Let's Face the Music and Dance: Working with Eroticism in Relational Body Psychotherapy: The Male Client and Female Therapist Dyad

Danielle Tanner

Received: 04 March 2014; accepted 02 June 2014

Abstract

The purpose of this paper is to present two cases documenting eroticism in a male client–female therapist heterosexual dyad. This phenomenological study will reflect upon the experiences of the researcher, in order to gain a deeper understanding of the human phenomena of erotic transference and countertransference in therapy. It will examine the theories of the aetiologies and common factors in erotic and eroticised transference. It will also seek to explore the therapeutic value of working with erotic transference, which is a naturalistic event, within the conceptual framework of humanistic principles and relational body-psychotherapy. Additionally it will examine the significance of the use of touch in erotic transference and countertransference.

Keywords: erotic transference, erotic countertransference, touch.

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 14, Number 2 fall 2015 pp 55 - 79. *ISSN 2169-4745 Printing, ISSN 2168-1279 Online*

Introduction

1. Touch and Seduction: The Seduction of Therapy

There is an inherent seduction within therapy: the intimacy of the relationship behind closed doors, the privacy, the confidentiality, the deep exploration of our inner world and the mystery of it, all potentiate the seduction.

The relational-humanistic approach holds that growth, healing and self-actualisation is facilitated by participation in the therapeutic relationship, characterised by key interpersonal conditions, namely mutual respect, warmth, acceptance, genuineness and empathy. A relationship is formed.

The very nature of psychotherapy invites the client to re-experience feelings of dependency, helplessness, and vulnerability (Kalsched, 1996). Who would not resist the unassailable threat of therapy, the insistence of another that we shine a light onto the memories and feelings that we do not want to talk about and that we do not even want to think about? By choosing to look, unblinking into our own past, psychotherapy is an act of great courage on the part of our clients; that we are willing to go there with them, creates a shared intimacy.

When we listen carefully and attentively, not only with our ears but our whole body, when we have our client "in our hands," the quality of our attention may recreate a

transferential longing and, as Winnicott (1960, 1965, 1990) discovered, holding can repair a rift between what they experienced in early life and what should have happened.

In the bonding between mother and child, there is also a seduction, a seductive and erotic quality to their relationship, which is not perverse or inappropriate, but occurs in a natural and spontaneous way. The client may fall in love with the therapist, recreating the primal seduction. Hopefully, with care, the illusion may fall away but the love that a client offers up is to be heard and the therapist can be appropriately reciprocating without acting upon this love.

Historically, there has been an assertion that male clients rarely experience sustained erotic transference in the male client- female therapist dyad (Lester, 1985; Goldberger & Evans, 1985; Kulish, 1984, 1986.) and that female therapists do not experience sexual arousal in the countertransference with their clients, of either gender (Orbach & Spector Person 1993), cited in Schaverien, 1995). I have found, from my own personal experience as a relational body psychotherapist and from the growing body of research, evidence that disconfirms this. Indeed, contrary to these earlier views, some research suggests that erotic charge and sexual arousal are commonplace, 'ubiquitous and presumably normal' (Tower, 1956, p. 232), regardless of the genders involved (Schaverien, 1995; O'Connor & Ryan, 2003). Not only is sexuality ubiquitous, but Eros has myriad different aspects and forms and erotic transference many meanings, which are multiplied when considered in an intersubjective context.

When it is acknowledged that not only maternal or nurturing feelings can exist within this dyad, but also sexual ones, then therapists can own their own sexual impulses and become more aware of the risk of acting on these impulses or transgressing the boundaries of the therapeutic relationship. This is essential when we are using touch. Without a more open dialogue, therapists risk creating both repression and re-enactment, to the detriment of the therapeutic encounter.

This paper seeks to contribute to the dialogue that was initiated in Asheri's UKCP conference presentation in 2004, 'Erotic desire in the therapy room, dare we embody it? Can we afford not to?' In this courageous and exciting presentation Asheri highlighted the role that erotic charge played in her body psychotherapy practice and the therapeutic value of working with erotic transference and her own countertransference (Asheri, 2004).

This paper advocates the appropriate use of touch within the erotic field. It challenges the psychoanalytic 'understood' that we should insist that 'however urgent' the clients desire is for 'actual bodily contact, the work [should] remain exclusively within the realm of fantasy and words' (Koo, 2001, p. 31.). I offer my own tentative exploration and experiences of working with touch whilst erotic transference and countertransference is present, with illustrations from my client practice. This paper seeks to demonstrate that touch, in many of its nuances, from the playful to the affirming, has a place when working in the erotic field. This is in the hope that other practitioners will engage in an exchange of experiences so that they can more effectively and collaboratively learn how to engage with eroticism and erotic charge in their practice.

From a body psychotherapy perspective there are moments in therapeutic situations when it would be unethical to withhold touch. Not touching can have a powerful detrimental effect. It can be counter-effective and can create a negative transferential dynamic, in that the client can regard us as a 'cold, withholding parent figure' (Wilson & Masson, 1986, p. 498), which can further concretise past trauma, and 'deter psychological growth' (Wilson, 1982, p. 65).

Whilst I fully acknowledge that psychotherapists have a responsibility to exercise caution when using touch with clients who have experienced physical or sexual abuse I do not believe it should be prohibited. However, there are contraindications to touch, which apart from certain medical considerations, encompass clients who are showing high levels of paranoia, hostility or aggression, or are highly sexualised or demanding of touch/ sexual touch (Durana, 1998, Zur & Nordmarken, 2011) or when the therapist finds their own erotic countertransference too overwhelming.

2. Defining Erotic Transference

Freud first attempted to define erotic transference in his paper, Observations on Transference-love (1915), a highly influential and often reviewed paper. In this paper, he examined erotic transference as a phenomenon that occurs when the patient openly declares that she has 'fallen in love' with the analyst. Hence, erotic transference is a theoretical construct from which to understand erotic charge and sexual feelings in therapy.

More recently, erotic transference has been defined as, 'any transference in which the patient's fantasies contain elements that are primarily reverential, romantic, intimate, sensual or sexual' (Book, 1995, p. 505). Schaverien (1995) broadened the original definition of erotic transference by the introduction of the term, 'eroticised transference'. Erotic transference is viewed as a natural phase of the therapeutic process, which reveals past behaviours with regards to relating to others, which are not necessarily sexual. Thus, given that the erotic needs of the client can be emotions and thoughts that are not necessarily sexual in nature and do not lead to the desire for sexual gratification from the therapist, erotic transference could then be seen as part of any therapeutic context. On the other hand, if eroticised transference is seen as a delusional form of transference, symbolisation is lost, as with any difficulty to understand the symbolic nature of transference dynamics, not just the erotic. Therefore, the transference is experienced as something real. The client may start to demand gratification, which could potentially destroy the therapeutic alliance and the potential for therapeutic growth (Schaverien, 1995).

Mann (1997) proposed that erotic transference, despite its association with sexual excitement and erotic charge, is not purely physical but psychological. He determined that we as humans have a psychological component to our sexual experiences, in that the erotic charge is not physical arousal alone. More contemporary views, like that of Garrett (1999), supported the idea that erotic transference is a frequently occurring phenomena and warn that to view it as an unique or rare occurrence can lead to a skewed perspective that has the danger of leading to a sexual relationship between therapist and client.

In body psychotherapy, Reich (1933) believed that it was the repression of our emotions and sexuality that lead to psychopathology. He took Freud's work on libidinal energy and suggested that it was a real, tangible energy, discharged during emotional expression and sexual orgasm. He believed that not only did parental or societal rejection of a child's expressions of emotion or of sexual love lead to internalised repression, but that this was accomplished by literally tightening our muscles, binding the energy and creating a conflictual, internal 'bioenergetic' tension. Transference, whether erotic or not, was viewed as an artefact of an armoured state that would fall away. Eroticism was no longer just an intellectual idea or feeling, but an embodied, felt sense. Reich believed that erotic aliveness is present between parents and their children, and between therapists and clients. He was not afraid to tread into the darker realms of the impassioned body in therapy (Cornell, 2003).

3. Erotic countertransference

Searles' (1959) groundbreaking paper opened the way for analysts to explore their own erotic countertransference and Davies (1994) eloquently wrote on how the therapist may be daunted by erotic transference and their own countertransference and how she used her own bodily states of awareness to comprehend the erotic subtexts within a clinical encounter and finally transform an impasse. She described how fear may be induced in the therapist when confronted with erotic transference, in that the 'universality of incestuous oedipal fantasy and boundaryless, preoedipal erotic terrors is lost within the horror and incomprehensibility of actual incestuous enactment' (p. 153). Davies surmised that, within this powerful transferential field, the therapist could lose touch with the distinction between thoughts and actions. I feel that the real threat is not that we'll throw ourselves at our clients but that we'll struggle, out of fear, to engage with our clients' erotic transference (Wrye, 1993).

Soth (2002, p. 126) felt that the therapist should be 'rooted in a continuous awareness of their own somatic reality' to inform their therapeutic practice. Somatic countertransference is an essential element of understanding erotic countertransference in body psychotherapy, as it is 'the therapist's awareness of their own body, of sensations, images, impulses, feelings, and fantasies that offer a link to the client's process and the intersubjective field'. (Orbach & Carroll, 2006, p. 64). Field (1998), described how feelings in the therapist of countertransference can include drowsiness, erotic and sexual arousal and trembling/ shaking, and as well as physical pain, tension, nausea, numbness and feelings of suffocation (Stone, 2006).

Recent research indicated that most therapists, at some point in their professional lives, experience sexual feelings towards a client (Ladany, et al, 1997; Pope et al, 1993, 2006). However, empirical studies have shown that acting out this desire is not widespread (Fisher, 2004). Yet, if therapists honestly engage with the experience and their feelings they can use their own erotic countertransference as a guiding tool in their therapeutic interactions (Asheri, 2004, Davies, 2013, Gentile, 2013, Slavin, 2013).

4. Aetiology and Development of Erotic Transference

Much has been written about the role of resistance in the development of erotic transference and the aetiological factors that may contribute to erotic or eroticised transference. In childhood, we acquire a way of living our love. Through interactions with others a pattern of expression and experience of emotions is formed. This pattern is replicated throughout our lives as we form relationships with other individuals. Transference love is a thread that connects the present to the past. Traditionally, erotic transference has been seen as a defence against internalised conflicts. However, I would argue that it is not simply resistance but also an expression of the client's deep desire for growth and transformational change, and that it is, 'potentially the most powerful and positive quality in the therapeutic context' (Mann, 1997, p. 10).

In my practice, seduction has been a key element in the emergence of the erotic transference. Laplanche (1989) described the seductive quality or erotic interplay that is present in the relationship between mother and infant. There is a seduction that occurs within the dyadic relationship: the primal seduction. In a healthy relationship between mother and child, this erotic charge would not shame or be acted upon, but delighted in and celebrated.

The seductive quality of this early relationship is unspoken, experienced pre-verbally and leaves us with a longing for this mystery and excitement (Weatherill, 2000). The therapeutic setting, with its perhaps unconscious seduction, nurturance, attention, and above all,

mystery, will re-enliven this yearning: 'the basis of the primal relationship with the other is one of primal seduction, and the basis of the relationship with the analyst reactivates that relationship' (Laplanche, 1989, p. 60). Clients pursue the therapist in the belief that they have the ability to transform their outer and inner world. We become their transformational object (Bollas, 1987).

Seduction and trauma are common 'genetic factors' in the development of eroticised transference (Koo, 2001, p. 30), as is 'sexual seduction in childhood' (Blum, 1973, p. 67). Bolognini (1994) further states that eroticisation defends against separation and abandonment and is a dramatic attempt to, once again, merge with the 'Oedipal object'.

5. The Use of Touch in Psychotherapy

Initially in his work, Freud recognised the importance of touch, massage and stroking to facilitate catharsis (Ventling, 2002) and allowed his patients to touch him (Breuer & Freud, 1895). However, Freud later held that touch stimulated sexual feelings and voiced his concerns about the dangers of touch, in particular, with regard to ethical violations by therapists who transgressed into the realms of sexual relationships with their clients. Yet, although Freud's 'rule of abstinence' and prohibition on touch has dominated the psychoanalytical world, there have been notable exceptions. Ferenczi (1933, 1953) used therapeutic contact, as did Balint (1968), Winnicott, (1965) and Little (1990). Winnicott and Little (who herself had been held by Winnicott during periods of psychotic anxiety) both felt touch to be compassionate, important and therapeutic within the therapist/ client dyad. Indeed, their case studies illustrated that touch provided a stabilising and orienting function for their clients (Maroda, 1999). Furthermore, Mintz (1969) stated that it 'seems absurd that any qualified psychoanalyst should be so carried away by contact with a patient, however attractive, that he (or she) could not refrain from complete gratification. Such an impulsive person would not be safe on a dance floor' (p. 371). Mintz (1969) described how both Fromm-Reichmann and Searles used facilitative and nurturing touch in their work with even deeply disturbed clients to good therapeutic effect.

However, touch remains a highly controversial and emotive issue in psychotherapeutic work. Maroda (1999) wrote about how touch is often seen by the psychoanalytic world as having an edge of exploitation, or being indicative of the clinician's failing verbal skills. It is even construed as a vulgarity. Instead, in the psychoanalytic 'heavenly scenario' there is no engagement with the body whatsoever. The therapist comes to a perfectly timed and executed interpretation, which is followed by the patient's illuminating insight, like mental cogs shifting seamlessly together. There is a metaphoric meeting of mind-mind, not body-mind.

The present paradigm that any touch is the first step on the 'slippery slope' towards sexual relationships is based upon an enduring and erroneous belief, which is an obstacle to an actual understanding of the importance of touch in therapy. The belief that all forms of touch are sexual is embedded within our western culture, and this prevalent belief is reflected within the field of psychotherapy (Zur & Lazarus, 2002).

6. The Historical Background of Erotic Transference

Freud's paper, in 1915, arose from his need to manage the unruly child of the analytical situation: erotic transference. In summation, Freud proposed that therapists should practice sexual 'abstinence' with their clients. Historically, there have been many prominent therapists who have transgressed this rule and acted upon their sexual feelings towards their clients:

Carl Jung had sexual relationships with at least two of his clients, Sabina Spielrein and Toni Wolff. Whilst Otto Rank had relations with Anaïs Nin, whose wild sexuality was inspiring, if tumultuous and sometimes bitterly painful. Other client/ therapist partnerings include August Eichhorn and Margaret Mahler, and Frieda Fromm-Reichmann and Erich Fromm (Coen, 1996; Gabbard, 1995; Tansey, cited in Schamess, 1999).

There has been a growing body of interest by psychotherapists in erotic transference and countertransference which has been mirrored in the media's attention to this phenomenon. Erotic transference in psychotherapy has become a subject of popular culture. In1909, Sabina Spielrein wrote in a letter to Sigmund Freud:

"Four and a half years ago Dr. Jung was my doctor, then he became my friend and finally my 'poet' i.e., my beloved. Eventually he came to me and things went as they usually go with 'poetry'. He preached polygamy; his wife was supposed to have no objection..." (Carotenuto, 1982, p. 93).

The David Cronenberg film, A Dangerous Method (2011), explored Carl Jung's prolonged, sexual entanglement with his patient Sabina Spielrein. This positive transference is portrayed as edgy, sexually exciting, risky and potentially dangerous. Spielrein was a disturbed young woman whom Jung first encountered in a mental asylum and who soon became his patient. Later in the film, they are portrayed as engaging in a lively, sadomasochistic, sexual relationship. In one scene, a corseted and half-dressed Spielrein is depicted being spanked by her former psychoanalyst: a woman 'undone'. Similarly, Jung is shown in the throes of a psychotic breakdown after his treatment of Spielrein. Jung's inability to tolerate transitional spaces, erotic transference and his own countertransference was in my opinion, much more dangerous when unexplored or dissociated from.

Television series, such as 'The Sopranos', which follows the protagonist's relationship with his therapist, as well as the HBO series, 'In Treatment', both explored the issue of erotic transference in therapy. This exploration of erotic dynamics and the presence of erotic transference and countertransference has in part contributed to the normalisation of this phenomenon. Yet, there remains an ambivalence. No one touches. Gutheil and Gabbard (1992) highlighted the current trend to politicise 'sexual transgressions by therapists' and that a few 'bad apples' (Gabbard, 1994), are hindering useful, systematic investigation into eroticism in therapy. A lack of systematic investigation of eroticism in therapy hinders not only the client's development but also that of the dyad and the therapist.

7. A Literature Review

The profession's fear of erotic transference is perhaps reflected in the paucity of literature on the therapist's own erotic countertransference (Tansey, 1994). We should all remain aware of the reality that erotic transference is a 'hot' topic and requires careful navigation, and that sexual transgression by therapists from all theoretical persuasions does occur (Sarkar, 2004). However, the fear of erotic transference and the belief that touch leads down the 'slippery slope' towards sexual enactment between client and therapist, may well be preventing the use of a potentially healing modality and a generative dynamic (Fagan, 1998; Smith et. al., 1998).

What was illuminating during a literature review was the lack of written matter in regards to the male client erotic transference to female therapists (Koo, 2001). This dearth may indicate that this is a rare phenomenon. However, rather than substantiate this assumption, this paper suggests that it may be insufficiently represented as a result of gendered bias of a profession while practised by many female practitioners, is still bound and thereby limited

by paternalistic and masculine guidelines and ancestry. The professional status of the female therapist has been hard won in an inherently chauvinistic domain. Freud patronisingly referred to Speilrein, an eminent psychoanalyst in her own right, as the 'little girl' or the 'little authoress' in his writings to Jung.

There may be little written on this particular dyad due to the embarrassment of the female therapist, that they may be viewed as being exhibitionistic or seductive, or the threat that if women are being sexually objectified, whilst at the same time being questioned as to their efficacy and worth as a therapist, it may devalue their therapeutic or professional standing.

Erotic countertransference is challenging, frequently uncomfortable and often a source of therapist discomfort and a scenario that therapists may be choosing to avoid. With few resources or an open discussion of how we, the therapist, can navigate these dark and often tempestuous waters, there is a danger of drowning or not even stepping onto the boat.

Erotic transference is a common event in my practice and is not gender specific, despite the literature's suggestion that male clients do not or rarely develop full erotic or eroticised transferences. Within my practice, I have also experienced the extreme of eroticised transference. However, even in these exceptional situations, there is, as my client pointed out, the possibility of making it through this ' strange situation' due to our 'mutual respect, trust and faith;" the faith that I had in him, which allowed us to traverse this complex intrapsychic landscape to 'break the spell' of idealisation and transferential longing. He also felt 'pride' in himself, in that I had so much faith in his ability to do so.

8. The Practitioner's Theoretical Orientation

I practice both Deep Bodywork (neo-Reichian body psychotherapy/ Postural Integration), and IMT (Integrative Mindbody Therapy), two modalities that utilise touch within their frameworks. IMT brings together relational psychotherapy, with bodywork, breath work and naturalistic trance and, therefore, uses touch, when appropriate, within the therapeutic and reciprocal encounter, recognising the intersubjectivity that is inherent within the dynamic (Rolef Ben-Shahar & MacDonald, 2011, Rolef Ben-Shahar, 2012, 2014). In relational body psychotherapy, there is an understanding that the innate complexity of the human spirit necessitates a creative approach to psychotherapy. In IMT, there is a core belief that not one single model or theory is comprehensive, or far-reaching enough to heal our wounds.

Throughout my practice, I have touched. I have engaged with bodywork throughout my professional career, first as a remedial body worker, then as an acupuncturist and now as a trained relational body psychotherapist. I have spent my career literally, 'hands on'. I have placed or had placed my hands on thousands of human bodies, from a myriad of cultural contexts, encompassing genders, sexual persuasions, ages and religions, from a black Pentecostal to a lesbian Jewess, from newborn to octogenarian, in life and in dying.

I subscribe to a humanistic theoretical orientation, and I passionately believe in the value of touch, both as a therapeutic intervention and to meet the fundamental human need to be touched. Within my own therapy, I have received touch and have touched my therapist. I have had the immense good fortune of having teachers and supervisors who not only support my touch-based practice, but also themselves believe in the legitimacy of touch as a tool within the therapeutic field.

I have used touch in trauma work, where a client with early trauma would inevitably have broken or invaded boundaries. If I had listened to the voices of risk management and caution I would have missed a hidden treasure. I trust that the human body and psyche has the plasticity and resilience to learn through experience and relationship, and that touch,

which is contained, appropriate and safe, also invites the possibility of it becoming normalised. Many contemporary writers on body psychotherapy support touch as a means to strengthen boundaries, not violate them (Hartley, 2005) and argue that 'touch can play a valuable role in developing and validating surface boundaries and a more secure sense of self' (Warnecke, 2008, p. 6). I welcome the stance that not only considers touch to be an important therapeutic tool, but also goes one step further towards an approach that normalises touch within psychotherapy and challenges psychotherapeutic practice, which, a priori, forbids and bans the consideration of touch.

Is there a place in the therapeutic world where we can normalise touch and embodied eroticism/ Eros? As a woman, I am aware that gender difference can foster an environment in which touch to and from a man can engender feelings of power inequalities and sexualisation. However, appropriate therapeutic touch can also allow a man and a woman to stretch out across the gender divide and meet with mutuality, equality and connection as well as safely explore these imbalances and cultural divides.

This paper seeks to explore the importance of touch. It will also look at the themes of seduction, and eroticism, in order to ensure both therapist and client feel safe within the interaction, without being overwhelmed by transferential material or dominated by fear.

9. Touch and Intention

Relational perspectives of touch need to be addressed whenever we engage. If we touched with the intention of creating erotic charge, this would indeed be problematic and unethical, but if, within touch and the transferential field, erotic charge takes shape and seductiveness become evident there is an opportunity to work with it, to allow it. We can celebrate erotic charge, as Samuels (1993) suggests in his theory of 'erotic' and 'aggressive playback', or utilise the transformational power of the erotic (Mann, 1997). Even within the erotic transference the client may recognise the containment. This containment may even make its creation possible. Therefore even if the client falls in love with you his therapist, while still being 'in touch', he recognises that the therapist is, in reality, inaccessible.

We should be aware of our client's perception of touch, especially if there is the possibility of early childhood violations and, therefore, a confused dialogue around touch. Some therapists consider touch of any kind to be inappropriate with clients who have been abused through violations of the body. However, many therapists and somatic therapists believe that a client will have great difficulty in fully recovering from such trauma if only verbal or cognitive approaches in therapy are used. Hunter & Struve (1998) held that therapeutic efforts to help 'a client heal from touch-related wounds ultimately ought to include experiential approaches that directly access the body and that provide the client with real-life opportunities to feel non-abusive touch' (p. 218).

Clients traumatised in childhood are often unable to make distinctions between affectionate touch and sexual touch (Ball, 2002), and 'healing is unlikely to occur if this positive and appropriate touch remains only an idea or intellectual concept' (Hunter & Struve, 1998, p. 218). In a study by Horton et al. (1995), it was found that sexually abused clients felt that touch repaired self-esteem, trust, and a sense of their agency, especially in regards to boundary and limit setting and asking for what they need.

There is both a need for us to acknowledge our client's aliveness, their sexuality, their child and their adult, whilst maintaining clear boundaries. We hold clear boundaries, even when they are being challenged by a seductive client whose needs and wants should be honoured, separated and acknowledged without shaming.

The instincts, impulses and desires of the client will all provide intricate complexity for the therapist, especially as these all relate to largely unconscious erotic touch biographies. As therapists it would be unwise to engage with touch when we are cautioned by our own internal boundaries, or when our client's boundaries are diffuse or their sense of reality poor or with 'regressed, dependent patients with ill-defined ego boundaries' (Kertay & Reviere,1998, p. 28). Each individual is unique, and the therapist should give careful and thoughtful analysis in each situation as to how appropriate touch would be. Clients can still be physically held by themselves, reminded of their own touch and of the physical outer boundary of their own skin.

10. The Ethics of Touch

Within the therapeutic arena, there is an ethical consideration. For touch to be clinically sound it needs to be boundaried, and the therapist requires sufficient insight into their own motivation for touch. Adequate supervision will enable the therapist in their endeavour to be able to recognise and manage transference and countertransference. No matter how courageous or emotionally available the therapist, Eros, with its skilfully laid 'tender trap' and all its complexities (Hedges, 2011,p. 67) requires supervisory input in order not to become ensnared by the powerful erotic/ psychotic projections in the countertransference.

The client should feel empowered enough to be able to know if they want to be touched and be able to say so and this is enabled through constant negotiation and underpinned by the therapist's trained understanding of touch. Totton (2003) explored the professional aspects of touch, and legitimate touch, as well as navigating the challenging issues of regression, re-traumatisation, false memory, transference and counter-transference that can arise when we touch.

When two biographies meet, a new story or a 'third space' is conceived. It is the therapist's responsibility to work ethically, with respect and transparency. In relational psychotherapy, touch can convey re-assurance, playfulness or provide grounding and re-orientation; but touch can also evoke, even within these parameters, feelings of excitement, aggression, possessiveness and eroticism in both the therapist and the client. Rather than rejecting these shadow emotions, they can be seen as an opportunity for deeper exploration, of working through these darker feelings. In relational work, we no longer embrace the tenet of neutrality. It is no longer possible to be just 'nice and tidy' therapists as this doesn't allow the other to work through their own feelings of eroticism, rejection, hatred or rage. If, during therapeutic work with erotic transference and countertransference, we, as therapists, treat ourselves with enough loving kindness, in that we ensure that we receive enough external support, both professionally and personally, and love in our outside lives, it will be easier to work in this universally challenging and rewarding scenario. Touch requires a degree of self-awareness in the therapist, a willingness to ensure the we are acknowledging our own needs for touch and connection and that we take responsibility for ensuring those needs are met well away from the therapeutic space.

Therapists work within a profession that cultivates and encourages intimacy. We provide a facilitative environment for growth, and we may offer ourselves up as objects at the beginning of the therapeutic journey: an object of transference. And yet as a relational psychotherapist I will bring my subjectivity. Relationality is essentially being professional in our humanity, even fighting for our humanity, not completely agreeing to be an object, or increasingly resisting to be 'just' an object for the client. We slowly expose our clients to their own subjectivity in the belief that if they can 'see' us, even for just a moment, then they can do also do that for themselves. If I as a therapist abandon my own personhood, abandon my own countertransference as irrelevant, then why would my client ever believe that theirs is worth holding onto?

When we are working relationally, intersubjectively, we have to take responsibility for the transferential field: both for the impact that we have on another and the impact they make on us. The thoughts and the feelings that arise are relevant to the field, are not solely our personal thoughts and feelings, but are also responding to the reverberations of relationship. This accounts for some of the reasoning for the therapist to bring some of their own material, without being insensitive or inappropriate.

When we work with the body, when we touch, we become more visible to the other. This visibility can be uncomfortable, and it can enhance the possibility of great eroticism or seduction to occur. Feelings that arise may be uncomfortable, or unpleasant. We can experience a sense of seduction, of strong sexual charge within the touch. If we allow these feelings a voice, even normalising instead of rejecting them, we embrace a wider world. Otherwise we risk declaring these parts forever unacceptable.

When we are working with touch and specifically with a client's libido, with their sexual energy, with a sense of empowerment, compassion and celebratory respect, we engage in a journey towards a healthier re-emergence of their sexuality, a sense of their self and the establishment of a more balanced and fulfilling sexual relationship. That I can be alive, and I can fully feel the erotic charge of the other in my own body, that I can attune and resonate to my clients' eroticism and be excited by their sexuality, whilst being able to recognise and hold a boundary where I do not succumb to this sexuality, enables my client to also witness another taking self-responsibility for their own sexual charge.

Contextually, I am aware to some extent that my physicality will also have an impact upon my relationship with my clients. I am an attractive woman in her late thirties. There will be clients (male and female), who are going to be attracted to me, regardless of their former relationships/history, and I need to acknowledge that this will be part of the dyad, in all senses. Most clients will notice a well-dressed and sexually expressive woman (comfortable and capable of enjoying that space), in front of them answering the door (whether consciously or unconsciously).

There are many possibilities for the therapist who might consider working in this way, but who may need a slower movement towards it. For example, a therapist may invite witnesses into the therapeutic space, or have a same sex assistant or helper. In addition to clients signing a consent form that explicitly mentions the use of touch, I feel that consent is a moment-to-moment process that I often refer to throughout my work with a client.

11. Case Vignettes

Case 1

James was a 45-year-old man. He was a perfectionist, controlled and over-defended. He had first entered individual and later group therapy several years ago as a result of the emergence of intrusive thoughts and the dawning realisation that as a child he had been sexually abused. Through the very nature of the sexual abuse, with its secrecy, denial and projection he had manufactured another reality. He had forgotten everything for the sake of his abuser. He re-entered therapy in order to explore his relationship, and sexual and intimacy difficulties within it. He felt that he was obstructed in his capacity to engage with his sexuality and this was causing problems with his partner who felt both alienated and frustrated. He had shown enough ego strength in the beginning of therapy to suggest that touch could be used, when appropriate.

When I began working with touch with James, the touch was at first tentative and slow, a constant negotiation. He was a survivor of early childhood sexual abuse, so I felt that it was

important to imbue in him a sense of his own internal and outer boundaries. I also recognised that I had a place for him, a space for him in me, a womb or 'matricial space', (Chetrit-Vatine, 2004, Schwalbe, 2013). I felt a state of being for the other, in which there was a sense of responsibility, vulnerability, proximity, contact and sensibility in the caress (Lévinas, 1974). I felt that, in our work together, I had a willingness to open into his reality and to embody a space or a new way of being, and that touch became a bearer of messages.

When I engaged in touch, I would mindfully lay my hands on his body, on a part that we both felt to be safe and then I would wait until I could feel him connect to the touch; often it was as though he was standing waiting for me. The quality of touch, in the therapeutic space, quickly became soft, hypnotic, and his connection enveloping. I felt that his body wrapped itself around my hands. The quality of his desire felt like a pre-oedipal holding, a baby holding my gaze, rather than the oedipal demand of wanting to have me. After a few months, our touch would often be playful; he would nuzzle my hands with his face, place my hands on his face as if he was demanding that I see, be curious, know who he was.

Our playfulness and our laughter dissipated his defences and his struggle for control. Winnicott, for whom playfulness was an indicator of mental health, felt that 'psychotherapy has to do with two people playing' and that the therapist's work should be directed towards bringing a client, 'into a state of being able to play' (1971, p. 38). Farrelly and Brandsma stated, 'the ability to laugh, temporarily regress, lose control, and then reintegrate may be seen as a cardinal sign of wellbeing' (1974, p. 127). Winnicott (1971) further theorised that play lies between subjective fantasy and reality and although he may have omitted erotic play in his writings, his theories on playfulness were integral in later works on erotic play by Benjamin (1995) and Gentile (2013) who drew parallels between play and erotic play. Gentile (2013) also supports the theory that play, when initiated by a client, allows them to become an 'agent' of their own therapeutic action that 'play is experimental agency'. The very act of playing for a survivor of sexual abuse becomes an act of reclaiming, of seizing back the controls.

The omnipresent and subtle role of playfulness, as an attitude, in the clinical situation, allows for a dyadic meeting on the edges of the boundaries between reality and fantasy. Ehrenberg (1990) wrote that playfulness often assumes a sense of mutuality that can give pleasure to both people involved and can meet the client on a multitude of layers. Playfulness can encompass humour, irony, affectionate teasing and co-created fantasy, and if skilfully utilised, it also has the power to break through barriers of communication and shame.

The playfulness also allowed for a different dynamic, one that invited seduction and I was aware that, had I chosen, I could have closed down this avenue for us both. I questioned whether this dynamic was a fragment of a re-enactment of an earlier seduction. I witnessed the transition from desire to play, from play to growing intimacy and then eroticism. However, as Davies (2013) warned, play can be 'impossible' for some survivors of sexual abuse as the child could have found fantasy swiftly moving into 'a terrifying and unknown reality', where imagination became 'a gateway to terror' (p. 176).

The dance of seduction began. There was a continual negotiation of external boundaries, of reinstating what he, scathingly, referred to as 'the rules'. Gifts, cards, poems, songs, music. Was it appropriate to listen to the story, the poem, when I had returned all other gifts? As he pushed the external boundaries, I struggled to hold and preserve them. My work with James became a focus of my supervision. I wondered at his attempts to invade my boundaries, of the intensity of my feelings of confusion, of feeling lost in the rupture of my own internal

boundaries and the movement to repair and regain my sense of self, in his drive for merging and symbiosis. Was this how it felt for him, to have to defend his own boundaries against the passions of an adult?

The erotic transference began with a gradual intensity of feelings, initially of a desire for more intimacy, more sensuality and then he began expressing feelings that were often, disconcertingly, reverential. These progressed towards more sexual feelings. His fantasies were at first understood, by him, to be unrealistic; but at times the transference became highly eroticised, his fantasies became more lucid, preoccupying and irrational. These fantasies became verbalised demands for love and sexual fulfilment. He had difficulty focusing on any appropriate insight and questioned whether he was attending the sessions for the therapeutic work or just to be physically close to me, hoping for any reciprocity.

Throughout this time, which lasted for many months, James appeared distressed and bewildered. He experienced hallucinations, an image of my face appeared to him in the sky, and he often had vivid dreams of me. He was unable to connect the intense sexual feelings that he had with any of his own past behaviour, he could not make sense of the situation and he felt disorientated. Throughout his life he had been controlled and measured in order to enhance his own sense of safety in the world. With the encouragement of my supervisor, we stayed together in this uncomfortable place, on the edge...

The quality of our contact had changed. Within two years the touch had moved between tender, nurturing, or affirming contact to playful, and then our touch became more challenging. It became charged with 'the push and pull' of seduction and invasion, as we struggled to make sense of our relationship, within the context of the therapeutic dyad and his own entangled history of incestuous abuse. During sessions we discussed his imagined sexual involvement/objectification of me. He would imagine kissing me, holding me, of 'making love' to me and of me carrying his triplets (I was pregnant throughout this period).

Asheri (2004) describes how the transition for the pre-oedipal eroticism to the oedipal can manifest in changes the quality of touch. Now when he moved into my hands, I no longer felt the sensuousness of his nuzzle, the soft suck of a child on the breast, but instead the pull of a man wanting me closer. I felt smothered and disorientated. I could no longer feel the erotic, subtle charge of the child, the quality of our touch no longer felt nurturing or maternal.

Over the course of this challenging time, he said that he was able to 'throw off the wet blanket' that had dampened his sexual drive throughout his life, as a result of the abuse he had experienced. He felt 'wildly alive' and spontaneous. I began to withdraw. As he engaged more and more with his sexual drive and charge I was more hesitant about working with touch, I would have less physical contact, or I found that I used one movement, for example, a hand on his back, or I would sit, my back to his, as he spoke. I stepped back, not to abandon him or reject him but to encourage his engagement with the outer world.

As a mother of three children, I have moved through this transitional stage with my eldest son as he stepped more into his oedipal stage. As my son engaged more with his own erotic charge, as his caresses have become more sexual and his interest in my body more than motherly, I have tenderly moved his hands away, yet I have remained his gentle support, recognising that the 'path to intimacy is not forged between [us] directly, but rather emerges in the symbolic anchoring of ineffable desire' (Gentile, 2013).

As I stepped back James's anger emerged, I became the object of hatred, the rejecting mother - James glared back at me. I inwardly winced, and I suddenly felt very clumsy and awkward, as if I'd been caught in an illicit act. 'But this is me,' his voiced was raised, 'this is not my child,

my teenager, this is me, a man, I know how I feel, I love you, and I want you and I feel you inside of me.'

We had been engaging in an angry tango for weeks; I had ignored the man in the room, constantly reminding him of the child within, and the unavailable or abusive attachment figures that he had experienced in his childhood. I was suddenly and acutely aware that I had done so in order to avoid meeting his adult sexuality and the power of his phallic drive. I felt shocked, confused and guilty. I noticed my reticence to bring the subject into my own supervision, my own desire not to see him and his demands to be seen. From my own biography, I could see how I would draw comfort in having a non-threatening boy rather than a stormy man.

What also became clear was the concrete relational stance that he held. He had an intractable belief that I would change my mind, that he could shape me to his desires, and that I would succumb to his seduction. He often related to me the story of his current partner, whom he had persuaded to engage in a relationship, one that had born three children, even though when they had first met she had insisted that he wasn't her type and that she had no romantic interest in him. I often wondered in supervision if this was the same construct that his abuser had forced onto him and that this stance was a destructive re-enactment (Slavin, 2013).

James and I continued together for two years. We struggled through the difficulty of erotic transference and my own countertransference, a period he was later to describe as an 'emotional crucifixion'. It was only when I reached out to him, that one small movement of me placing my hand on his heart, and touched him that we both understood. 'You can move your hand if you want, you don't have to stay there', he said, 'I'm not ready yet, to let you go'. I replied. Our dynamic transformed when I engaged with my own erotic counter-transference, when I meet his as a sexual adult woman and when I accepted that he too had a place in my heart.

Our therapy ended soon after this session, although he was to return over a year later. When he returned to therapy he was no longer in love with me, he was intrigued by the dynamic that had occurred between us, by his 'infatuation', but he no longer felt in the midst of its hold. It was to re-occur occasionally, but it no longer held the sway that it had before. He felt that that one moment of touch allowed him to integrate his feelings of rejection and that he was loved and worthy of love, 'since that moment I have felt valued, loved, I have started to take care of myself'.

Throughout our work together, I had had experiences of eroticism, arousal, fear and overstimulation, which at times had left me bewildered and silent. This tumultuous episode was the epicentre of our struggle, him acknowledging his feelings and the grief and acceptance of the reality of our relationship, of the love between us, and me acknowledging the man before me, not just the abused, disconnected or neglected child.

A discussion of this vignette with James will follow after the second case.

Case 2

Peter was another man in midlife who sought therapy during his divorce. He had come into therapy bewildered. His marriage had dissolved as his wife felt unheard and disconnected in their relationship. Every time she attempted to make connection, he withdrew into silence. He had a history of secrecy, and adultery in all of his adult relationships and he came into therapy to understand what had happened in his marriage break-up. He also experienced pain in most of his body, had severe digestive pain and raging eczema. We have worked together over the course of five years and continue to do so. He is a robust, compact man, who has spent his life outdoors; he builds houses and prefers to work alone. As a child, he lived with an emotionally absent mother,

an uncommunicative father, and a sexual perpetrator within his family. There were no avenues of safety, no one to protect him. His abuser was there alongside him throughout his childhood. Every game of rough and tumble, every playful interaction had the potential to become sexual.

At first, these sexual interactions, which began when he was seven years old, were 'just a bit of fun and sometimes I wanted to'. Later as he advanced into adolescence, he started to avoid his abuser and 'push him away'. He felt that it was 'wrong', but had no one to speak to and the abuse was hidden. Peter felt alienated in his own peer groups. He despised school and 'all the children in it' as it seemed they wouldn't be able to understand or would reject him if they did know. They didn't seem to have the anxiety that he felt all the time. He spent his teenage years, once he realised what had happened to him, feeling unclean and holding the thought that he harboured a dark secret and possibly a venereal disease. His shame became embodied and deeply entrenched, and he was silenced. He had difficulty making eye contact, he sat hunched and curled, and we spent many sessions saying very little to each other.

The development of touch with Peter was very different; it never became easy. It grew at such a different pace from the work with touch that I had engaged in with James. At first Peter allowed me to use touch. He encouraged me to, 'just go ahead and do it', and it was only when I noticed that he disappeared in the interaction that I stopped. He was dissociating, splitting off or freezing when I came near; I had become a threat. Touch can either help or perpetuate dissociative tendencies, and I risked re-traumatising him as he defensively responded to me as a remembered threat (Rothschild, 2000). Our touch is now very minimal.

When I withdrew my touch then the erotic charge became alive in him. However, touch remains crucial as it is also the string that binds us, for as he describes, 'it's the only tether that holds me to life'. Our work with touch has become a carefully choreographed tightrope walk.

I also became aware of my own feelings of wanting to guide him, to feel the almost irrepressible desire to manipulate him, to re-model him. I recognised the seduction of his malleability. He came to know of his impact on me. In my own history I have been wilfully manipulated, and I was horrified when I experienced this desire to push myself inside of him, to shape him and to feel aroused. I felt a surge of energy move up my body and into my chest. I experienced a burning sense of shame around my desires.

It was after careful consideration that I shared my own countertransference with Peter. It was 'a moment of truth', which contained both hope for the integrity of the relationship and risk. Slavin (2013) and Renik (1999) both support that, as therapists, we may disclose feelings that may appear to be difficult and unsettling, and I felt that it was imperative to his growth. It was, as Ogden (1995) defined, one of those moments where I had to 'face the music'. His reaction was one of surprise, not that I would feel that way, but that he could make enough of an impact upon me to initiate these feelings. This surprise gave way to his suppressed rage, 'that everyone just uses me; they're just all out to get what they can'. For the first time, I saw his rage uncoil. I felt the rage that had often placed us into a stupor. Slowly over time, he has come to recognise his part, his self-responsibility in this dynamic and to develop his autonomy, his own will. If I hadn't acknowledged the seduction and the erotic transference, and my own countertransference of wanting to penetrate and dominate, I could have denied both of our biographies.

It was after this moment that we began to speak about the layers of armour that he felt he had. Hidden under the soft, malleable exterior, there lay not one, but two walls of defence. We also began to speak of his own erotic attraction to secrecy. Today I glimpse his inner world, but I am always aware of his almost impenetrable armouring. Underneath his passivity and apparent pliability was a hardened interior through which no one has yet entered.

12. Discussion of the Vignettes

These two men were very different; they each had different developmental experiences, pathologies and very different kinds of erotic transferences/ Eros. Rather than comparing, it may be more helpful to contrast these two cases.

Earlier developmental infantile patterns of erotic constructions and transferences were evident in the second case. Peter struggled to be alive, he felt that often he did not have the right to exist and he experienced bouts of severe, numbing depression. He struggled with his inner conflict of wanting connection and his habitual movement toward social isolation, dissociation and disconnection. He continues to re-enact his original trauma through a loveless, 'secret' and long-standing affair.

I would also find that I would collude with Peter's own horror of eroticism. I noticed his reluctance to deal with erotic material and his persistent distancing from his own sexual feelings and any form of intimacy. However, despite this resistance he has been able to relinquish, at times in our relationship, infantile patterns in favour of a more mature erotic attachment that was less dependent on incestuous repetitions.

The outcome in James' therapy was reparative, in that it was boundaried, but it also allowed us to internalise a 'mutual loving desire' (Davies, 1994, p. 153), which was an important factor in strengthening James' ego function in that he felt that his love was reciprocated. But within that, there was an embodiment of the necessary disappointment of having his desires refused and the consequential feelings of loss and grief. If I had chosen not to engage with the eroticism which enlivened both of us, by avoiding the 'erotic horror' (Kumin, 1985) due to my own resistance of the transferential material, the dynamic would have remained a blind spot and a lost opportunity.

In recognising my own somatic experiences, I allowed the other to know what it is to live in their own body, to begin to separate their own subjective experience out from the other, in relation to another, in the therapeutic environment that was safe from sexual invasion, from parental rejection, silence or shaming. I had to recognise my own and his desire, without assuming it to be based solely in infantile and unconscious drives (Samuels, 1993).

In our relationship, there had been a developmental movement from idealised pre-Oedipal sensuality and love, an amorphous, full body sensuality, to an eroticised, conflictual Oedipal drive (of erotic power and physical desire), which finalised with a stage of integration and transformation. It felt that these stages moved from an initial entrancement to an illusion of love and then through to an understanding and acknowledgment of the real love that existed between us (Asheri, 2004).

I felt that our work with physical contact allowed for an intimacy and an exploration of the playfulness of a child's sexuality, without the adult acting upon it. Our work together encompassed many forms of touch. Totton (2003, p118-123) explored and categorises the various types of touch: touch as comfort, touch to explore contact, touch as amplification, touch as provocation and touch as a skilled intervention. And then there's King's (2011) conceptualisation of Rolef Ben-Shahar's (2010) addition, of a sixth form of touch: touch as relational affirmation. King (2011), delineated how 'touch as relational affirmation can support, develop and deepen the therapeutic endeavour' (p. 109).

A boundary was held where it had not been before. At times, the transference felt overwhelming, acquisitive, even devouring. At times I was lost in his call for more. There were moments, on his part, of a weakened sense of reality when he was no longer content with the substitute of fantasy.

When I understood the client's sexual feelings to be based purely in the mother-child transference dynamic it fostered regression. When I acknowledged the powerful sexual atmosphere, I could feel for the first time, his sexual arousal; I could no longer reduce the erotic charge to the desires of an infant. It would have been humiliating to us as adults in the room. There had to be an acknowledgement of the adult who desires sexual intimacy, in both of us, as well as the infantile sexual demands. There was a need to move fluidly between both of these transferences, not merely relate to one. It demanded fluidity from me, from object to a container to an 'other' and my pertinent feelings of wanting to protect, hold and be present ensured that there was not a re-traumatisation or a re-enactment of his original body story. For this to be possible, for me to adopt this flexibility, I relied upon the anchoring and use of supervisory input to navigate these muddy waters. I needed the solidity of a skilled witness for me to stay centred.

13. Commonalities

I noticed that the male clients who developed erotic transference neurosis all had close physical relationships with their mother, even for those whose mothers weren't emotionally available, whilst at the same time having absent fathers, within a conflictual or dysfunctional parental relationship. Therefore, the onus was placed on maternalistic, often consuming or idealised relationships with women. The erotic transference was often very quick to develop: 'as soon as I heard your voice', 'after a few weeks I knew that I loved you'. They had poor male role models: idolised, superhero fathers who it later transpired were cons, emotionally weak, absent or sexually abusive. There was repeated disappointment or rejection from father figures, or the threat of male violence. Often I would notice that there was intermittent abandonment from the mother, either unintentionally through ill health or emotional dissociation, or the threat that they could leave if their sons weren't 'perfect', that they had had to prove themselves 'worthy of love'.

By working through the eroticism, my clients were able to transform their 'outer' relationships. Being able to have an open dialogue of the eroticism that was present in the therapeutic relationship enabled my clients to come to term with, or at least to have a greater understanding of, their defensive or ill-fated patterns of behaviour in their other relationships. In James' case, his desire for control, and his anger at being objectified and for wanting to merge with another was preventing deep intimate relationships or sexual fulfilment; and in the second, Peter was able to examine his resistance and fear of intimate relationships and an unexamined aggression, even an impulsive, hatred of women.

Aside from the two presented cases, of my male clients who exhibited erotic transference they had the commonality in their early life relationships, of missing, unstable or inconsistent self-object experiences (Kohut, 1972). Both of the men presented in these cases yearned for connection, the contact that they had enjoyed only sporadically, or at a high cost to their own sense of self (Rappaport, 1956). Through the therapy work, they were, sometimes, able to recognise their urges to merge and their desire to fuse once again into a symbiotic relationship. At times they were able to see that their desire for engaging in a sexual relationship with me, their therapist, was a re-enactment of the early parental relationship. I also experienced periods of their hatred or anger as they spurned these interpretations of their 'love'. Their strivings were often an attempt to stave off the dreadful fear of separation, of aloneness. However, I would argue that our experience was also intersubjective; there was a shared feeling of mutual regard and love. It was also an opportunity to discover that they could be loved in ways that were

different from the way they experienced their primary love. They began their own external journey. They were able to engage with more meaningful human relationships and greater intimacy.

In the sessions, I never perceived a sexual threat, or a feeling of predation. Instinct and impulses often guide me when I have felt this threat, and they have helped me to discern whether or not it was safe enough to engage erotically. There have been times in my practice when it has not felt safe enough, where I have chosen to not touch, and have stayed seated in my chair, not even wishing to move to the mat on the floor that I often use. I have stayed seated, with clear spoken boundaries, restricting physical contact. I have found clear, direct honesty to be compelling in these interactions which I would have found overwhelming at the beginning of my practice. I have stated to a male client that I did not want to have sex with him, nor would we ever have sex, which was much more 'real', and for us in that moment, more progressive than re-iterating rules and codes of ethics. All of which sounded strangely hollow when faced with his forceful demands and drive for sex. As a woman, I do not think it is always possible to work with these powerful feelings and referring clients on, with whom I do not have the resources to work, has been a newfound skill.

The calls for sexual engagement, from these two men that openly spoke of their feelings, were more demands for loving touch, physical proximity or closeness than sexual intercourse (Swartz, 1969). I feel that the ability to make this discernment and to remain anchored to this reality is pivotal to engaging with eroticism. I was also surprised by the passivity of both of these clients. Often in their positioning they would immediately lie down, and in the touch they both preferred to be very passive, this would often be a point of discussion. I had an expectation that in the erotic transference, they may attempt to sexualise the contact in an effort to remain in control, but the control was more often verbal. James was a skilled craftsman in intellectual 'battle'. Neither man made a conscious effort to use touch as a vehicle, to be either prescriptive or directive in the touch. The seduction was much more subtle, unspoken, thus not only did touch not disturb the process of symbolisation, but it was quite the opposite. It also supported symbolisation.

Among the clients that experienced eroticised transference, there was a commonality, an intractable belief and a role reversal that if they were able to persuade me of their love, then I would change for them. This presented an ongoing challenge as they resisted any attempt by me to engage with therapeutic insights for a considerable time. It was a humbling experience.

I also questioned my own part in the dynamic, as to whether touch, due to its physical intimacy, was also curious as to why, within the eroticisation, my clients chose to stay in the realm of love fantasy, rather than sexual fantasy. Perhaps my own sexual inhibitions were subtly preventing the client from explicitly exploring sexual fantasy or imagery; instead they chose to use romanticised, veiled or shadow imagery.

14. Working Relationally with Touch and Eroticism.

It would not be within the remits of this paper to do a comprehensive review of relational therapy; however there have been a few principles that I have found helpful and have guided me in my work with these two men.

By utilising a relational approach the therapist and client are in a position to recognise the erotic dynamics, imagery and experience brought from the past of both participants. These experiences are necessarily repeated or enacted in some form in the therapeutic relationship and the limiting, internalised object-relation structures of erotic feelings, sex, sexuality and gender

become known and therapeutically explored.

The core of working as a relational therapist is that it is seen as a joint adventure, as an opportunity for two human beings to develop their intersubjectivity and to reduce the client's vulnerability to the shadows of past relational trauma and dysregulated affect (Bromberg, 2011). Therapy enables an enactment of the shadows of the past and co-creates a new experience. Healing and growth are non-linear but depend on our relatedness. The relationship between the therapist and the client informs the therapeutic process, therefore, there has to be a willingness of the therapist to allow and not deny the eroticism in the room.

By working within a relational frame there is a consideration that erotic transference does not exist in isolation, rather it is actively and continuously co-created with the therapist, and therefore it calls for a collaborative approach that acknowledges the real relationship. The evolving dynamics or erotics of the relationship allows for the possibility of a 'new space and new tension', and of a 'dance' of joint negotiation towards mutual regulation and transformation (Hedges, 2011, p. 41).

Erotic encounters are culturally positioned, gender informed, and socially constructed interactions (Nagel, 2003). They are also alive, not static in nature and therefore present a dynamic movement in the therapy relationship that allows the therapist access to the client's intimate transactions.

If we are not prepared to be seduced and to 'psychologically seduce' a client then we may not be their best 'match' (Maroda, 1999, Forrester, 1990). Such encounters are contextually placed and unique to the particular dyad involved. The two-person dyad inevitably creates interpersonal dynamics that stem from unresolved experiences. These re-enactments are happening at both subtle and more evident levels of awareness and require careful attunement to the shifting nuances in the therapy room. The interweaving of subjectivities creates a complex picture that requires care.

In the work our body informs the process. It becomes an instrument with which the therapist can attune and resonate to the other, to contain and tolerate this experience. The therapist becomes aware of and is guided by their own bodily sensations, impulses and feelings, and those of the other, of transference, counter transference and the possibility of a movement and an opening toward an 'I-thou' relationship (Buber, 1937) where 'man becomes a self. And the fuller it's sharing in the reality of the dialogue, the more real the self becomes' (Buber, 1957). We become an embodied therapist engaging in the present moment (Stern, 1998) thereby encouraging and facilitating this in the other. This fluidity also allows a shift from the hold of past distress. The therapeutic relationship provides the other with a sense of self, and a validation of the self; and touch can, when it also takes into account the transferential dynamic, hold greater meaning than mere physical contact.

In relational body psychotherapy, the therapist touches the parts of the other that have been disowned, abandoned, hated, or unconscious. The contact can seal the fractured parts of the self and create a more cohesive sense of the self. Touch has immediacy and an intimacy and when it has warmth and compassion, it can be relationally affirming (Rolef Ben-Shahar, 2010). It is this intimate edge, which is characterised by both a developing therapeutic intimacy and the client's growing edge that can lead to greater self-awareness and aliveness (Ehrenberg, 1992).

15. The Pitfalls of Defensive Practice

The issue of touch can instill anxiety, if not terror, within the therapy profession. Society fears that touch can lead to uncontrollable or unruly feelings and behaviours and in the

psychotherapeutic world there has been a developing concept of holding 'appropriate' therapeutic boundaries (Totton, 2010). However, fears of litigious assault may be quelling our instinctual and creative impulses in therapy as well as our professional resolves and ethical intentions. Fear freezes and immobilises us. As therapists, if we are reacting defensively in our practice to an unseen threat, we may not be meeting the needs of our clients. Guidelines may form an important parameters to ensure a sense of safety, and a therapist without boundaries can be potentially harmful. But rigidly held, dogmatic boundaries that do not flex to the individual needs of our clients may be counterintuitive and at the cost of warm and genuine connection. By not touching, out of fear, we are adhering to a belief that our client is a potential hazard to be circumnavigated and possibly reinforcing a belief in them that touch is inherently threatening or dangerous, or they themselves are.

When I use touch in my practice I am informed by my understanding that, without infantilising the other, my client also embodies their inner child. I hold this knowing within my body knowledge and support that part of them in my work. I am not informed or led by risk management or regulation but by the reality that, 'here is the adult and the child'.

Laplanche (1989) recognised the dimension of mutuality in mother-child relations; but he speaks of 'a child whose psyche and body are open to the other, capable of being influenced, seduced', where, there is no mutuality. On the contrary, there is clear asymmetry between the child and the adult. Relationalists (Aron, 1996, Hoffman, 1998 and Mitchell, 1997) all advocate a movement towards mutuality. When we engage with a relational model there is a movement from asymmetry (the transferential relationship that can occur between the therapist and client) to mutuality, when we engage with our client both as a child and an adult. Stern (1998) discusses how mutuality allows us to reach the 'now' moments of transformation, to move away from habitual patterns and constellations of the past into the present moment. It has been through creative and spontaneous touch and movement that I have been able to able to come to these moments.

16. Conclusion

Erotic transference and countertransference are important in psychotherapy. However, this paper has its limitations in that multiple sources of evidence were not used, but only the author's experience as a therapist. It would be difficult to draw conclusions from two cases, and further investigation is warranted. This enquiry may be furthered by interviews with the clients that the author used. Further elucidation of rupture repairs, supervisory content and touch nuances utilised would further assist the therapist who is considering engaging in this work.

I believe that erotic charge is a naturalistic event which is an innate part of our aliveness. It is our sexuality, our creativity, our passion and our willingness to connect. When we work responsibly and ethically (held by another, such as a supervisor or a therapist) then we can work with feelings of sexual arousal in ourselves and the other. We can recognise that the motivation behind the desire to seduce may be the deep desire to connect. If we ignore erotic charge we can miss an important therapeutic opportunity, and if out of a fear we ignore or dilute it, we risk a re-enactment further down the therapeutic road.

Touch is important in healing the very violations that were aetiological in the development of erotic transference. Touch communicates a safety and a stable and consistent experience of nurturance that was insufficiently experienced in the earlier lives of our clients. Eroticism

within therapy can provide an opportunity for our clients to be alive in their sexuality, without the danger of violation.

As a profession, if therapists are prepared to engage with a more open dialogue including their own eroticism in practice, we do not risk abandoning our client or ourselves. Breuer, driven to distraction by Bertha Pappenheim, (better known as Anna O.), gave up any further analytical work with 'neurotic' cases as he found it impossible, without his activity and the conduct of his life being 'completely ruined'; and he vowed never to subject himself 'to such an ordeal' again (Grubich-Simitis, 1997, cited in Britton, 1999, p. 26). Professionally, it is important that erotic transference and our own countertransference are dealt with effectively. Jung after his treatment of Spielrein, appeared to suffer from a psychotic breakdown and continued to develop erotic transferences, or act upon his own countertransference, to his female patients (Covington, 2001).

If we can acknowledge that our own erotic psychosomatic arousal and the fantasies that are associated with it, without guilt or shame, we can access crucial, raw therapeutic material, with significance both for our client and ourselves. A strong enough therapeutic relationship can withstand an awareness of eroticism and the acknowledgement that it is just that, and that sexual arousal and excitement will fade, without the need to act upon it. It has the potential to teach tolerance and acceptance of what is and what will pass.

I would argue that erotic charge is an embodiment of connection, of life force, and that without it an essential ingredient is absent. Eroticism is one of alchemical, or 'explosive forces' that are a prerequisite to enlivenment. Erotic charge in our clients and in our own embodied self, is naturalistic, often inevitable and a desirable catalytic agent for transformation and life-enhancing change.

For a client who has experienced early childhood violations or sexual abuse, seduction can become a mode of resolving internalised conflict. Their sexuality would have been shaped by their traumatic experience and the need for control can become a central issue. Seduction may be a vehicle for control, a means of controlling the unknown. Through necessity, the child learns that seduction is both animated and powerful, in that it can entrance another. The real pain of loss during childhood has been transmogrified; the erotic and enigmatic longing for the other has been transformed into revenge against the other.

Eroticism can be chaotic and anarchic. However, acknowledging that seductive eroticism comes from loss serves to give voice to the clients child-self and can allow the therapist to also see how alive, playful and yearning Eros can be. If, as Rosiello (2000) posits, we can recognise that these erotic feelings come from a childhood fraught with confusion and conflict we can engage with both humility and compassion for both erotic transference and our own countertransference.

Therapists can become proficient in the language of touch, seduction, and eroticism, through training and concurrent supervision in touch, sexuality and the unconscious. They can protect themselves and their clients through clear communication and appropriate self-disclosure that is neither gratuitous nor burdening to the client. The intricacies and risk of working with sexual imagery and dynamic re-enactment that arise in the transference-countertransference engagement have long been confused with the destructive sexualisation of the relationship and the 'slippery slope' of sexual acting out and I believe this arena requires further definition and separation. Through educational foundations and practice we can become more fluent in the body's language, and we can better meet the greater complexity of the seductive client.

BIOGRAPHY

Danielle Tanner is the mother of three children, a wife and a body psychotherapist. She trained with Silke Ziehl, of the Entelia institute at The Open Centre in Deep Bodywork/ Postural Integration. She has furthered her training with Dr. Asaf Rolef Ben-Shahar in Integrative Mindbody therapy (IMT).

Research support: Deepest gratitude for her teachers, Silke Ziehl, and Dr. Asaf Rolef Ben-Shahar and her supervisor, Nick Totton.

Email: daniellecolclough@hotmail.com

REFERENCES

Aron, L. (1996). *A Meeting of Minds: Mutuality in Psychoanalysis.* New Jersey: The Analytic Press.

Asheri, S. (2004). Erotic desire in the therapy room. Dare we embody it? Can we afford not to? A talk given at the UKCP conference on the 11 September 2004. Retrieved 01 February 2012 from http://www.eabp.org/.

Balint, M. (1968). *The Basic Fault: Therapeutic Aspects of Regression.* London: Tavistock

Ball, A. (2002). *Taboo or Not Taboo: Reflections on Physical Touch in Psychoanalysis and Somatic Psychotherapy*. Australia: Psychoz Publications.

Benjamin, J. (1995). Recognition and destruction: an outline of intersubjectivity. *In Like Subjects, Love Objects: Essays on Recognition and Sexual Difference.* New Haven, CT: Yale University Press.

Blum, H.P. (1973). The concept of erotized transference. *Journal of the American Psychoanalytic Association*, 21, 61-76.

Bollas, C. (1987). *The Shadow of the Object: Psychoanalysis of the Unthought Known.* New York: Columbia University Press.

Bolognini, S. (1994). Transference: eroticized, erotic, loving, affectionate. *International Journal of Psychoanalysis,* 75, 73–86.

Book, H.E. (1995). The erotic transference: some technical and countertransferential difficulties. *American Journal of Psychotherapy,* 49(4), 504-513.

Breuer, J. A. and Freud, S. (1895). *Studies on Hysteria.* Standard edition. London: Hogarth Press, 1955.

Britton, R. (1999). Getting in on the act: the hysterical solution. *The International Journal of Psychoanalysis*, 80(1), 1-14.

Bromberg, P. (2011). *The Shadow of the Tsunami and the Growth of the Relational World.* London: Routledge.

Buber, M. (1937). *I and Thou.* London: Continuum International Publishing Group, 2004.

Buber, M. (1957). *Pointing the Way: Collected Essays.* London: Routledge.

Carotenuto, A. (1982). *A Secret Symmetry: Sabina Spielrein between Jung and Freud.* New York: Pantheon.

Chetrit-Vatine, V. (2004). Primal seduction, matricial space and asymmetry in the psychoanalytic encounter. *The International Journal of Psychoanalysis,* 85 (4), 841-856.

Coen, S.J. (1996). Love between patient and therapist: a review. *The American Journal of Psychoanalysis,* 50(1), 14-27.

Cornell, W.F. (2003). The impassioned body: erotic vitality and disturbance in psychotherapy. *British Gestalt Journal,* 12 (2), 92-104.

Covington, C. (2001). Comments on the Burgholzli hospital records of Sabina Spielrein. *Journal of Analytical Psychology,* 46, 105-116.

Davies, J.M. (1994). Love in the afternoon: a relational reconsideration of desire and dread in the counter transference. Psychoanalytic Dialogues: *The International Journal of Relational Perspectives,* 4, 153-170.

Davies, J.M. (2013). My enfant terrible is twenty: a discussion of Slavin's and Gentile's retrospective reconsideration of 'Love in the afternoon'. Psychoanalytic Dialogues: *The International Journal of Relational Perspectives,* 23(2),170-179.

Durana, C. (1998). The use of touch in psychotherapy: ethical and clinical guidelines. *Psychotherapy,* 35(2), 269-280.

Ehrenberg, D.B. (1990). Playfulness in the psychoanalytic relationship. *Contemporary Psychoanalysis*, 26, 74-94.

Ehrenberg, D.B. (1992). *The Intimate Edge: Extending the Reach of Psychoanalytic Interaction.* New York: WW. Norton.

Fagan, J. (1998). Thoughts on using touch in psychotherapy. In E. W. Smith, P. R. Clance, & S. Imes; *Touch in Psychotherapy.* New York: Guilford Press.

Farrelly, F. & Brandsma, J. (1974). *Provocative Therapy.* Capitola, CA: Meta Publications Inc.

Ferenczi, S. (1933). Confusion of tongues between adults and the child. In M. Balint (Ed.), *Final Contributions to the Problems and Methods of Psychoanalysis.* London: Karnac.

Ferenczi, S. (1953). *The Theory and Technique of Psychoanalysis.* New York: Basic Books.

Field, N. (1989). Listening with the body: an exploration in the countertransference. *British Journal of Psychotherapy,* 5(4), 512–522.

Fisher, C. (2004). Ethical issues in therapy: therapist self-disclosure of sexual feelings. *Ethics and Behavior,* 14(2), 105-121.

Forrester, J. (1990). *The Seductions of Psychoanalysis. Freud, Lacan and Derrida.* Cambridge: Cambridge University Press.

Freud, S. (1915). *Observations on Transference Love: Further Recommendations on the Technique of Psychoanalysis, III.* Standard Edition. London: Hogarth Press.

Gabbard G. O. (1994). On love and lust in erotic transference. *Journal of the American Psychoanalytic Association*, 42, 385–403.

Gabbard, G. O. (1995). The early history of boundary violations in psychoanalysis. *Journal of the American Psychoanalytic Association,* 43(4), 1115-1136.

Garrett, T. (1999). Sexual contact between clinical psychologists and their patients: qualitative data. *Clinical Psychology and Psychotherapy,* 6, 54–62.

Gutheil, T.G., and Gabbard, G.O. (1992). Obstacles to the dynamic understanding of therapist-patient sexual relations. *American Journal of Psychotherapy,* 46(4), 515-25.

Goldberger, M. & Evans, D. (1985). On transference manifestations in male patients with female analysts. *International Journal of Psycho-Analysis,* 66, 295-309.

Gentile, J. (2013). From truth or dare to show and tell: reflections on childhood ritual, play and the evolution of symbolic life. *Psychoanalytic Dialogues: The International Journal of Relational Perspectives,* 23 (2), 150-169.

Hartley, L. (2005). Embodying the sense of self. In N. Totton (Ed.) *New Dimensions in Body Psychotherapy.* England: Open University Press.

Hedges, L.E. (2011). *Sex in Psychotherapy: Sexuality, Passion, Love and Desire in the Therapeutic Encounter.* New York: Routledge.

Hoffman, I.Z. (1998). *Ritual and Spontaneity in the Psychoanalytic Process: A Dialectical-Constructivist View.* New York: Analytic Press.

Horton et al. (1995). Fat and carbohydrate overfeeding in humans: Different effects on

energy storage. *American Journal of Clinical Nutrition, 62*(1), 19—29.
Hunter, M. & Struve, J. (1998). *The Ethical Use of Touch in Psychotherapy.* Thousand Oaks, CA.: Sage.
Kalsched, D. (1996). *The Inner World of Trauma: Archetypal Defences of the Personal Spirit,* London: Routledge.
Kernberg, O.F. (1994) Love in the analytical setting. *Journal of the American Psychoanalytic Association.* 42,1137-1157.
Kertay, L., & Reviere, S. L. (1998). Touch in context. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), *Touch in Psychotherapy: Theory, Research, and Practice.* New York: The Guilford Press.
King, A. (2011). Touch as relational affirmation. Attachment: *New Directions in Psychotherapy and Relational Psychoanalysis,* 5,108-124.
Kulish, N. M. (1984). The effect of the sex of the analyst on transference: A review of the literature. *Bulletin* of the Menninger Clinic, 48, 95-110.
Kulish, N. M. (1986). Gender and transference: The screen of the phallic mother. *International Review of Psychoanalysis*, 13, 393-404.
Kumin, I. (1985). Erotic horror: desire and resistance in the psychoanalytical situation. *International Journal of Psychoanalytical Psychotherapy,* 11, 3-20.
Kohut, H. (1972). *The Analysis of the Self.* New York: International Universities Press.
Koo, M.B. (2001). Erotized transference in the male patient-female therapist dyad. *The Journal of Psychotherapy Practice and Research,* 10(1), 28–36.
Ladany, N., O'Brien, K.M., Hill, C.E., Melincoff, D., Knox, S., & Peterson, D.A. (1997). Sexual attraction towards clients, use of supervision and prior training: A qualitative study of predoctural psychology interns. *Journal of Counseling Psychology,* 44, 413-424.
Laplanche, J. (1989). *New Foundations for Psychoanalysis.* Oxford: Blackwell.
Lester, E. P. (1985). The female analyst and the erotized transference. *International Journal of Psycho-Analysis.* 66, 283-293.
Levinas, E. (1974). *Otherwise Than Being: or Beyond Essence.* London: Martinus Nijhoff.
Little, M. (1990). *Psychotic Anxieties and Containment. A Personal Record of Analysis with Winnicott.* Northvale, NJ: Aronson.
Mann, D. (1997). *Psychotherapy, an Erotic Relationship: Transference and Countertransference Passions.* London: Routledge.
Maroda, K. (1999). *Seduction, Surrender and Transformation: Emotional Engagement in the Analytic Process.* New Jersey: The Analytic Press.
Mintz, E. E. (1969). On the rationale of touch in psychotherapy. *Psychotherapy: Theory, Research & Practice,* 6(4), 232-234.
Mitchell, S. A. (1997). *Influence and Autonomy in Psychoanalysis.* Hillsdale, NJ: The Analytic Press.
Nagel, J. (2003). *Race, Ethnicity, and Sexuality: Intimate Intersections, Forbidden Frontiers.* New York: Oxford University Press.
O'Connor, N., & Ryan, J. (2003). *Wild Desires and Mistaken Identities: Lesbianism and Psychoanalysis.* London: Karnac Books.
Ogden, T. H. (2005). *The Art of Psychoanalysis.* London: Routledge.
Orbach S., & Carroll, R. (2006). Contemporary approaches to the body in psychotherapy: two psychotherapists in dialogue. In J. Corrigall, H.Payne, & H.Wilkinson (eds.) *About a Body: Working with the Embodiment in Psychotherapy.* London: Routledge.

Pope, K.S., Sonne, J.L., & Holroyd,J. (1994). *Sexual Feelings in Psychotherapy.* Washington, DC: American Psychological Association Press.

Pope, K.S., Tabachnick, B.G., & Keith-Spiege, P. (2006). Sexual attraction to clients: the human therapist and the (sometimes) inhuman training system. *Training and Education in Professional Psychology,* S(2), 96-111.

Rappaport, E.A. (1956). The management of an erotized transference. *Psychoanalytic Quarterly* 25, 515–529.

Reich, W. (1933). *Character Analysis*. New York: Farrar, Straus & Giroux, 1980.

Renik, O. (1999). Playing one's cards face up in analysis. *Psychoanalytic Quarterly,* 68, 521–539.

Rolef Ben-Shahar, A. (2010). IMT Intensive workshop lecture, Tel Aviv.

Rolef Ben-Shahar, A. & MacDonald, G. (2011). Meeting through grace: relational body-psychotherapy. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis,* 5, 45-69.

Rolef Ben-Shahar, A. (2012). A therapeutic anatomy: a historical and theoretical review of body psychotherapy. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis,* 6(1), 73-93.

Rolef Ben-Shahar, A. (2014). *Touching the Relational Edge.* London: Karnac.

Rosiello, F. (2000). Deepening Intimacy in Psychotherapy. Northvale, NJ: Aronson.

Rothschild, B. (2000). *The Body Remembers. The Psychophysiology of Trauma and Trauma Treatment.* London, New York. W.W. Norton.

Sarkar, S.P. (2004). Boundary violations and sexual exploitation in psychiatry and psychotherapy: a review. *Advances in Psychiatric Treatment,* 10, 312-320.

Samuels, A. (1993). *The Political Psyche.* London: Routledge.

Schamess, G. (1999). Therapeutic love and its permutations. *Clinical Social Work Journal*, 27(1), 9-26.

Schaverien, J. (1995). *Desire and the Female Therapist: Engendered Gaze in Psychotherapy.* London: Routledge.

Schwalbe, A. (2013). The therapeutic womb space: A feminine approach to psychotherapy and embodied transformation. Retrieved 15th April 2013 from http://www.annetteschwalbe.co.uk.

Searles, H. (1959). Oedipal love in the countertransference. *International Journal of Psychoanalysis,* 40, 180-190.

Slavin, J. H. (2013). Moments of truth and perverse scenarios in psychoanalysis: revisiting Davies' 'Love in the afternoon'. *Psychoanalytic Dialogues: The International Journal of Relational Perspectives,* 23 (2), 139-149.

Smith, E. W., Clance, P. R., & Imes, S. (1998). *Touch in Psychotherapy.* New York: Guilford Press.

Soth, M. (2002). 'What is 'working with the body'?' *The European Journal of Counselling, Psychotherapy and Health,* 5 (2), p. 121-133.

Stern, D. (1998). *The Interpersonal World of the Infant:* A View from Psychoanalysis and Developmental Psychology. London: Karnac.

Stone, M. (2006). The analyst's body as tuning fork: embodied resonance in countertransference. *Journal of Analytical Psychology,* 51 (1), 109–124.

Swartz, J. (1969). The erotized transference and other transference problems. *Psychoanalytic Forum,* 3, 307-317.

Tansey, M.J. (1994) Sexual attraction and phobic dread in the countertransference. *Psychoanalytic Dialogues: The International Journal of Relational Perspectives,* 4, 139-152.
Totton, N. (2003). *Body Psychotherapy: An Introduction.* Open University Press.
Totton, N. (2005). *New Dimensions in Body Psychotherapy.* Open University Press.
Totton, N. (2010). Boundaries and boundlessness. *Therapy Today,* 21(8), 10-15.
Tower, L.E. (1956). Countertransference. *Journal of the American Psychoanalytic Association,* 4, 224-255.
Ventling, C.D. (2002). *Body Psychotherapy in Progressive and Chronic Disorders.* Basel: Karger.
Warnecke, T. (2008). The borderline experience - a somatic perspective. A presentation given at the AChP Annual General Meeting in London on November 6th 2004. *The British Journal of Psychotherapy Integration,* 4(1), 1-12.
Weatherill, R. (2000). The seduction of therapy. *British Journal of Psychotherapy,* 16(3), 263-273.
Wilson, B.G., & Masson, R.L. (1986). The role of touch in psychotherapy: an adjunct to communication. *Journal of Counselling and Development,* 64, 497-500.
Wilson, J.M. (1982). The value of touch in psychotherapy. *American Journal of Orthopsychiatry,* 52 (1), 65-72.
Winnicott, D.W. (1960). The theory of the parent-infant relationship. *International Journal of Psycho-Analysis.* 41, 585-595.
Winnicott, D.W. (1965). *The Maturational Process and the Facilitating Environment: Studies in the Theory of Emotional Development.* New York: International Universities Press.
Winnicott, D. W. (1971). *Playing and Reality.* New York: Basic Books.
Winnicott, D.W. (1990). *Home is Where We Start From.* 2nd Edition. London: Penguin Books.
Wrye, H.K. (1993). Erotic terror: male patients' horror of early maternal erotic transference. *Psychoanalytic Inquiry,* 13, 240-257.
Zur, O. & Lazarus, A. A. (2002). Guidelines for non-sexual dual relationships in psychotherapy. In A. A. Lazarus, & O. Zur (Eds.) *Dual Relationships and Psychotherapy.* New York: Springer.
Zur, O. and Nordmarken, N. (2011). *To Touch or Not To Touch: Exploring the Myth of Prohibition on Touch in Psychotherapy and Counseling.* Retrieved 5th March 2013 from http://www.zurinstitute.com/touchintherapy.html

INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS

INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL

volume fourteen ● number two ● fall 2015

TABLE OF CONTENTS

The cover image is Earth by Hilde Hendriks

EABP
EUROPEAN ASSOCIATION FOR BODY-PSYCHOTHERAPY

USABP
United States Association for Body Psychotherapy
The Hub of Somatic Psychology

Connecting professionals, exchanging expertise, enabling collaboration

Journal (ISSN 2169-4745)