own experiences of relationships, sexuality, and adolescence, as well as their current emotional and relational situation, influence how they receive and understand patients' communications. Working with adolescents can expose therapists to their own limitations and to aspects of themselves that they may find troubling (Phillips, 2011). As Phillips notes: "We may, that is to say, secretly recognise in these adolescents our own preoccupations about sex, and solitude, and sociability; we may identify with them, and sometimes more than we want to" (p.190). This seems related to Spilly's (2008) observation that countertransference responses can be intensified when the therapist is

struggling in personal relationships or experiencing loneliness. CAPTs are not immune to the wish to be liked and wanted; they want patients to want them and to recognize that they have something valuable to offer (Phillips, 2011). Participants highlighted that having an adolescent flirt with the therapist can be experienced as both disturbing because of the age difference and the nature of the therapeutic relationship, and as exciting or flattering. This dynamic may stir memories of youth or resonate with the therapist's contemporary personal life. Such experiences can heighten anxiety around disclosing countertransference reactions in supervision or discussions with colleagues, underscoring the importance of self-awareness and reflexive practice for therapeutic effectiveness.

As Davies (2003) points out, Oedipal love involves both child/parent and patient/therapist dynamics. Working through erotic transference requires both parties to process their feelings and to mourn the unrealisable relationship. Davies also notes the therapist's need to occupy the "excluded" position when witnessing the patient embarking on their own sexual life, a dynamic Participant 3 described as the reverse Oedipal complex. Therapists may need to hold and contain feelings of exclusion and abandonment on behalf of the patient, thereby enabling the development of appropriate, autonomous relationships. Personal analysis, self-awareness, and supervision are therefore paramount for CAPTs to discern whether the way they work or avoid working with erotic transference reflects a conscious clinical choice rather than a defensive reaction.

An original finding of this project, not highlighted in pre-existing research, was the importance of the match between therapist and patient. While personal characteristics and experiences appear to shape the way CAPTs respond to erotic transference, participants highlighted that these responses can also vary depending on the patient's characteristics. Celenza (2024) argues that "the conscious experience of the sex and/or gender(s) of the analyst is important for the alliance but not for the transference" (p. 56). In her view, erotic

transference is unconsciously structured by individualised psychic fantasies about anatomical sex and gender, which do not necessarily correspond to material reality. This suggests that different types of transferences and countertransferences can develop independently of the actual anatomical gender of therapist and patient, though they may go unnoticed because of internal biases and resistances. Sexual orientation was found to be particularly significant in influencing this dynamic. Findings indicated that erotic transferences that are dystonic to a therapist's and/or patient's sexual orientation may be more difficult to acknowledge.

Heterosexual CAPTs may struggle to recognize homoerotic feelings, creating a blind spot in the transference relationship. This aligns with Sherman's (2002) view that heterosexual transferences are generally deemed more socially acceptable, and that being in touch with homoerotic transference can be challenging for both heterosexual and gay therapists. Sherman suggests that internalized homophobia can lead gay therapists to feel ashamed, guilty, or worried about feeling out of control or potentially leading their patients on. Conversely, heterosexual therapists may experience fear in response to homoerotic feelings, leading to dissociation or denial. As adolescents are in the process of exploring and understanding their sexuality, awareness of internal biases that may interfere with this exploration both within the therapeutic relationship and in the therapist's own mind is paramount. Findings suggested that the role of CAPTs' gender in working with erotic transference is influenced by societal and cultural norms and expectations. Participants expressed differing perspectives on how this may unfold. On one hand, it was thought that men may feel more socially permitted to be sexual beings, and therefore freer to explore sexuality with their patients. This aligns with Barnewall's (2016) finding that female therapists may experience resistance and discomfort when dealing with erotic dynamics, sometimes presenting with reduced awareness or confidence. At the same time, men may also feel more at risk of being perceived as seductive by female patients, and thus of potential allegations. This may relate to Lans et al. (2024)

finding that male therapists tend to focus more on boundaries. On the other hand, women were thought to be less socially conditioned to be perceived as a threat and may underestimate how frightening they can nonetheless feel to patients. Being a woman was also associated with the societal perception of being a potential victim of sexual advances, a position that may evoke greater sympathy and understanding. Participants did not discuss the experiences or potential impact on erotic transference of therapists who do not identify as cisgender. Another factor influencing how CAPTs work with erotic transference is clinical experience. Findings highlighted that trainee CAPTs may find navigating erotic dynamics particularly challenging due to limited clinical experience and potentially shorter engagement in personal analysis. Because erotic transference can be both unsettling and easily enacted at a subtle level, therapists need to maintain deep awareness of their vulnerabilities, blind spots, and limitations through personal analysis and supervision. Trainee CAPTs are therefore in a particularly vulnerable position. Participants described the experience of facing erotic feelings as simultaneously anxiety-provoking and exciting. Trainees may feel eager to learn and intrigued by the possibilities the erotic transference presents, which can increase the risk of losing themselves in the dynamic. Participants also noted that discussions of erotic transference in supervision can generate excitement within the group, which may not always be conducive to reflective thinking. I personally observed similar excitement when presenting the topic of this research to fellow trainees. It was also pointed out that trainees are often closer in age to adolescent patients than more experienced analysts, situating them nearer to the “realm of possibilities” for the patient. It is therefore notable that working explicitly with erotic transference is not more prominently addressed during training. My own training mirrored participants’ accounts of limited explicit teaching on erotic phenomena, which may partly explain why discourse around this topic remains defensive. This gap in training and preparation is highlighted in existing research (Luca, 2018; Pope et al., 1986; Rodgers, 2011;

Spilly, 2008). However, existing studies largely include clinicians trained in approaches where transference is not central, whereas in child psychotherapy it remains the primary instrument for exploring the patient's internal world.

Findings suggested that a therapist's culture impacts the way sexuality is viewed and experienced, and consequently, how erotic transference is worked with. A culture that is not persecutory or judgmental and that promotes curiosity and growth will support the exploration of sexuality. For example, the religiosity of either the therapist or the patient may influence the unfolding of erotic transference. This aligns with Lans et al.'s (2024) finding that more religious therapists are less likely to perceive erotic transference as growth-promoting. CAPTs should therefore be aware of and reflect on how their own belief system may shape their approach to erotic transference, while also considering the cultural context of the patient.

The role of supervision and institutional culture was also highlighted as central to CAPTs' capacity to engage with erotic transference. Therapists working in environments perceived as judgmental, risk-averse, or overly constrained by societal taboos reported greater difficulty acknowledging and reflecting on erotic material. Conversely, safe, supportive, and non-judgmental supervisory spaces enabled therapists to explore these dynamics with confidence. This aligns with adult-focused literature emphasizing the protective function of reflective supervision, particularly when managing shame- or anxiety-provoking material (Barnewall, 2016; Luca, 2018; Pope et al., 1986). These findings suggest that adolescent erotic transference is not solely an intrapsychic phenomenon but also a relational and organisational one, shaped by the broader context in which therapy occurs.

These findings underscore the importance of CAPTs reflecting on both conscious and unconscious dynamics and on their own attitudes toward sexuality, as well as on the need to foster working and supervisory environments that support exploration of this sensitive topic. Participants emphasized that an open and curious supervisory stance can facilitate thinking

about erotic dynamics. Both participants and the literature highlighted that institutional climates marked by scrutiny around sexual misconduct (Rodgers, 2011) can hinder CAPTs' ability to explore erotic transference dynamics, potentially leading to neglect of important aspects of the patient's emotional life and even ruptures in the therapeutic relationship.

As Luca (2018) points out, internalized social and moralistic taboos can lead trainees to fear punishment from supervisors or institutions, leaving them ill-equipped to address erotic transference in clinical work and prompting defensive responses. Creating a curious and non-persecutory culture is therefore particularly important during training, as it can shape CAPTs' attitudes and capacities for reflective practice. Internalized biases or anxiety should be addressed in personal analysis, but supervisors especially of less experienced CAPTs can also normalize discussion of erotic phenomena in supervision, reducing anxiety and supporting professional development. This view partially contrasts with Barnewall's (2016) findings, as participants in that study found supervision useful in addressing erotic issues, but not personal therapy. These findings highlight the tension between ethical responsibility, adolescent developmental needs, and societal anxieties around sexuality. They also underscore the necessity of reflexivity, supervision, and what psychoanalytic literature often terms the "third position", a reflective stance enabling therapists to navigate complex relational, ethical, and cultural dynamics.

Taken together, these findings suggest that erotic transference in adolescent psychotherapy presents both challenges and opportunities. While defensive responses may protect therapists and patients, they risk limiting developmental insight. Conversely, when therapists engage with erotic material thoughtfully and reflectively supported by supervision, institutional guidance, and self-awareness, erotic transference can become a conduit for therapeutic deepening, relational growth, and adolescent developmental exploration. These dynamics highlight the central importance of training, supervision, and reflective practice, and

point to areas where clinical education and institutional culture could better support therapists in managing this complex and underexplored domain.

### **Reflexivity**

I will now reflect on the different positions I juggled in relation to this topic, which at times both aided and interfered with my role as a researcher.

Firstly, this was my first experience as a researcher, and my inexperience and occasional lack of confidence likely influenced different aspects of the process. For example, Braun and Clarke (2022) suggest that less experienced researchers may initially code data more at a semantic rather than a latent level. While my confidence increased over time, allowing me to engage more in latent-level coding, much of the analysis was likely conducted at a more semantic level.

My initial tentativeness stemmed from the challenge of embracing the subjective nature of data analysis in RTA and trusting that there was no right or wrong way to engage with the data. Actively reminding myself that RTA is about meaning-making rather than truth-seeking helped manage the anxiety of “getting it wrong” and facilitated the development of my identity as a researcher. As Braun and Clarke (2022) note, “different coders will notice and make sense of data in different ways” (p. 55).

My clinical experience and psychoanalytic background aided my understanding of participants’ thoughts and experiences. At times, I noticed myself asking leading questions that reflected my own experiences and expectations. My analysis and self and ability to reflect on countertransference allowed me to recognize this pull toward confirmation bias and recalibrate my interview style as the project progressed.

All participants had extensive experience in adolescent work, and some had developed particular expertise in erotic transference. Being a trainee, I felt both excited and intimidated. During data analysis, I experienced strong anxiety about misinterpreting participants’ words

or exposing them, interestingly paralleling the risks of misinterpreting erotic transference in the data. I also felt a desire to impress participants, alongside a sense of inadequacy about not being “expert enough” and a potential fear of exposing aspects of myself. Maintaining my researcher-self helped me stay grounded and connected to the data.

I was particularly aware of pre-existing relationships with some participants, which may have consciously and unconsciously influenced their responses and my approach to interviews and analysis. Participants were generous and open in sharing their experiences despite the sensitivity of the topic. While an analysis of potential parallel processes during the interviews is beyond the scope of this project, it is plausible that both my characteristics and those of the participants influenced the data.

I am a newly qualified CAPT trained in the Kleinian and post-Kleinian tradition, which likely shaped my perspective on the topic and influenced how I conducted interviews and analysed data. A clinician from a different theoretical orientation or with more experience may have approached the project differently. My specific conceptualizations of transference and countertransference guided how I interpreted subtle communications and coded erotic dynamics. For example, both the participants and I considered indirect presentations as an indication of erotic transference.

The interviews took place either in person (two) or online (four), which may have influenced the dynamics of the interaction.

Finally, my personal-self warrants consideration. Similar to participants and the literature on clinical work, my own experiences and identity may have influenced the project. As mentioned in the introduction, my interest in this research arose from personal experience. Awareness of this connection allowed me to mitigate the risk of confirmation bias and remain reflective throughout the process.

Engaging in ongoing reflexivity throughout the project contributed to the trustworthiness of the findings. By acknowledging my theoretical orientation, clinical experience, personal biases, and emotional responses, I critically examined how these factors influenced the research process. Reflexive practices, including supervision and revisiting the data with awareness of potential biases, helped ensure that interpretations remained grounded in participants' accounts rather than my assumptions. For example, reflecting on my excitement or intimidation during interviews helped me notice when I might have unconsciously emphasized certain participant narratives over others. This reflexive engagement enhanced the credibility and transparency of the study and strengthened its methodological rigor, demonstrating a careful and thoughtful approach to exploring such a complex and sensitive phenomenon.

### **Strengths and Limitations**

This research project presents several strengths that contribute to its credibility and relevance. One of the primary strengths lies in the rich reflexive insight incorporated throughout the study. By explicitly acknowledging my positionality as a newly qualified CAPT with a Kleinian/post-Kleinian background, I was able to critically reflect on how my experiences, anxieties, and expectations may have influenced both data collection and analysis. This reflexivity not only enhanced the trustworthiness of the findings but also mirrored the clinical sensitivity required when working with erotic transference in adolescent psychotherapy.

The study is theoretically grounded, drawing on psychoanalytic literature and integrating participants' accounts with existing theory. This allowed for both conceptual and empirical depth, facilitating a nuanced understanding of erotic transference in adolescent psychotherapy, a phenomenon that remains under-explored despite its clinical significance. The focus on adolescent psychotherapy is particularly original, as existing research

predominantly examines adult populations, and this study therefore addresses an important developmental and clinical gap. Furthermore, the project accessed a rare sample of psychoanalytically trained CAPTs, providing unique insight into a specialist population. Purposeful sampling strengthened the project by including CAPTs with varied clinical experiences and a special interest in adolescent erotic transference. This yielded rich, detailed data and allowed insights into both qualified and trainee perspectives. This helped illuminate the ways in which personal, relational, and systemic factors intersect in the management of erotic transference.

However, the study is not without limitations. The small, homogenous sample, comprised primarily of experienced clinicians trained within the Kleinian/post-Kleinian tradition, limits generalisability. Therapists from other theoretical orientations may approach erotic transference differently; while this limits the breadth of applicability, the detailed accounts still offer meaningful insights into clinical practice. The sensitive nature of erotic transference may have encouraged socially desirable self-presentation, with participants consciously or unconsciously portraying themselves as more reflective or ethically vigilant than in practice; however, the reflexive approach and triangulation with psychoanalytic literature help mitigate this risk.

While culture, religion, and societal norms emerged as relevant factors in the analysis, the study did not systematically explore the intersectional influences of race, sexual orientation, and gender identity, leaving potential blind spots in understanding how these factors shape erotic transference dynamics. Methodologically, RTA enabled meaningful thematic capture but may have limited exploration of unconscious processes, subtle enactments, and parallel process dynamics; nevertheless, the approach provided a structured yet flexible framework to capture clinically rich themes. Finally, variability in interview settings (two in-person and four online) may have influenced the quality of interaction and

data richness, though this was not systematically examined; even so, all participants provided detailed accounts, supporting the study's analytic depth. Despite these limitations, the project offers a meaningful contribution to understanding an under-researched and clinically complex area of child psychotherapy.

### **Recommendations for Clinical Practice and Future Research**

The findings of this study carry important implications for clinical practice, training, supervision, and future research. Clinically, CAPTs are encouraged to engage in ongoing reflective practice, encompassing personal analysis, supervision, and peer discussions. This reflective stance is particularly vital when working with erotic countertransference, as participants reported that erotic feelings can elicit excitement, flattery, or anxiety. Therapists may feel drawn toward these feelings, whether consciously or unconsciously, creating a risk of colluding with the patient's defences or responding in ways that gratify the dynamic. Such enactments could compromise therapeutic boundaries and developmental outcomes.

Erotic material should therefore be held reflectively, without assuming it is inherently developmental or purely defensive. Each expression of erotic transference may serve multiple functions: it could reflect emerging sexuality, relational curiosity, or experimentation, but it could equally act as a defensive manoeuvre, a boundary test, or a strategy to manage anxiety. The therapist's task is to observe, contain, and think about the dynamic, using supervision and self-reflection to determine how best to respond in ways that maintain the adolescent's safety and support the therapeutic process.

Structured, case-based workshops could provide additional opportunities for clinicians to explore erotic dynamics in a safe environment, facilitating both professional learning and confidence. The findings also suggest the value of cross-theoretical dialogue, whereby therapists from different psychoanalytic schools share perspectives and approaches. Such exchanges could broaden understanding of erotic transference, highlighting how theoretical

orientation shapes interpretation and intervention. Moreover, supervisors and training programs should incorporate discussion of cultural, religious, and societal influences on erotic dynamics, fostering culturally sensitive and ethically informed practice. Training curricula might integrate explicit teaching on erotic transference, including assessment, timing, and technique for intervention, as well as strategies for managing the anxiety and excitement these dynamics can evoke, particularly for trainees.

Future research is needed to expand and diversify these findings. Studies that include therapists from varied theoretical, cultural, and experiential backgrounds would illuminate differences in understanding and managing erotic transference. Further insight could be gained by investigating erotic dynamics in adolescent group therapy, by employing observational designs in supervision or clinical practice rather than relying solely on self-report, and by exploring longitudinal trajectories of therapist responses across clinical experience. Intersectionality-focused research examining how race, gender identity, sexual orientation, and cultural context intersect with erotic transference is also warranted, as these factors were largely absent from the current study but may significantly shape therapeutic encounters.

Taken together, these recommendations underscore the need for reflective, ethically informed practice, enhanced training, and continued research to support CAPTs in navigating the complexities of erotic transference. By fostering open dialogue, supervision, and institutional support, both therapists and adolescents can benefit from a richer, developmentally attuned therapeutic process.

## Conclusion

This study explored how CAPTs engage with erotic transference in adolescent psychotherapy, a complex, sensitive, and under-researched area. Findings indicate that erotic transference is experienced as both an opportunity for relational and developmental exploration and as a potential defensive or anxiety-provoking dynamic. Therapists' responses oscillate between reflective engagement and defensive avoidance, shaped by personal characteristics, theoretical orientation, training, supervision, and broader institutional and cultural contexts.

The study underscores that erotic transference cannot be understood in isolation as purely intrapsychic; it is relational, developmental, and systemic. Therapists' awareness of their own reactions, biases, and vulnerabilities, as well as the quality of supervision and institutional culture, critically shape how they navigate erotic dynamics. Personal characteristics such as gender, sexual orientation, experience level, and theoretical background influence both the recognition and management of erotic material, highlighting the need for reflective practice and ongoing professional development.

Despite challenges, the findings suggest that when therapists engage thoughtfully with erotic transference, supported by reflective supervision, institutional guidance, and self-awareness, it can serve as a conduit for deepening the therapeutic relationship, enhancing adolescent development, and fostering insight into relational and emotional processes. However, failure to acknowledge or contain erotic dynamics risks developmental foreclosure, misattunement, or disruption of the therapeutic alliance.

The study contributes to the field by illuminating the nuanced and multifaceted nature of erotic transference in adolescent psychotherapy, offering evidence of its developmental, defensive, and relational functions, and highlighting the factors that facilitate or impede therapists' engagement. By integrating psychoanalytic theory with the lived experiences of

CAPTs, the research provides a foundation for more reflective, ethically informed, and developmentally attuned clinical practice.

Finally, the study emphasizes the importance of explicit training, supervision, and institutional support in preparing therapists to navigate erotic transference thoughtfully. By fostering open dialogue and reflective engagement, child and adolescent psychotherapy can address an often-defended topic in ways that support both clinician and patient, advancing professional understanding and enhancing therapeutic efficacy.

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## Appendix

### Table of appendices

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## Appendix A

### **Exploring the taboo: How do Child & Adolescent Psychotherapists work with the erotic transference with adolescents?**

You have been given this information sheet to invite you to take part in a research project. This information sheet describes the study and explains what will be involved if you decide to take part.

#### **What is the purpose of this study?**

With this study, I aim to explore the way the erotic transference can present itself in the work with adolescents and young adults, how Child and Adolescent Psychotherapists work with it, what the risks and gains of working with this type of transference are and why the erotic transference is a topic that has become difficult to talk about.

#### **Who is conducting the study?**

My name is Giulia Vignali, I work in the Tavistock and Portman NHS Trust, and I am training to be a Child and Adolescent Psychotherapist. This project is being sponsored and supported by The Tavistock and Portman Centre and has been through all relevant ethics approval (TREC). This course is overseen and certified by The University of Essex.

#### **Why this project?**

My interest in this topic has developed through my experience of working with adolescents and young adults in different capacities for several years, in particular in my current placement in a specialist psychotherapy service for this age range.

Adolescence is an age of tumultuous feelings and confusing and overwhelming changes. Secondary sexual characteristics develop, the adolescent is overwhelmed with hormonal storms and becomes able to procreate. The adolescent has now a body that can act on those feelings and phantasies that in childhood could only stay at such. But what happens when these enter the therapeutic relationships? The literature as well as conversations with colleagues have highlighted the difficulty of exploring the erotic transference in the work with adolescents. There seems to be tension between acknowledging the importance of the exploration of sexual feelings and the anxiety that doing so can bring up both in the clinician and the patient.

I am interested in understanding more about how the erotic transference presents itself in the work with adolescents and young adults and how Child and Adolescent Psychotherapists work with this type of transference.

I would also like to find out more about the reasons why the erotic transference has become a topic difficult to talk about and the risks and gains of working with this type of transference.

### **What will your participation involve?**

You will be invited to take part in an individual interview, offering a space for you to talk freely about the topic, with some questions and prompts from me. I will be interested to hear about how in your experience erotic transference can present itself in the work with adolescents and young adults and how Child & Adolescent Psychotherapists currently work with this type of transference. I will be keen to hear one or more examples of adolescent patients whom you have one of your supervisees has worked with, where the exploration of the patient's erotic transference has been part of the work.

In the interview, I would like to explore your thoughts on why the erotic transference has become a topic that is difficult to talk about, and the risks and gains related with working with the erotic transference with adolescents.

Interviews will last between 45 and 75 minutes and will be audio recorded. I hope to conduct these in person, but if this is not possible then they will take place via video link or telephone. If it is possible to conduct interviews in person, this will be at the Tavistock Centre or at your usual workplace at a time that suits you. No extension to your usual working hours will be necessary.

### **Do I have to take part?**

No, it is completely your choice whether or not you take part in the study. If you agree to take part, you can withdraw without giving any reason, any time up to three weeks after the interview. After this time, the data will then be processed and analysed. If you do decide to withdraw, all data collected will be destroyed immediately.

### **To take part in this study, you will need to:**

- Be a qualified Child and Adolescent Psychotherapist
  - Have experience in working with adolescents
  - Having developed a particular interest in the erotic transference in your career (for example having written about it, or having done presentations/lectures about it)
- OR
- Having developed a particular interest in other topics in your career, but that may overlap with the erotic transference, and have written about it (for example the bodily transference, or the work with victims of sexual abuse, etc.)

### **What will happen to any information I give?**

The UK-based Tavistock and Portman NHS Foundation Trust is the sponsor for this study. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for 5 years after the study has finished. The interview will be audio recorded and transcribed by me.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

Quotes from the transcript will be used in the write up of the project but these will be de-identified. However, please note that it is possible that you may be able to identify yourself in the final report, and that other colleagues who know you well may recognise you in some of the quotes used, although every effort will be made to prevent this. Any extracts from what you have said that are quoted in the research report will be entirely anonymous.

All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for 5 years.

If you would like more information on the Tavistock and Portman and GHC privacy policies please follow these links:

<https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/>

<https://www.ghc.nhs.uk/privacy-notice/>

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: [IHenderson@tavi-port.nhs.uk](mailto:IHenderson@tavi-port.nhs.uk).

There will be limitations to the confidentiality of information provided if it is deemed yourself or someone else is at risk.

### **What will happen to the results of the project?**

The results of this study will be used in my Research Dissertation Project and Doctorate Qualification. It may also be used in future academic presentations and publications.

I would be happy to send you a summary of the results if you wish. Please contact me to request this if it is of interest to you.

### **What are the possible benefits of taking part?**

There will be no direct benefits for you. However, by taking part you will be given the opportunity to reflect on your therapeutic understanding of sexual feelings in the work with adolescents. It is hoped that it will provide a space for you to consider and reflect on your experience in a way that may be helpful for future work.

**Are there any risks?**

No, there are no direct risks. However, details of a confidential service you can access for emotional support will be provided if needed.

**Contact details**

I am the main contact for the study. If you have any questions about the project or would like to discuss this further please don't hesitate to contact me. My contact details are:

Giulia Vignali

Email: [removed]

Address: The Tavistock Clinic, 120 Belsize Lane, London NW3 5BA

Alternatively, any concerns or further questions can be directed to my supervisor:

Elena Della Rosa

Email: [removed]

This research has received formal approval from TREC. If you have any queries regarding the conduct of this research, please contact: Helen Shaw, Head of Academic Governance and Quality Assurance, Tavistock & Portman NHS Trust, email: [academicquality@tavi-port.nhs.uk](mailto:academicquality@tavi-port.nhs.uk) .

**Thank you for considering taking part in this study and taking the time to read this information.**

**If you are willing to take part in the research, please complete the consent form provided.**

**Appendix B**

The Tavistock and Portman   
NHS Foundation Trust

Dear \_\_\_\_\_,

I am about to embark on my Doctoral Research Project as part of my Child and Adolescent Psychotherapy training. I am contacting you to see if you would be interested in taking part.

The project title is:

**Exploring the taboo: How do Child & Adolescent Psychotherapists work with the erotic transference with adolescents?**

I am interested in exploring psychotherapists' views on how the erotic transference presents itself in the work with adolescents and young adults and how Child and Adolescent Psychotherapists work with it. This could come from experiences with patients who you have worked directly and/or that other clinicians you have supervised have worked with.

I am interested in exploring why the erotic transference has become a topic that is difficult to talk about and what the risks and gains are of working with this type of transference.

I would like to invite qualified Child and Adolescent Psychotherapists who have had experience in working with the erotic transference with adolescents and have developed in their career an interest in this topic (for example who have written or have taught seminars/lectures or have done presentations in conferences about it) or in topics that can overlap with the erotic transference (bodily transference, victims of sexual abuse, adolescents that present with harmful sexual behaviour, etc.). Participation will take the form of an interview, which will last between 45 – 75 minutes. This would take place at the Tavistock Clinic, or your usual place of work, or online if necessary.

If you would be interested and willing to take part, please find attached a participant information sheet.

Kind regards,

Giulia Vignali

## Appendix C

### Semi-Structured Interview Schedule

#### **Exploring the taboo: How do Child & Adolescent Psychotherapists work with the erotic transference with adolescents?**

##### **Welcome**

Explain to the participant that:

This is a semi-structured interview lasting between 45 and 75 minutes.

While I have some questions that I'd like to ask you, I'd like to encourage you to talk freely about your thoughts on how Child & Adolescent Psychotherapists work with the erotic transference with adolescent patients. It would be great to hear about examples of patients you have worked with or that you indirectly heard of, for example in your role as supervisor. Worth saying that although I will not include any identifying details in my final project, it would be preferable if you could also try not to include anything names or details that might identify the patients you discuss.

##### **Questions**

- Can you tell me how, based on your experience, adolescent patients bring the erotic transference into the work?
  - Do they talk about sexual feelings in an explicit or implicit way?
  - Do they express erotic feelings explicitly towards the therapist or do they talk about them in an indirect way (for example by talking about other people in their life)?
  - Do you have any thoughts about whether differences and similarities between patient and therapist (age, gender, race, sexual orientation, etc.) have an impact on the erotic transference and how it is worked with?
  - Do you have any examples in mind?
- Having one or more examples in mind, how in your experience Child & Adolescent Psychotherapists work with the erotic transference with adolescent patients?
  - Do they take the erotic transference up explicitly or implicitly?
  - Do they bring the erotic transference to supervision or to colleagues?
  - Is the erotic transference always recognised in the work?
  - Do you think there is a difference between how Child & Adolescent Psychotherapists and Adult Psychotherapists/Analysts work with the erotic transference?

- What do you think are the risks and gains of working with the erotic transference?
- Do you think that the erotic transference is talked about enough and why?
- Do you think that Child & Adolescent Psychotherapists could work with the erotic transference in a different way? Do you have any examples in mind?
- Why do you think the erotic transference has become a taboo?

**End**

- Is there anything the participant would like to mention, that has not yet been covered?
- Thank the participant for taking part.
- Let participant know they can contact me if any questions, or require further information.
- Signpost them to colleagues, supervisors and senior staff who are within the clinic at that time if they need support following the interview discussion.
- Send debrief letter via email.

## Appendix D

The Tavistock and Portman 

NHS Foundation Trust

Quality Assurance & Enhancement  
Directorate of Education & Training  
Tavistock Centre  
120 Belsize Lane  
London  
NW3 5BA

Tel: 020 8938 2699

<https://tavistockandportman.nhs.uk/>

Giulia Vignali

### By Email

18 July 2023

Dear Giulia,

### Re: Trust Research Ethics Application

**Title:** 'Exploring the taboo: How do Child & Adolescent Psychotherapists work with the erotic transference with adolescents?'

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

**Please be advised that any changes to the project design including changes to methodology/data collection etc. must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.**

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

**Michael Franklyn**



Academic Governance and Quality Officer

T: 020 938 2699

E: [academicquality@tavi-port.nhs.uk](mailto:academicquality@tavi-port.nhs.uk)

cc. Course Lead, Supervisor, Research Lead

## Appendix E

Dear

I am writing to thank you for your contribution to my Doctoral Research Project. I hope you found it as interesting as I did.

If following taking part in the study there are any issues concerning you, I hope that you are able to access the support network around you including colleagues, supervisors or your training analyst. However, if this isn't possible then I would encourage you to contact the Human Resources department of the trust in which you are currently employed. All services will be able to provide a free confidential talking service that could be a space that you could use to reflect on and process taking part in the interview.

If you have any questions, would like any further information or would like to have a debrief meeting with me my contact details are:

Email: [removed]

Phone: [removed]

If you have any concerns about how the study has been conducted, please contact myself, my supervisor Elena Della Rosa ([removed]), or Head of Academic Governance and Quality Assurance Helen Shaw ([academicquality@tavi-port.nhs.uk](mailto:academicquality@tavi-port.nhs.uk)).

Kind regards,

Giulia Vignali

**Appendix F****Consent Form**

**Project title:** Exploring the taboo: How do Child & Adolescent Psychotherapists work with the erotic transference with adolescents?

**Name of researcher:** Giulia Vignali

- I, \_\_\_\_\_, voluntarily agree to participate in this research project.
  
- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
  
- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to three weeks after the completion of the interview.
  
- I understand that the interview will be digitally recorded and transcribed, as described in the participant information sheet.
  
- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk.
  
- I understand that direct quotes from the audio recording may be used in this research study, that these will be made anonymous to the reader and held securely by the researcher, but that I may be able to identify myself in the final report.

- I understand that it is my responsibility to anonymise any examples referring to cases I choose to discuss during the interview.
- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications.

**Contact details:**

Researcher: Giulia Vignali

Email: [removed]

Supervisor: Elena Della Rosa

Email: [removed]

Participant's name (printed):

Participant's signature:

Date:

**Thank you for agreeing to take part in this study.**

**Your contribution is very much appreciated.**

## Appendix G

### **Tavistock and Portman Trust Research Ethics Committee (TREC)** **APPLICATION FOR ETHICAL REVIEW OF STUDENT RESEARCH PROJECTS**

This application should be submitted alongside copies of any supporting documentation which will be handed to participants, including a participant information sheet, consent form, self-completion survey or questionnaire.

Where a form is submitted and sections are incomplete, the form will not be considered by TREC and will be returned to the applicant for completion.

For further guidance please contact Paru Jeram ([academicquality@tavi-port.nhs.uk](mailto:academicquality@tavi-port.nhs.uk))

#### **FOR ALL APPLICANTS**

**If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters. You need only complete sections of the TREC form which are NOT covered in your existing approval**

|  |                |
|--|----------------|
| Is your project considered as 'research' according to the HRA tool?<br>( <a href="http://www.hra-decisiontools.org.uk/research/index.html">http://www.hra-decisiontools.org.uk/research/index.html</a> ) | Yes/ <u>No</u> |
| Will your project involve participants who are under 18 or who are classed as vulnerable?<br>(see section 7)   | Yes/ <u>No</u> |
| Will your project include data collection outside of the UK?   | Yes/ <u>No</u> |

#### **SECTION A: PROJECT DETAILS**

|  |   |                                     |                |
|--|---|-------------------------------------|----------------|
| <b>Project title</b>   | Exploring the taboo: How do Child & Adolescent Psychotherapists work with the erotic transference with adolescents? |                                     |                |
| <b>Proposed project start date</b>   | ASAP  | <b>Anticipated project end date</b> | September 2024 |
| <b>Principle Investigator (normally your Research Supervisor): Elena Della Rosa</b>  |   |                                     |                |
| <b>Please note: TREC approval will only be given for the length of the project as stated above up to a maximum of 6 years. Projects exceeding these timeframes will need additional ethical approval</b> |   |                                     |                |
| <b>Has NHS or other approval been sought for this research including through submission via Research Application System (IRAS) or to the Health Research Authority (HRA)?</b>                            | <b>YES (NRES approval)</b>  | <input type="checkbox"/>            |                |
|  | <b>YES (HRA approval)</b>   | <input type="checkbox"/>            |                |
|  | <b>Other</b>  | <input type="checkbox"/>            |                |
|  | <b>NO</b>   | <input checked="" type="checkbox"/> |                |
| <b>If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters.</b>   |   |                                     |                |

#### **SECTION B: APPLICANT DETAILS**

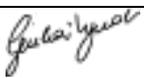
|  |                |
|--|----------------|
| <b>Name of Researcher</b>                  | Giulia Vignali |
| <b>Programme of Study and Target Award</b> | M80            |
| <b>Email address</b>                       | [removed]      |
| <b>Contact telephone number</b>            | [removed]      |

### **SECTION C: CONFLICTS OF INTEREST**

|  |  |
|--|--|
| <p><b>Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above their normal salary package or the costs of undertaking the research?</b></p> <p>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>If YES, please detail below:</p>  |  |
| <p>Is there any further possibility for conflict of interest? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>  |  |
| <p><b>Are you proposing to conduct this work in a location where you work or have a placement?</b></p> <p>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>If YES, please detail below outline how you will avoid issues arising around colleagues being involved in this project:</p> <p>There is a possibility that I will recruit participants that work in a location where I work and I am aware that this could have an impact on mine and the participant's experience of the interview. My interpretation of the data could also be affected and I plan to acknowledge this both with the participants and in my report.</p> |  |
| <p><b>Is your project being commissioned by and/or carried out on behalf of a body external to the Trust? (for example; commissioned by a local authority, school, care home, other NHS Trust or other organisation).</b></p> <p><small>*Please note that 'external' is defined as an organisation which is external to the Tavistock and Portman NHS Foundation Trust (Trust)</small></p> <p>If YES, please add details here:</p>   | <p>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> |
| <p><b>Will you be required to get further ethical approval after receiving TREC approval?</b></p> <p>If YES, please supply details of the ethical approval bodies below AND include any letters of approval from the ethical approval bodies (letters received after receiving TREC approval should be submitted to complete your record):</p>   | <p>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> |
| <p>If your project is being undertaken with one or more clinical services or organisations external to the Trust, please provide details of these:</p> <p>I will recruit participants via purposive sampling. All participants will be registered with the ACP.</p>  |  |

|  |   |
|--|---|
| If you still need to agree these arrangements or if you can only approach organisations after you have ethical approval, please identify the types of organisations (eg. Schools or clinical services) you wish to approach: |   |
| N/A  |   |
| Do you have approval from the organisations detailed above? (this includes R&D approval where relevant)  | YES <input type="checkbox"/> NO <input type="checkbox"/> NA <input checked="" type="checkbox"/> |
| Please attach approval letters to this application. Any approval letters received after TREC approval has been granted MUST be submitted to be appended to your record   |   |

### SECTION D: SIGNATURES AND DECLARATIONS

|  |   |
|--|---|
| <b>APPLICANT DECLARATION</b>   |   |
| I confirm that:  |   |
| <ul style="list-style-type: none"> <li>• The information contained in this application is, to the best of my knowledge, correct and up to date.</li> <li>• I have attempted to identify all risks related to the research.</li> <li>• I acknowledge my obligations and commitment to upholding ethical principles and to keep my supervisor updated with the progress of my research</li> <li>• I am aware that for cases of proven misconduct, it may result in formal disciplinary proceedings and/or the cancellation of the proposed research.</li> <li>• I understand that if my project design, methodology or method of data collection changes I must seek an amendment to my ethical approvals as failure to do so, may result in a report of academic and/or research misconduct.</li> </ul> |   |
| Applicant (print name)   | Giulia Vignali  |
| Signed   |  |
| Date   | 18/06/2023  |

### FOR RESEARCH DEGREE STUDENT APPLICANTS ONLY

|  |   |
|--|---|
| Name of Supervisor/Principal Investigator  | Elena Della Rosa  |
| <b>Supervisor –</b> <ul style="list-style-type: none"> <li>• Does the student have the necessary skills to carry out the research?<br/>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></li> <li>▪ Is the participant information sheet, consent form and any other documentation appropriate?<br/>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></li> <li>▪ Are the procedures for recruitment of participants and obtaining informed consent suitable and sufficient?<br/>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></li> <li>▪ Where required, does the researcher have current Disclosure and Barring Service (DBS) clearance?<br/>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></li> </ul> |   |
| Signed   |  |
| Date   | 17/06/2023  |

|  |  |
|--|--|
| <b>COURSE LEAD/RESEARCH LEAD</b>   |  |
| Does the proposed research as detailed herein have your support to proceed? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>Signed</b>  |  |
| <b>Date</b>  |  |

### **SECTION E: DETAILS OF THE PROPOSED RESEARCH**

- 1. Provide a brief description of the proposed research, including the requirements of participants. This must be in lay terms and free from technical or discipline specific terminology or jargon. If such terms are required, please ensure they are adequately explained (Do not exceed 500 words)**

This research project will aim at exploring how Child & Adolescent Psychotherapists work with erotic transference with adolescent patients. With erotic transference I refer to both the following concepts:

- Erotic transference (Person, 1985): 'some mixture of tender, erotic, and sexual feelings that a patient experiences in reference to his or her analyst and, as such, forms part of a positive transference' (p. 161);
- Erotized transference (Blum, 1973): 'an intense, vivid, irrational, erotic preoccupation with the analyst, characterized by overt, seemingly ego-syntonic demands for love and sexual fulfilment from the analyst' (p. 61).

When thinking about transference, I will consider Joseph's (1985) view of the transference as a total situation, a framework where it is assumed that the patient's communication always convey how they feel towards their therapist. Whilst adolescent patients may still bring erotic transference in an explicit way to their therapist, it may also be that the erotic transference may present itself in a more indirect way with patients of this age range, for example by talking about other people in the young person's life.

Participants will be qualified members of the profession who have experience of having worked with adolescents where they had to deal with erotic transference in the therapy. These facts will be known because the participants have either published papers about this topic, have talked about it in public events or have stated their experience and are able to refer to clinical cases. I will aim to recruit 4-5 participants.

I plan to conduct semi-structured interviews to collect qualitative data and to focus on the following aspects of the phenomenon:

- The ways adolescent patients may bring erotic transference into the work: explicit or implicit?
- The ways in which Child and Adolescent Psychotherapists work with the erotic transference with adolescent patients
- Whether, in the participants' experience, working with the erotic transference with adolescent patients is thought about enough and why
- The risks/gains of thinking about the erotic transference in the work with adolescent patients.

Interviews will be audio or video recorded and transcribed verbatim. I will then analyse the data using Reflexive Thematic Analysis (RTA) as described by Braun and Clarke (2006) in order to identify patterns of meaning in the material via a flexible and rigorous coding process.

**2. Provide a statement on the aims and significance of the proposed research, including potential impact to knowledge and understanding in the field (where appropriate, indicate the associated hypothesis which will be tested). This should be a clear justification of the proposed research, why it should proceed and a statement on any anticipated benefits to the community. (Do not exceed 700 words)**

Freud (1905) put sexuality at the centre of the person's emotional development and began to think about the concept of transference love which he linked with the experience of the female patient falling in love with the analyst and that he saw as an obstacle to the analysis and a risk for the analyst to act on their countertransference.

In Heimann's (1950) point of view, countertransference was instead a tool to understand the patient's unconscious. Sexual transference and countertransference could therefore be useful instruments for therapists even if potentially challenging to manage. Brady (2018) preferred the term erotic field over erotic transference and countertransference, in order to convey the complexity of this dynamic. She stressed in fact that at times it can be hard to understand who these feelings belong to in the therapeutic relationship.

Despite an agreement within child psychotherapists on the importance of thinking about erotic (Person, 1985) and erotized transference (Blum, 1973) and the challenge and anxiety that they arise, literature on the topic is limited (Lena, 2017; Jackson, 2017). Jackson (2017) highlighted how difficult it could be even for experienced clinician to bring this type of dynamic to supervision, but he also stressed the importance of helping the patient to process these uncomfortable and disturbing experience of part of their treatment. Being able to seek guidance and supervision is therefore paramount.

Sexuality entering the transference relationship has the potential of rising anxiety and may be even more of a challenge to address and manage both in the consulting room and supervision. Psychotherapists can worry about having manipulated the child, introduced him/her to the world of adult sexuality, breached incest taboos, or of retaliation from the parents and/or society (Atkinson & Gabbard, 1995) as well as the analyst's own parental superego (Brady, 2018). This could lead to a denial of the erotic elements of the transference, which would be left unexplored. Instead, psychotherapists should find a way to allow the sexual feelings to exist without being seductive or seduced (Alvarez, 2010).

I am particularly interested in exploring the phenomenon of the erotic transference with adolescent patients. Adolescence is an age of transition where the person undergoes deep and sudden psychological and physical changes. Sexual development has a big role in this phase of life. The

body changes and primary and secondary sexual characteristics develop, as well as the person being bombarded by hormonal storms. For example, during puberty, 'there are greater and more rapid physiological, endocrinological, and neurological changes occurring than at any other stage of life except in the womb' (Waddell, 2018, p. 47). Early feelings and conflicts are re-evoked in this moment of life, which can become an overwhelming one.

As Freud (1905) stated in his work on sexuality, sexual instincts are present in childhood, but it is in adolescence that they are integrated and directed towards a person of choice.

Adolescence is a tumultuous age and so it is working with patients that age as the therapist is to experience the emotional rollercoaster they are going through. Sexuality is part of this emotional rollercoaster and can be therefore part of the experience of the therapist too. One could think that managing the erotic transference may be particularly important for these reasons, and yet as aforementioned there is a lack of literature on the topic as well as resistance in bringing it up in our clinical work.

Why has sexuality, whilst initially at the centre of psychoanalytic theory, become a taboo (Davids, 2023)? This project will aim at exploring the thoughts of the participants on how Child & Adolescent Psychotherapists (CAPTs) currently work with the erotic transference in the work with adolescents.

I will be interested in hearing their ideas on technique (e.g. taking up the erotic transference in a direct way with the patient) as well as their thoughts on why the erotic transference has become a taboo. I will aim at exploring their opinion on what risks and gains thinking about the erotic transference could bring and how these could inform our practice.

This project will offer an overview on the status quo of the profession's practice when working with adolescent patients' erotic transference and therefore has the potential of informing future practice. It could also highlight areas for further research.

**3. Provide an outline of the methodology for the proposed research, including proposed method of data collection, tasks assigned to participants of the research and the proposed method and duration of data analysis. If the proposed research makes use of pre-established and generally accepted techniques, please make this clear. (Do not exceed 500 words)**

I will recruit 4-5 qualified CAPTs using purposive sampling. Participants will have either published papers about erotic transference, have talked about it in public events or have stated their experience and are able to refer to clinical cases. They will have extensive experience in both direct clinical work with adolescent patients and indirect supervisory roles, which will allow them to have a wide breath of experienced or observed examples of practice.

I will gather data using a semi-structured interview.

Interviews will be of about an hour and an interview schedule will be agreed beforehand with my research supervisor. Interview's questions will be about:

- The participants' thoughts on how erotic transference can present itself in the work with adolescents (e.g. explicit towards the therapist or implicit towards other people in the patient's life)
- The participants' ideas and opinions on how Child & Adolescent Psychotherapists currently work with the erotic transference, referring both to their own experience as clinicians and as supervisors
- The participants' sense on why erotic transference has become a taboo, and what would be the risks and gains of thinking more about it

Interviews will be flexible and led by the participants' exploration of the topic, in order for themes and associations to emerge. I will encourage further exploration of the themes by asking questions and facilitate a conversational reflection on the participants' thoughts and ideas on the aforementioned topics.

Interviews will be audio- or video-recorded online and will be transcribed verbatim.

The data will be analysed using Reflexive Thematic Analysis (RTA). RTA uses a rigorous coding process in order to identify patterns of meaning in the material. It is a-theoretical, which will allow me to analyse the data in an objective and linked to the material way. It will be important for me to adopt a reflexive approach and to reflect on my own identity as researcher as well as clinician and the impact that this could have on data analysis.

## **SECTION F: PARTICIPANT DETAILS**

**4. Provide an explanation detailing how you will identify, approach and recruit the participants for the proposed research, including clarification on sample size and location. Please provide justification for the exclusion/inclusion criteria for this study (i.e. who will be allowed to / not allowed to participate) and explain briefly, in lay terms, why these criteria are in place. (Do not exceed 500 words)**

I am planning to do a purposive sampling of 4-5 CAPTs who have taken a particular interest in the topic of erotic/erotized feelings in the transference relationship during their career. This would be known by the fact that they will have either published papers about erotic transference, have talked about it in public events or have stated their experience and are able to refer to clinical cases.

Given the sensitivity of the topic, selecting CAPTs who have expertise on the erotic transference could mean that they may be more likely and interested in participating in my project as well as being

more open and less defended. They will be more likely to have formulated ideas about how CAPTs work with the erotic transference with adolescents both in terms of theoretical understanding and clinical experience, both direct with patients and indirect in a supervisory role, and therefore potentially offering rich data for the project.

The limitation would be that the data collected may be skewed, as it may not take into account thoughts and ideas of clinicians that do not have the expertise, but that could offer raw and potentially interesting data. Perhaps including a different sample could be the scope of further research.

When approaching possible participants, I will forward them the Participant Information Sheet for them to gather more information about my project. If interested in participating, I will obtain their consent and forward them the interview schedule prior to the interview (over 24 hours before). Being aware of the type of questions I will ask may make the interview less distressful as participants will not be asked something that they did not expect.

Given that I will use purposive sampling, participants may be concerned that they could be more easily recognisable. I will make the participants aware that I will make sure that they and the data will be de-identified and that any detail will be anonymised. I will also consult with my research supervisor on how to ensure this.

Interviews will take place preferably in person. Given the sensitivity of the topic, it would be important to offer participants a comfortable and confidential environment. When possible, I will try to keep the environment of the interview consistent and interview participants at the Tavistock clinic as it would give me more control over the setting of the interviews. However, it is probable that participants will not be able to travel to the clinic and interviews will have to take place in alternative settings, likely their place of work or homes. In the instance that participants are unable to be interviewed in person (for example they live out of London), I will interview them online (Zoom or Microsoft Teams).

**5. Please state the location(s) of the proposed research including the location of any interviews. Please provide a Risk Assessment if required. Consideration should be given to lone working, visiting private residences, conducting research outside working hours or any other non-standard arrangements.**

**If any data collection is to be done online, please identify the platforms to be used.**

It would be ideal that interviews take place in person. Given the sensitivity of the topic, it would be important to offer participants a comfortable and confidential environment. Ideally, interviews would take place in the same environment (the Tavistock Clinic). This would allow me to have more control on the setting of the interviews and ensure a consistent environment for the interviews as I am familiar with the clinic and its policies and procedures.

At the same time this may not be realistic as CAPTs may be based in different localities and/or unable to reach the clinic. When possible, I will arrange to meet in person in a location is suitable to them. One possible alternative will be the participants' workplace. Some very experienced CAPTs may be

of an age and/or present with physical limitation that may make it hard for them to come to the clinic. It is ordinary practice that these CAPTs offer supervision in their own home, and it would be therefore likely that their home may also be the most comfortable location for them for the interviews. In these cases, I will follow the following lone working procedure: I will inform my research supervisor about the address of the location, the time of the interview and the name of the person I am meeting (who will be an ACP registered professional, previously identified as suitable participant by my supervisor and I). I will then inform my supervisor when the interview has terminated.

In the situation that the interviews cannot take place in person, for either the participant's preference or practicalities (for example the CAPT lives far away or abroad), the interview will take place online either on Zoom or Microsoft Teams.

Interviews will take place during working hours if possible, however there may be some flexibility on times if this is not possible (for example due to the participant's work commitments).

Interviews will be audio or video recorded and transcribed verbatim.

Participants will be able to take breaks or to leave interviews at any point and will be able to withdraw their participation up to three weeks after the interview.

**6. Will the participants be from any of the following groups?(Tick as appropriate)**

- Students or Staff of the Trust or Partner delivering your programme.
- Adults (over the age of 18 years with mental capacity to give consent to participate in the research).
- Children or legal minors (anyone under the age of 16 years)<sup>1</sup>
- Adults who are unconscious, severely ill or have a terminal illness.
- Adults who may lose mental capacity to consent during the course of the research.
- Adults in emergency situations.
- Adults<sup>2</sup> with mental illness - particularly those detained under the Mental Health Act (1983 & 2007).
- Participants who may lack capacity to consent to participate in the research under the research requirements of the Mental Capacity Act (2005).
- Prisoners, where ethical approval may be required from the National Offender Management Service (NOMS).
- Young Offenders, where ethical approval may be required from the National Offender Management Service (NOMS).
- Healthy volunteers (in high risk intervention studies).
- Participants who may be considered to have a pre-existing and potentially dependent<sup>3</sup> relationship with the investigator (e.g. those in care homes, students, colleagues, service-users, patients).
- Other vulnerable groups (see Question 6).
- Adults who are in custody, custodial care, or for whom a court has assumed responsibility.
- Participants who are members of the Armed Forces.

<sup>1</sup>If the proposed research involves children or adults who meet the Police Act (1997) definition of vulnerability<sup>3</sup>, any researchers who will have contact with participants must have current Disclosure and Barring Service (DBS) clearance.

<sup>2</sup> 'Adults with a learning or physical disability, a physical or mental illness, or a reduction in physical or mental capacity, and living in a care home or home for people with learning difficulties or receiving care in their own home, or receiving hospital or social care services.' (Police Act, 1997)

<sup>3</sup> Proposed research involving participants with whom the investigator or researcher(s) shares a dependent or unequal relationships (e.g. teacher/student, clinical therapist/service-user) may compromise the ability to give

*informed consent which is free from any form of pressure (real or implied) arising from this relationship. TREC recommends that, wherever practicable, investigators choose participants with whom they have no dependent relationship. Following due scrutiny, if the investigator is confident that the research involving participants in dependent relationships is vital and defensible, TREC will require additional information setting out the case and detailing how risks inherent in the dependent relationship will be managed. TREC will also need to be reassured that refusal to participate will not result in any discrimination or penalty.*

**7. Will the study involve participants who are vulnerable? YES  NO**

For the purposes of research, 'vulnerable' participants may be adults whose ability to protect their own interests are impaired or reduced in comparison to that of the broader population.

Vulnerability may arise from:

- the participant's personal characteristics (e.g. mental or physical impairment)
- their social environment, context and/or disadvantage (e.g. socio-economic mobility, educational attainment, resources, substance dependence, displacement or homelessness).
- where prospective participants are at high risk of consenting under duress, or as a result of manipulation or coercion, they must also be considered as vulnerable
- children are automatically presumed to be vulnerable.

**7.1. If YES, what special arrangements are in place to protect vulnerable participants' interests?**

If **YES**, a Disclosure and Barring Service (DBS) check **within the last three years** is required.

Please provide details of the "clear disclosure":

Date of disclosure:

Type of disclosure:

Organisation that requested disclosure:

DBS certificate number:

*(NOTE: information concerning activities which require DBS checks can be found via <https://www.gov.uk/government/publications/dbs-check-eligible-positions-guidance>). Please **do not** include a copy of your DBS certificate with your application*

**8. Do you propose to make any form of payment or incentive available to participants of the research? YES  NO**

If **YES**, please provide details taking into account that any payment or incentive should be representative of reasonable remuneration for participation and may not be of a value that could be coercive or exerting undue influence on potential participants' decision to take part in the research. Wherever possible, remuneration in a monetary form should be avoided and substituted with vouchers, coupons or equivalent. Any payment made to research participants may have benefit or HMRC implications and participants should be alerted to this in the participant information sheet as they may wish to choose to decline payment.

**9. What special arrangements are in place for eliciting informed consent from participants who may not adequately understand verbal explanations or written information provided in English; where participants have special communication needs; where participants have limited literacy; or where children are involved in the research? (Do not exceed 200 words)**

I will only invite participants who are able to adequately understand verbal explanations and written information about the project. Children will not be involved in the research.

## **SECTION F: RISK ASSESSMENT AND RISK MANAGEMENT**

### **10. Does the proposed research involve any of the following? (Tick as appropriate)**

- use of a questionnaire, self-completion survey or data-collection instrument (attach copy)
- use of emails or the internet as a means of data collection
- use of written or computerised tests
- interviews (attach interview questions)
- diaries (attach diary record form)
- participant observation
- participant observation (in a non-public place) without their knowledge / covert research
- audio-recording interviewees or events
- video-recording interviewees or events
- access to personal and/or sensitive data (i.e. student, patient, client or service-user data) without the participant's informed consent for use of these data for research purposes
- administration of any questions, tasks, investigations, procedures or stimuli which may be experienced by participants as physically or mentally painful, stressful or unpleasant during or after the research process
- performance of any acts which might diminish the self-esteem of participants or cause them to experience discomfiture, regret or any other adverse emotional or psychological reaction
- Themes around extremism or radicalisation
- investigation of participants involved in illegal or illicit activities (e.g. use of illegal drugs)
- procedures that involve the deception of participants
- administration of any substance or agent
- use of non-treatment of placebo control conditions
- participation in a clinical trial
- research undertaken at an off-campus location (risk assessment attached)
- research overseas (please ensure Section G is complete)

### **11. Does the proposed research involve any specific or anticipated risks (e.g. physical, psychological, social, legal or economic) to participants that are greater than those encountered in everyday life?**

YES  NO

If YES, please describe below including details of precautionary measures.

### **12. Where the procedures involve potential hazards and/or discomfort or distress for participants, please state what previous experience the investigator or researcher(s) have had in conducting this type of research.**

I do not anticipate there being any potential hazards, discomfort or distress for participants. However, if participants experience distress or discomfort, I will stop the interview and signpost the participant to available support. Participants will also be free to terminate the interview at any time.

**13. Provide an explanation of any potential benefits to participants. Please ensure this is framed within the overall contribution of the proposed research to knowledge or practice. (Do not exceed 400 words)**

**NOTE:** Where the proposed research involves students, they should be assured that accepting the offer to participate or choosing to decline will have no impact on their assessments or learning experience. Similarly, it should be made clear to participants who are patients, service-users and/or receiving any form of treatment or medication that they are not invited to participate in the belief that participation in the research will result in some relief or improvement in their condition.

By taking part, participants will have a chance to reflect and talk about their thoughts and experiences about how CAPTs work with the erotic transference with adolescents. It would be an opportunity for them to reflect on the status quo of clinical practice and to think in depth about risks and gains of taking up the erotic transference with patients as well as with colleagues and in supervision. The hope is that it could inform their future practice as well as potentially stimulate ideas for future research.

**14. Provide an outline of any measures you have in place in the event of adverse or unexpected outcomes and the potential impact this may have on participants involved in the proposed research. (Do not exceed 300 words)**

During the interview, the researcher will use their observer skills and be mindful of adopting a sensitive and thoughtful approach. For example, if a participant expresses upset or discomfort, tact will be applied and consideration given when deciding how far to inquire about a distressing experience. If needed, I could offer to finish the interview or pause/stop the recording or reschedule the interview.

**15. Provide an outline of your debriefing, support and feedback protocol for participants involved in the proposed research. This should include, for example, where participants may feel the need to discuss thoughts or feelings brought about following their participation in the research. This may involve referral to an external support or counseling service, where participation in the research has caused specific issues for participants.**

All participants will be qualified CAPTs, and as such will have access to supervision and analysis. A debrief email will be sent out following the interviews, which will include contact details for the researcher, the project supervisor, and the Head of Academic Governance and Quality Assurance.

**16. Please provide the names and nature of any external support or counselling organisations that will be suggested to participants if participation in the research has potential to raise specific issues for participants.**

I do not anticipate that participating in the research will raise issues for the participants. Participants will be experienced clinician that will have colleagues and supervisors' support. If this however is not sufficient, I will signpost them to their Trust's confidential counselling service.

Information about the service will be provided in the debrief letter, which will also include the contact details of myself, my supervisor and the Head of Academic Governance and Quality Assurance

**17. Where medical aftercare may be necessary, this should include details of the treatment available to participants. Debriefing may involve the disclosure of further information on the aims of the research, the participant's performance and/or the results of the research. (Do not exceed 500 words)**

This project will not require medical aftercare.

#### **FOR RESEARCH UNDERTAKEN OUTSIDE THE UK**

**18. Does the proposed research involve travel outside of the UK?**

YES  NO

**If YES, please confirm:**

I have consulted the Foreign and Commonwealth Office website for guidance/travel advice? <http://www.fco.gov.uk/en/travel-and-living-abroad/>

I have completed a RISK Assessment covering all aspects of the project including consideration of the location of the data collection and risks to participants.

All overseas project data collection will need approval from the Deputy Director of Education and Training or their nominee. Normally this will be done based on the information provided in this form. All projects approved through the TREC process will be indemnified by the Trust against claims made by third parties.

If you have any queries regarding research outside the UK, please contact [academicquality@tavi-port.nhs.uk](mailto:academicquality@tavi-port.nhs.uk):

Students are required to arrange their own travel and medical insurance to cover project work outside of the UK. Please indicate what insurance cover you have or will have in place.

**19. Please evidence how compliance with all local research ethics and research governance requirements have been assessed for the country(ies) in which the research is taking place. Please also clarify how the requirements will be met:**

#### **SECTION G: PARTICIPANT CONSENT AND WITHDRAWAL**

**20. Have you attached a copy of your participant information sheet (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials.**

YES  NO

If **NO**, please indicate what alternative arrangements are in place below:

**21. Have you attached a copy of your participant consent form (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials.**

YES  NO

If **NO**, please indicate what alternative arrangements are in place below:

**22. The following is a participant information sheet checklist covering the various points that should be included in this document.**

- Clear identification of the Trust as the sponsor for the research, the project title, the Researcher and Principal Investigator (your Research Supervisor) and other researchers along with relevant contact details.
- Details of what involvement in the proposed research will require (e.g., participation in interviews, completion of questionnaire, audio/video-recording of events), estimated time commitment and any risks involved.
- A statement confirming that the research has received formal approval from TREC or other ethics body.
- If the sample size is small, advice to participants that this may have implications for confidentiality / anonymity.
- A clear statement that where participants are in a dependent relationship with any of the researchers that participation in the research will have no impact on assessment / treatment / service-use or support.
- Assurance that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied.
- Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations.
- A statement that the data generated in the course of the research will be retained in accordance with the [Trusts 's Data Protection and handling Policies](https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/).:  
<https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/>
- Advice that if participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Simon Carrington, Head of Academic Governance and Quality Assurance ([academicquality@tavi-port.nhs.uk](mailto:academicquality@tavi-port.nhs.uk))
- Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

**23. The following is a consent form checklist covering the various points that should be included in this document.**

- Trust letterhead or logo.
- Title of the project (with research degree projects this need not necessarily be the title of the thesis) and names of investigators.
- Confirmation that the research project is part of a degree
- Confirmation that involvement in the project is voluntary and that participants are free to withdraw at any time, or to withdraw any unprocessed data previously supplied.
- Confirmation of particular requirements of participants, including for example whether interviews are to be audio-/video-recorded, whether anonymised quotes will be used in publications advice of legal limitations to data confidentiality.
- If the sample size is small, confirmation that this may have implications for anonymity any other relevant information.
- The proposed method of publication or dissemination of the research findings.

- Details of any external contractors or partner institutions involved in the research.
- Details of any funding bodies or research councils supporting the research.
- Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

#### **SECTION H: CONFIDENTIALITY AND ANONYMITY**

**24. Below is a checklist covering key points relating to the confidentiality and anonymity of participants. Please indicate where relevant to the proposed research.**

- Participants will be completely anonymised and their identity will not be known by the investigator or researcher(s) (i.e. the participants are part of an anonymous randomised sample and return responses with no form of personal identification)?
- The responses are anonymised or are an anonymised sample (i.e. a permanent process of coding has been carried out whereby direct and indirect identifiers have been removed from data and replaced by a code, with no record retained of how the code relates to the identifiers).
- The samples and data are de-identified (i.e. direct and indirect identifiers have been removed and replaced by a code. The investigator or researchers are able to link the code to the original identifiers and isolate the participant to whom the sample or data relates).
- Participants have the option of being identified in a publication that will arise from the research.
- Participants will be pseudo-anonymised in a publication that will arise from the research. (I.e. the researcher will endeavour to remove or alter details that would identify the participant.)
- The proposed research will make use of personal sensitive data.
- Participants consent to be identified in the study and subsequent dissemination of research findings and/or publication.

**25. Participants must be made aware that the confidentiality of the information they provide is subject to legal limitations in data confidentiality (i.e. the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions). This only applies to named or de-identified data. If your participants are named or de-identified, please confirm that you will specifically state these limitations.**

YES  NO

If **NO**, please indicate why this is the case below:

**NOTE: WHERE THE PROPOSED RESEARCH INVOLVES A SMALL SAMPLE OR FOCUS GROUP, PARTICIPANTS SHOULD BE ADVISED THAT THERE WILL BE DISTINCT LIMITATIONS IN THE LEVEL OF ANONYMITY THEY CAN BE AFFORDED.**

#### **SECTION I: DATA ACCESS, SECURITY AND MANAGEMENT**

**26. Will the Researcher/Principal Investigator be responsible for the security of all data collected in connection with the proposed research? YES  NO**

If **NO**, please indicate what alternative arrangements are in place below:

**27. In line with the 5<sup>th</sup> principle of the Data Protection Act (1998), which states that personal data shall not be kept for longer than is necessary for that purpose or those purposes for which it was collected; please state how long data will be retained for.**

1-2 years  3-5 years  6-10 years  10> years

**NOTE: In line with** Research Councils UK (RCUK) guidance, doctoral project data should normally be stored for 10 years and Masters level data for up to 2 years

**28. Below is a checklist which relates to the management, storage and secure destruction of data for the purposes of the proposed research. Please indicate where relevant to your proposed arrangements.**

- Research data, codes and all identifying information to be kept in separate locked filing cabinets.
- Research data will only be stored in the University of Essex OneDrive system and no other cloud storage location.
- Access to computer files to be available to research team by password only.
- Access to computer files to be available to individuals outside the research team by password only (See 23.1).
- Research data will be encrypted and transferred electronically within the UK.
- Research data will be encrypted and transferred electronically outside of the UK.

**NOTE:** Transfer of research data via third party commercial file sharing services, such as Google Docs and YouSendIt are not necessarily secure or permanent. These systems may also be located overseas and not covered by UK law. If the system is located outside the European Economic Area (EEA) or territories deemed to have sufficient standards of data protection, transfer may also breach the Data Protection Act (1998).

Essex students also have access the 'Box' service for file transfer:

<https://www.essex.ac.uk/student/it-services/box>

- Use of personal addresses, postcodes, faxes, e-mails or telephone numbers.
- Collection and storage of personal sensitive data (e.g. racial or ethnic origin, political or religious beliefs or physical or mental health or condition).
- Use of personal data in the form of audio or video recordings.
- Primary data gathered on encrypted mobile devices (i.e. laptops).

**NOTE:** This should be transferred to secure University of Essex OneDrive at the first opportunity.

- All electronic data will undergo secure disposal.

**NOTE:** For hard drives and magnetic storage devices (HDD or SSD), deleting files does not permanently erase the data on most systems, but only deletes the reference to the file. Files can be restored when deleted in this way. Research files must be overwritten to ensure they are completely irretrievable. Software is available for the secure erasing of files from hard drives which meet recognised standards to securely scramble sensitive data. Examples of this software are BC Wipe, Wipe File, DeleteOnClick and Eraser for Windows platforms. Mac users can use the standard 'secure empty trash' option; an alternative is Permanent eraser software.

- All hardcopy data will undergo secure disposal.

**NOTE:** For shredding research data stored in hardcopy (i.e. paper), adopting DIN 3 ensures files are cut into 2mm strips or confetti like cross-cut particles of 4x40mm. The UK government requires a minimum standard of DIN 4 for its material, which ensures cross cut particles of at least 2x15mm.

**29. Please provide details of individuals outside the research team who will be given password protected access to encrypted data for the proposed research.**

No one outside the research team will be given password protected access to encrypted data.

**30. Please provide details on the regions and territories where research data will be electronically transferred that are external to the UK:**

Research data will not be electronically transferred to regions external to the UK.

## **SECTION J: PUBLICATION AND DISSEMINATION OF RESEARCH FINDINGS**

**30. How will the results of the research be reported and disseminated? (Select all that apply)**

- Peer reviewed journal
- Non-peer reviewed journal
- Peer reviewed books
- Publication in media, social media or website (including Podcasts and online videos)
- Conference presentation
- Internal report
- Promotional report and materials
- Reports compiled for or on behalf of external organisations
- Dissertation/Thesis
- Other publication

- |  |
|--|
| <input checked="" type="checkbox"/> Written feedback to research participants<br><input type="checkbox"/> Presentation to participants or relevant community groups<br><input type="checkbox"/> Other (Please specify below) |
|--|

### **SECTION K: OTHER ETHICAL ISSUES**

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| <b>31. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of Tavistock Research Ethics Committee (TREC)?</b> |
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|-----|
| No. |
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### **SECTION L: CHECKLIST FOR ATTACHED DOCUMENTS**

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| <b>32. Please check that the following documents are attached to your application.</b> |
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| <input type="checkbox"/> Letters of approval from any external ethical approval bodies (where relevant)<br><input checked="" type="checkbox"/> Recruitment advertisement<br><input checked="" type="checkbox"/> Participant information sheets (including easy-read where relevant)<br><input checked="" type="checkbox"/> Consent forms (including easy-read where relevant)<br><input type="checkbox"/> Assent form for children (where relevant)<br><input type="checkbox"/> Letters of approval from locations for data collection<br><input type="checkbox"/> Questionnaire<br><input checked="" type="checkbox"/> Interview Schedule or topic guide<br><input type="checkbox"/> Risk Assessment (where applicable)<br><input type="checkbox"/> Overseas travel approval (where applicable) |
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| <b>34. Where it is not possible to attach the above materials, please provide an explanation below.</b> |
|---|

## Appendix H

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|---|---|
| <p>And there was also something about it that really, you know, I was a trainee at the time, it was in my second year. So it was, it was, on the one hand, I thought, gosh, this feels very hard to weather and kind of sustain this, or withstand it rather. And then another part of me thought, Oh gosh, how exciting this is. This is so, there's so much rich psychoanalytic potential here. And so I also thought, wow, we can really get into something.</p> | <p>2.9 The impact of experience</p> <p>2.10 ET difficult to withstand as trainee</p> <p>2.11 ET can feel exciting to trainee</p> <p>2.12 ET as a potential for exploration</p>  |
| <p>So I think that's the majority of cases. It's this very subtle, nonverbal, intense transference rather than a teenager overtly letting the therapist know that they have sexual fantasies about the therapist. I think that may come up later in the work or it may only come up when the therapist's names something about these feelings in my experience.</p>   | <p>1.18 Adolescent ET is rarely explicit</p> <p>1.19 ET may come up explicitly later in the work</p> <p>1.20 ET may become more explicit after being named</p> <p>1.21 Importance of therapist's receptivity to notice ET</p> |

|  |  |
|--|--|
| <p>So for example I can think of times where I didn't take things up because either I didn't think the patient was ready or maybe I was afraid to take things up or maybe I didn't know how to take things up. And I can think of times where I didn't take things up and then the patient has gone off and possibly acted out because something had not been picked up. I can think of the times where patients went off and were promiscuous, went off and had affairs out of their own relationships and one occasion where a patient even came back from a break, Christmas break, having got married.</p> | <p>6.44 Not taken ET up because patient not ready</p> <p>6.45 Not taken ET up for therapist's anxieties</p> <p>6.46 Not taken ET up because unsure how to</p> <p>6.47 If ET not taken up, risk of patient acting out</p> |
|--|--|