Teaching Psychiatric Trainees to Respond to Sexual and Loving Feelings: The Supervisory Challenge

Nancy A. Bridges, LICSW, BCD

Abstract
Although trainees often encounter sexual and loving feelings in therapeutic relationships, specialized curriculum addressing sexual dilemmas and boundary issues is often absent from graduate coursework and clinical training programs for mental health professionals.1-8 With inadequate preparation, trainees run the risk of engaging in destructive behavioral enactments or developing restricted practice styles that stunt the psychotherapeutic process.1-3,5-8 Unfortunately, this same lack of formal curriculum leaves many supervisors inadequately prepared to deal with sexual feelings and the resultant complex clinical issues in supervision.5,7,9-13

In this article, I propose a model of individual psychodynamic clinical supervision that addresses sexual feelings in trainees and in their treatment relationships. The psychotherapy supervisor is in a unique position to foster in the trainee more confidence and competence in his or her ability to manage these complex treatment situations in an ethical and therapeutically sound manner. This model of individual supervision increases trainees' comfort, confidence, and ability to respond to sexual and loving feelings in the treatment relationship with a formulation that advances the treatment process. It aims to provide trainees with a psychodynamic framework for analyzing and managing erotic and loving feelings. Examples of how the supervisor introduces and manages the emergence of sexual feelings, and of the use of the supervisor's self as a model, are provided and discussed.

Of course, in psychotherapy supervision, one attends to all intense feelings in therapeutic relationships, including among others rage, disgust, and grief. For the purposes of this article, the exclusive focus is on sexual feelings and longings.

ROLE OF THE SUPERVISOR

The intimate nature of the psychotherapy process requires that trainees be educated to deal competently with erotic feelings and longings that naturally arise during phases of psychotherapy. Presently, many trainees' concerns about the technical handling of erotic and loving aspects of treatment go unanswered, and others are frightened by the much-talked-of slippery slope of misconduct.1,3,5,6,10 The prevalence of sexual misconduct by psychotherapists of all disciplines suggests that increased training and education about the erotic aspects of clinical work is indicated.1-5

The issue of how much, if at all, supervision should focus on the student's intrapsychic issues and person is a long-standing debate.12-15 Many supervisors and
Trainees have made a clear and conscious effort to restrict discussion to the patient's data as a way to protect the trainee from any risk of boundary confusion between supervision and personal therapy. This approach neglects crucial areas of psychotherapeutic discourse and instruction, namely, the discussion and sorting out of projective identifications and mutual enactments by therapists and patients. Thus, for many supervisory dyads, personal feelings and issues and their effect on the psychotherapeutic relationship and process become a part of the dialogue of supervision only when a serious problem or a boundary violation occurs. Clearly, this is too late.

Trainees may feel dangerously isolated and inadequately prepared for the intense and intimate nature of the psychotherapy process. Supervision may, in fact, be the only arena where models for understanding and psychodynamically managing erotic and loving feelings are discussed. The shame, phobic dread, and self-consciousness associated with these feelings in clinical practice require that the supervisor initiate the discussion of these issues and feelings.

The supervisor may establish a milieu of safety and openness where learning can occur by offering the following frame for the supervisory relationship and for work around these issues. Consider the following comments to a supervisee:

Clinical work often evokes strong feelings including attraction and sexual arousal, in our patients and ourselves. It is to be expected. Often, these feelings signal important information about our patients' development and relational difficulties, and about ourselves, and the therapeutic work to be done. Supervision is a place to sort out the nature and meaning of these feelings when they arise to guide your clinical work. I trust as these issues present themselves to you in your clinical work, you will bring them to supervision. I will be happy to share with you my own experience struggling with these issues as we feel it's useful. I neither want to pry nor do I want to leave you to struggle alone with these complicated feelings.

A matter-of-fact introduction to sexual feelings and longings diminishes the embarrassment and shame trainees may fear around the discussion of such feelings, and in my experience it increases the possibility of meaningful dialogue as they raise such issues and feelings.

Supervision for the purpose of understanding and managing erotic transference/countertransference focuses attention on the student's personal feelings and self. Additionally, the supervisor assumes a self-revelatory stance in supervision with regard to these clinical issues and consciously uses herself as a demonstration model for the trainee. The probability of a parallel process between the trainee's supervisory experience and the patient's psychotherapy experience has been noted.

Go to:

Guidelines for Supervision
Suggested Teaching Strategies

1. Combating Taboo and Silence:

The legacy of silence, stigma, and shame surrounding these feelings and issues needs to be addressed in supervision. The supervisor directly and simply addresses feelings of self-consciousness and dread by normalizing these feelings. Trainees long for mentors in regard to these issues and are deeply appreciative of supervisors who share ways in which they have understood and managed erotic feeling states in their own practices. Personal disclosures by supervisors of erotic feelings, useful interventions, and dilemmas with patients are invaluable when judiciously shared. Supervisors who model the process of not knowing, of developing hypotheses, of bearing intense affect, and of muddling through to a useful understanding and intervention are particularly valued.\textsuperscript{1,3,5,12-15}

Many trainees express the wish for supervisors of a specific gender. In my experience, some trainees may find it is more possible for them to raise these issues with a supervisor of one gender and overwhelmingly difficult with someone of the other gender.

2. Introducing Phases of the Process of Mastery:

The literature suggests that for trainees, the process of mastering this clinical material has identifiable stages.\textsuperscript{1,3,5,7} The process of attaining comfort with sexual material involves shifting from concrete to symbolic understandings, from a focus on external factors to attention to intrapsychic and interpersonal issues, and from a simple one-sided analysis to more complex formulations.\textsuperscript{3} For the supervisor, a thorough understanding of the normative developmental sequence of mastering these issues is useful. The most important points for supervisors to bear in mind and to communicate to trainees are discussed below.

Erotic and loving feelings, when unexpected or unprepared for, are frightening and overwhelming.\textsuperscript{1,3,6} The power of these feelings to startle and disorient trainees needs to be recognized. The sense of anxiety and powerlessness may be so intense that trainees temporarily lose the distinction between erotic and loving feelings on the one hand and behaviors on the other.\textsuperscript{1,3} Commonly, at first, trainees react and respond to sexual feelings, fantasies, and erotic dreams as if the feelings were unethical or a manifestation of misconduct.\textsuperscript{1-3} This sense of anxiety and danger is infectious. Sometimes supervisors respond as if these feelings were dangerous or “inappropriate” as well. Consultations from a trusted colleague may be of benefit to the supervisor as she attempts to assess degree of risk and to sort out the meaning of these feelings to the patient, the trainee, and the treatment process.

In the process of mastering the feelings of powerlessness associated with intense erotic or loving states, trainees may first focus on boundary issues and treatment contracts. Harsh assessments of themselves and their patients often mark the early phases of engagement with these intense states and complex treatment situations.\textsuperscript{1,3,5,12} Trainees worry that they will humiliate or harm a patient with an
unhelpful intervention. Supervisors need to reassure trainees, support the distinction between feelings and behaviors, and give permission for the trainee to experience and explore these feeling states. Supervisors who communicate to trainees an abiding faith in their learning process and convey information about the normative developmental phases of mastering these aspects of psychotherapy are valued.

3. Teaching Trainees to Listen to Physical Sensations:

Supervisors guide the trainee to listen to her body and physical sensations. Often, the first signs of sexual tension in a therapeutic relationship are experienced in shifting physical sensations, a sense of emotional stirring or arousal and of interpersonal heat in the trainee's body. These may be accompanied by sexual longings, fantasies, and night or day dreams accompanied by feelings of intense pleasure that are coupled with dread, guilt, or shame. Often, these conflicting images, sensations, and affects are confusing and deeply unsettling to the trainee. With supervisory support and instruction, trainees learn to rely on these physical sensations to inform and guide them through exploration of the multiple layers of meaning so that they can reach a clearer understanding of the possible transference/countertransference enactments and useful therapeutic interventions.

4. Offering Models of Therapeutic Action:

Trainees can be offered a developmental and a relational model of therapeutic action. A relational model views psychotherapy as a two-person model and relies on the integration of interpersonal, object relations, and self psychology theories. A developmental model focuses on strivings and deficits in self-consolidation. Deficits or delays in self-consolidation and strivings for affect mastery compel the patient to rely on others for support of a fragile sense of self and troublesome affects. The patient delivers into the therapeutic relationship the earlier developmental needs for self-growth and consolidation and reenacts predetermined relational paradigms that are a source of conflict. The therapist is cast in various roles by the patient in order to recreate the patient's well-established relational matrix with the hope of a different outcome.

Erotic states in therapeutic relationships are best understood as a mixture of needs, unresolved longings, repetition of earlier object relations, and the real relationship for both trainee and patient. Arriving at a useful understanding often requires analysis of both parties' contribution. Employing these models, the supervisor instructs the trainee and models the exploration of erotic feelings from both the trainee's and patient's perspective with the understanding that these feelings signal information about developmental issues and relational experiences.

Questions the supervisor may pose to assist a trainee in the exploration of these issues from the patient's experience include:

- Do these feelings inform you about developmental deficits, developmental gains, boosting of self-esteem, wishes for admiration? What
developmental issues and attendant affects are being longed for, repeated, or defended against with these feelings?
- Do these feelings defend against more intolerable affects—for example, disappointment, hate, grief, expression of rage, sadism, terror around others, or denial of vulnerability/dependency?
- Do these feelings represent an unconscious effort to maintain positive feelings, a wish to be loved, to be cherished, or to love another?
- Do these feelings signal a reenactment of an earlier traumatic relationship or experience of exploitation with a trusted other?

With experience and practice, trainees will develop and integrate a model of conceptualization that fits their personal and clinical style. Models of therapeutic action offered by supervisors assist trainees with this developmental task.

Consider the following vignette:

A female trainee troubled by sexual feelings for a male patient who has been in treatment with her for 2 years presents the case in supervision. The patient, a 40-year-old, physically attractive man employed as the CEO of a well-known major company, presents for treatment of interpersonal difficulties. From the trainee’s perspective, the patient has a glamorous life filled with extensive international travel to exotic destinations, enormous interpersonal and financial power, and success. The trainee finds this patient to be irresistibly attractive and enormously appealing. During sessions, the trainee catches herself staring at this man’s body and being filled with erotic fantasies. The trainee wonders how to make sense of these feelings.

The supervisor begins with, “It's good that you let yourself feel and know about these feelings. Often, these feelings are unsettling for therapists. Usually these sensations and feelings alert us to important information about our patient, the phase of the psychotherapy, and ourselves. Let's begin by assuming there is some projective identification process operating here. What might these feelings be telling us about your patient? For example, if we look at these feelings as symbolic communications about your patient’s wishes, needs, and reenactments, what’s your understanding of the possible meaning? We don't need to have the ’right answer.’ What’s helpful is to generate possible hypotheses and try them out.”

The supervisor begins by giving the trainee support in several ways. The supervisor normalizes the trainee's experience and protects her self-esteem while explaining how to proceed by offering a cognitive instructive approach.²⁰ By normalizing the trainee's experience and providing a cognitive frame of reference, the supervisor supports the trainee in efforts to manage the experience of being overwhelmed, of not knowing, and of feeling helpless, with the accompanying feelings of shame. Support also takes the form of praise or admiration for the trainee's courage and efforts.

5. **Increasing Capacity to Tolerate and Analyze Intense Sexual States:**

Supervision aims to increase the trainee's capacity to endure intense sexual feeling states. The supervisor assists the trainee in the development of tolerance and
understanding of her own and her patients' affective experiences. Often, the best supervisory approach is to begin with a patient-focused discussion detailing the subjective experience of the patient and the relationship to the trainee.\textsuperscript{1,3,13} A supervisory focus on the patient's inner experience and developmental issues is recommended for the inexperienced trainee or for those who are particularly fearful of affect. With the development of tolerance for and familiarity with their own affective responses, trainees can turn their attention to analyzing erotic sensations and feelings, with the following understandings.

Erotic transference/countertransference represents a complex interaction and process between trainee and patient, involving a mixture of the real relationship and past object relationships for both parties. These intense states represent transferences from both the patient and trainee and are best understood as a joint creation between trainee and patient.\textsuperscript{1,3,16,17,20,21,25,27,31,33} ‘Trainees' and patients' sexual feelings and declarations of love have multiple and varied meanings, representing wishes, fears, conflicts, unacknowledged and defended-against affects, and developmental delays and gains. For the trainee, understanding and responding therapeutically requires a self-reflective stance where the trainee allows herself to freely fantasize and follow her own associations and feelings. If one follows physical sensations, affect, and fantasies, then it is possible to explore the origins of these symbols, and their meanings to the trainee and the patient in the treatment process, and arrive at a therapeutically useful stance. The trainee needs adequate support and instruction to assist her in bearing the intense and disorienting affect involved and exploring the questions, “Is this me or is this you?”; “Is this now or is this then?” (P. L. Russell, personal communication, 1982); and “What is the meaning of these feelings/fantasies to this patient, this therapist, and at this juncture in the treatment?”

The supervisor recognizes that this approach holds the potential for embarrassment and heightened anxiety in the trainee. Supervisors must remain alert to the trainee's sense of emotional privacy and make allowance for individual differences in affect tolerance and mastery.\textsuperscript{13,15,22,23} Some trainees may or may not choose to explore these issues personally in supervision and may remain more patient-focused. Equipped with a model for conceptualization, these trainees may choose to examine privately the affects and issues involved. Other trainees may choose appropriately to take these feelings to personal therapy. Supervision is not intended to explore or work through the trainees' conflicts around sexual feelings and issues. Rather, the ultimate educational goal is to assist the trainee with the identification and management of intense affect and the development of a psychodynamic formulation with regard to erotic transference/countertransference. Containment and symbolic understanding of these feeling states is crucial in order to decide how best to use this information therapeutically.

Consider the following vignette:
In supervision, a trainee in her late twenties discusses a male patient whom she feels is attracted to her. Her patient's feelings of attraction make her uncomfortable. Through her body language and descriptions of the patient it becomes clear to the
supervisor that the feelings of attraction and perhaps arousal are mutual between the patient and the trainee. After exploring and attending to her questions and concerns about her patient's feelings and developing a patient-based formulation, the supervisor inquires about the trainee's feelings toward this patient. The trainee is aware of a special fondness for her patient and describes the qualities of person she finds admirable and even attractive. With further discussion, the trainee reports paying closer attention to her personal appearance and dressing attractively on the days she meets with him, and she anxiously recounts an erotic dream. In the dream, the trainee is making love to her patient and discusses with the patient concerns about being lovable.

The supervisor comments: “Thank you for sharing your feelings and the dream. This is useful information. I wonder if this patient has become very special to you, in a personal way. It is important that you figure out what this patient and your relationship with him mean to you. You do not have to discuss this with me, although I would be happy to help you if you wish. What's important is that you understand why this patient has become so significant in your inner life. If it would be useful, I can share with you a personal experience with similar feelings toward a patient and how I made sense of it for myself.”

In the supervisory dialogue, the supervisor praises the trainee for acknowledging her feelings and revealing the dream, but also pushes her to deepen and expand her understanding of the meaning of these feelings in herself and to her patient. The trainee begins by accepting the supervisor's offer to share a personal experience. The supervisor responds with:

*This reminds me of a patient I treated whom I felt overwhelmingly attracted to, and I, like you, dreamt of a sexual encounter with this patient. This treatment occurred during a time in my life when I was without a significant other. My personal longings contributed to my special attachment and sexual feelings toward my patient. It helped me to know this about myself.*

Sharing a clinical vignette exposes more of the supervisor's professional self and her own experience with these issues. The sharing of the personal professional experience takes the focus off the trainee and her feelings for a moment and places the focus on the supervisor.215 By example, the supervisor's self-revelation declares that identifying and processing these feelings and dilemmas is a normative aspect of professional development. Following the supervisor's comments, the trainee accepts the invitation to approach her exploration of the therapeutic relationship in a more anxiety-provoking and personally intense way. She deepens her exploration of attraction and erotic fantasies about this patient with the following insights.

On reflection in supervision, the trainee came to view her sexual feelings and fantasies as primarily a reflection of her intense attachment to this patient as a longed-for love object, and as a response to her patient's gratifying idealization of her. The trainee shared that her intimate partner had relocated recently to a distant city. The intensity of her affective response to this patient signaled to her the depth of her own
sense of loneliness, and perhaps grief over the relocation of her lover. As she became more compassionate and in touch with her own personal vulnerabilities, needs, and longings, she observed more clearly the ways in which her patient was flirtatious and beckoned her closer. The trainee now clearly understood how her erotic dream was connected to her own wishes and needs as well as her patient's.

Supervision aims to increase trainees' comfort with their inner experience and their capacity to examine it compassionately. It also helps trainees accept the inevitability of enactments by therapists and patients. The normative process of attaining comfort and mastery of erotic feelings for trainees involves shifting from concrete concerns to symbolic understandings.13 In my experience, in the beginning phases of engagement with these issues trainees' thinking is concrete, and they seem to lose their capacity for abstract and symbolic thinking. It is as if sex is sex, although even beginning clinicians know that psychotherapy is characterized by images, multiple and varied metaphors, and shifting symbols.2 The supervisor may be of particular help here as she assists the trainee in managing anxiety, which often allows for the shift to symbolic understanding.3 Gabbard and Lester's33 consideration of the "thickness" and "thinness" of both the therapist's internal boundaries (access to unconscious processes) and her external boundaries (within and between the therapist and patient) is relevant here. While acknowledging variations in innate individual capacities with regard to permeability of inner boundaries, supervision ideally assists the trainee in developing as fully as individually possible the capacity to fantasize and productively employ fantasy for mastering intense countertransference states.2,3,7 The supervisory challenge and task is to initiate and conduct the discussion in a respectful and bounded manner that in fact proves useful to the trainee, the patient, and the therapeutic process.

Consider the following supervisory vignette:

---

**Case Report**

A male trainee in great subjective distress presents a 3-month treatment relationship for supervision. The patient, a young woman, presents with severe depression, social phobia, intermittent drug abuse, and a childhood history of abuse and abandonment. Beginning in the third session, the patient presents with an erotic transference as revealed in requests to be hugged and to sit in his lap, comments on his clothing and body, and in-vitations to meet for a drink. The trainee feels overwhelmed with anxiety, confusion, and un-certainty about where to set the therapeutic boundary.

The supervisor assists the trainee in conceptualizing the patient's issues and presentation from a dynamic, developmental perspective and arrives at an understanding of what might be clinically useful. After this discussion, it becomes clear that the trainee is still experiencing great distress. The supervisor comments, "You look upset." The trainee responds, "I am, please give me a minute." The supervisor continues, "Would you be comfortable talking about your feelings here? Perhaps it has something to do with this treatment?" The trainee responds, "I don't
know exactly why I'm so upset. It's about this patient. I'm not sure it will be OK with you to discuss personal feelings here.” The supervisor reassures the trainee that continuing the discussion of his feelings is appropriate and fine. However, the supervisor suggests that they also pay attention to the trainee's level of comfort and privacy.

The supervisor begins with, “What's your understanding of why you're so upset?” The trainee comments, “My feelings of wanting to physically comfort this patient are much too strong, confusing, and overwhelming at moments. I don't think I can work with this patient. It's too difficult for me.” The supervisor asks, “How do you make sense of your wish to comfort this patient?” The trainee then shares that this patient's history resembles that of his own family and that this patient reminds him of a troubled younger sibling whom he had been very involved with as a surrogate parent. As a child, he felt compelled to honor his sibling's requests for nurturance even at personal cost to himself. He's not sure he can separate his feelings about his sibling from this patient and is concerned about his capacity to manage his affect and maintain therapeutic boundaries. The trainee and supervisor discuss ways for the trainee to modulate his affect, remain patient-focused, and take the next step in the treatment.

The supervisor suggests the trainee take up these intense feelings and issues in his personal therapy. The supervisor wishes to support and preserve the trainee's self-esteem during his struggle to manage raw and overwhelming feelings, commenting, “It's brave of you to be so self-revealing in here. Clinical work may be deeply emotionally stirring. I know it has been in my professional work. I admire your willingness to be attuned to your inner experience and how it affects your work. When we are open to ourselves and our patients, we become reacquainted with our unfinished business. It happens to all therapists. If it would be helpful, I can share an experience of mine struggling with overwhelming feelings for a patient.” Finally, the supervisor asks, “Has this discussion felt OK for you?”

6. Considering Countertransference Use and Misuse:

Internal and intersubjective exploration of the meaning of these feelings presents the trainee with a broad array of choices about how best to use this information to advance therapeutic aims. After thoughtful decision-making and a considered response, trainees may decide to use this information directly through interpretations, clarifications, or comments to patients.

All direct comments to patients about erotic feelings require skill and sensitivity. Direct use of countertransference data, although a delicate process, works best if all comments are compassionate, self-enhancing, and instructive.

Direct disclosure of therapists' sexual feelings to a patient is likely to frighten the patient, particularly in light of the incidence of professional sexual misconduct, and it is not recommended.\textsuperscript{7,18-20,29,30} Davies\textsuperscript{27} describes a case in which she directly disclosed sexual feelings to a patient with what she feels were ultimately successful results.
However, the patient initially felt intruded upon, even assaulted, by his analyst's unsolicited disclosure.

Ehrenberg\textsuperscript{21} wisely warns us to be alert to the possibility that any effort to attend to one set of transference/countertransference issues may be a form of resistance with respect to other issues. Therapists and trainees do well to exercise restraint with regard to direct disclosure of sexual feelings to patients even if they can justify them based on a belief in the centrality of the countertransference experience. Although a minority propose such disclosures, as yet there are not enough data to support such proposals, and we must be aware of the real possibility of burdening or traumatizing our patients and unnecessarily derailing a psychotherapy. Research and more published accounts of therapists' experiences, both positive and negative, with direct disclosures are needed. Thoughtful discussion of the usefulness and danger of such disclosures continues.

\textbf{Unhelpful Supervisory Responses}

Unhelpful supervisory responses may emerge if there is difficulty in establishing safety in the supervisory relationship or if the supervisor lacks the clinical skill to manage these treatment dilemmas. The supervisor needs to be alert to several areas of potential difficulty with regard to establishment of a psychologically safe interpersonal educational milieu. Although a supervisor will be aware of trainees' vulnerabilities and issues, intrusive personal comments or interpretations are never useful or appropriate.\textsuperscript{13-15} Pressure or demands for a trainee's self-disclosure, even in the context of helping her work more effectively with patients, may be harmful to the trainee, the supervisory relationship, and the open exploration of clinical material.

Supervisors who reflexively or universally view these treatment dilemmas as indicative of character issues or boundary maintenance problems confuse the educational context with the treatment context. Supervisors who deny or ignore these feelings or alternatively become overly concerned about these feelings are likely to be of little help to trainees. Trainees in these types of supervisory relationships are unlikely to allow themselves to be vulnerable or to present anxiety-provoking clinical material in supervision.

\textbf{Causes for Concern}

Gabbard and Lester\textsuperscript{13} outline several factors they view as red flag indicators of concern about a trainee's performance. A trainee who demonstrates a marked, repetitive pattern of boundary crossings with the absence of self-observing capacity about the treatment relationship and the therapeutic process warrants careful attention. Practitioners who engage in a pattern of boundary crossings without self-reflection and critical examination may, indeed, harm patients.

The capacity of trainees to discuss and study the inevitable transference/countertransference enactments is critical to the development of a non-exploitative therapeutic relationship. In particular, trainees who consciously or
unconsciously misrepresent their conduct in the treatment process signal to the supervisor serious personal difficulties. Self-observation and revelation by trainees in supervision is at times crucial and contributes to the therapy of the patient and the education of the therapist.\textsuperscript{3,6,7,12,13,15} Trainees who are unwilling or unable to consider alternate perspectives and new data about themselves and their patients are of concern.

**CONCLUSIONS**

All trainees will at some point be faced with sexual and loving feelings in their psychotherapeutic work. The incidence of professional sexual misconduct by all disciplines indicates the continued need for training on the erotic aspects of clinical practice.\textsuperscript{3,8,12,13,15} While we now have much clinical data and sophisticated information about how to understand and manage these feelings in therapeutic relationships, this information has not yet been integrated into core curriculum. Presently, the psychodynamic psychotherapy supervisor, who may or may not feel adequately prepared, is the primary clinical teacher around these complex clinical situations.

Matter-of-fact integration of the understanding and management of sexual feelings into supervision is indicated. Addressing trainees' dread and self-consciousness concerning identification and discussion of these feelings and issues opens up the possibility of dialogue and is helpful. Clear articulation of models of therapeutic action is valued by trainees and promotes feelings of competence.

Employing a developmental model for affective mastery around sexual feelings is useful. Supervisors who share experiences about their own development of mastery struggling with these issues become important models for trainees' professional development. A safe, shame-free, trustworthy supervisory relationship provides the arena for open dialogue, self-revelation, and deep clinical curiosity about these issues for both the trainee and patient.

If the supervisor creates an atmosphere of mutual exploration with a heightened awareness of the possibility for shame and humiliation and remains sensitive to the trainees' subjective experience, these issues may be openly, honestly, and fruitfully discussed. Emphasis and empathic attunement to the trainees' development of the sense of professional self is critical. Supervision becomes an arena to promote mastery and demystify complicated erotic treatments and transference/countertransference enactments.

**References**


Articles from The Journal of Psychotherapy Practice and Research are provided here courtesy of American Psychiatric Publishing

PubReader format: click here to try

Formats:
- Article
- PubReader
- ePub (beta)
- PDF (57K)
• Citation

Share

• Facebook

• Twitter

• Google+

Save items
Add to Favorites View more options

Similar articles in PubMed

• Love and sexuality in the therapeutic relationship, [J Clin Psychol. 2014]
• The analyst's awkward gift: balancing recognition of sexuality with parental protectiveness, [Psychoanal Q. 2011]
• Supervision and privacy in psychotherapy training, [Am J Psychiatry. 1988]
• The place of erotic transference and countertransference in clinical practice, [J Am Acad Psychoanal Dyn Psych...]
• Reflections on psychodynamic psychotherapy supervision for psychiatrists in clinical practice, [J Psychiatr Pract. 2004]

See reviews... See all...

Links

• PubMed

Recent Activity
Clear Turn On

Activity recording is turned off.

Turn recording back on

• Therapist sexual feelings in hypnotherapy: managing therapeutic boundaries in hypnotic work, [Int J Clin Exp Hypn. 1996]
• A national survey of training directors about education for prevention of psychiatrist-patient sexual exploitation.[Acad Psychiatry. 1996]

See more ...

• Therapist sexual feelings in hypnotherapy: managing therapeutic boundaries in hypnotic work.[Int J Clin Exp Hypn. 1996]

• A national survey of training directors about education for prevention of psychiatrist-patient sexual exploitation.[Acad Psychiatry. 1996]

• Therapist sexual feelings in hypnotherapy: managing therapeutic boundaries in hypnotic work.[Int J Clin Exp Hypn. 1996]

• A national survey of training directors about education for prevention of psychiatrist-patient sexual exploitation.[Acad Psychiatry. 1996]

• Therapist sexual feelings in hypnotherapy: managing therapeutic boundaries in hypnotic work.[Int J Clin Exp Hypn. 1996]

• A pilot course for residents on sexual feelings and boundary maintenance in treatment.[Acad Psychiatry. 1996]

• Therapist sexual feelings in hypnotherapy: managing therapeutic boundaries in hypnotic work.[Int J Clin Exp Hypn. 1996]

• A national survey of training directors about education for prevention of psychiatrist-patient sexual exploitation.[Acad Psychiatry. 1996]

• Therapist sexual feelings in hypnotherapy: managing therapeutic boundaries in hypnotic work.[Int J Clin Exp Hypn. 1996]

• Sexual excitement and countertransference love in the analyst.[J Am Psychoanal Assoc. 1994]

• A pilot course for residents on sexual feelings and boundary maintenance in treatment.[Acad Psychiatry. 1996]

• Transference-countertransference: realizing a love by not actualizing it.[Isr J Psychiatry Relat Sci. 1994]

• Sexual excitement and countertransference love in the analyst.[J Am Psychoanal Assoc. 1994]

• Love in the analytic setting.[J Am Psychoanal Assoc. 1994]

• Therapist sexual feelings in hypnotherapy: managing therapeutic boundaries in hypnotic work.[Int J Clin Exp Hypn. 1996]

• Sexual excitement and countertransference love in the analyst.[J Am Psychoanal Assoc. 1994]

• Varieties of sexualized countertransference.[Psychoanal Rev. 1985]
- Love in the analytic setting. [J Am Psychoanl Assoc. 1994]

- Therapist sexual feelings in hypnotherapy: managing therapeutic boundaries in hypnotic work. [Int J Clin Exp Hypn. 1996]

- Psychotherapists who transgress sexual boundaries with patients. [Bull Menninger Clin. 1994]

- A pilot course for residents on sexual feelings and boundary maintenance in treatment. [Acad Psychiatry. 1996]

- Psychotherapists who transgress sexual boundaries with patients. [Bull Menninger Clin. 1994]