Part I

Relational Perspectives on Sexual Attraction in Therapy
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‘Hot Cognition in Sexual Attraction’

Clarifying, Using and Defusing the Dionysian in Cognitive Behavioural Psychotherapies

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A young-ish male therapist walks downstairs to meet a new client for an initial assessment session. The setting is a shabby NHS out-patient psychology department. Sitting in the waiting room is a well-dressed young female client who regards the approaching therapist with a detached look of mild curiosity. The therapist greets the client and asks her to follow him upstairs to the consulting room. The client says nothing and follows as directed. The therapist has already noted that this new client is well dressed, composed and out of place in this grey and grubby environment that the therapist has increasingly come to experience as oppressive.

Upon sitting down in the comfortable but worn chairs, the therapist somewhat lazily starts the session with the usual enquiry “so . . . what is it that brings you here today?”. The client does not respond immediately with the usual rush of description regarding anxiety or low mood but instead looks into the distance in an apparently reflective manner. The therapist thinks to himself “how interesting . . . she seems pretty reflective . . . really composed . . . she looks a bit European . . . quite sophisticated.” He sits up straighter in and pays more attention. There is some sense of discomfort as well, a vague anxiety. Finally, the client responds. “You know . . . sometimes I think there is nothing at all going on inside my head . . .” instantly the spell is broken . . .¹

¹ All case materials presented in this chapter are fictional.
Russ (1993), writing from a psychodynamic perspective, suggests that ‘Sexual Drama infuses therapy’. Is sexual attraction between a therapist and a client a phenomenon encountered in cognitive behavioural therapy (CBT)? If one were to judge this according to the amount of theoretical or research literature devoted to this topic within CBT, in comparison to the psychodynamic literature, one would conclude that it is either non-existent or of such small significance as to not warrant attention. In fact, at the time of writing, there appear to be no substantive theoretical contributions nor research reports that specifically address sexual attraction between therapists and clients within CBT. Possibly, the domain of sexual dynamics in therapy is one that has been seen by CBT therapists as the preserve of the psychodynamically inclined, an area of enquiry that has long ago been demarcated as alien territory. In seeking to address the topic of ‘sexual attraction in CBT’, it is useful to briefly outline some of the essential aspects of CBT that will function as part of the context for how sexual attraction might be disclosed and responded to. A consideration of some of these features may also go some way towards explaining the lack of attention given to this phenomenon by CBT therapists.

**What Is CBT?**

The field of the cognitive and behavioural therapies has expanded considerably in recent years and it has become increasingly difficult to make generalizations that would cover all its variations of theory and practice. CBT is increasingly an umbrella term for a range of approaches that share a concern with developing an empirically grounded approach to psychotherapy. In this chapter I will primarily be concerned with discussing what might be referred to as ‘Beckian’ CBT, that approach to CBT developed by Aaron Beck and his colleagues (Beck, 1976). This seems to me to be appropriate, given that Beckian CBT is likely the most widely practised form of CBT worldwide and also the version of CBT that has been the most productive in terms of research and theory development. Beckian CBT can, in some senses, be regarded as the ‘standard version’ or ‘mainstream CBT’. Perhaps the most important feature of CBT in regard to the present topic, and the feature that has led to the most criticism and challenge from therapists of other orientations, is the relative importance placed on the therapeutic relationship. In contrast to relationally oriented forms of psychotherapy that see the relationship between client and therapist as the primary, if not sole, driver of beneficial change, CBT practitioners regard a good therapeutic relationship as *necessary* but not
sufficient for beneficial change to occur. CBT has tended to place a strong emphasis on specific technical interventions and skills as the primary driver for therapeutic outcomes. The therapist in CBT explicitly takes up a role of collaborating with clients to identify new cognitive and behavioural skills that may be of benefit in addressing the difficulties the clients experience in their day to day lives. In contrast to approaches to psychotherapy that seek to create and subsequently manage a particular type of relationship, that for its effectiveness needs in some important senses to be seen as separate and different from the client’s everyday life (a container or vessel that needs to have strong boundaries to eliminate potential contaminants from the ‘outside world’), the CBT therapist’s focus is primarily upon what is happening ‘outside’ of sessions, in the client’s everyday world. In fact, CBT therapists will very frequently venture into the client’s world in a direct fashion, whereby therapy sessions (such as exposure work for phobias) may take place in the clients home, in a supermarket or in a crowded lift.

Therapy sessions in CBT are usually highly structured, with a clear agenda set at the beginning of sessions, and efforts made at the end of sessions to review what has been covered and to seek clear and direct feedback from clients regarding how the session was experienced. This emphasis on structured sessions and an active–directive stance of the therapist, has led some to criticize CBT therapists for apparently taking up an ‘expert position’, seeking to control clients and to teach them how to think or how to behave. In response, CBT therapists have argued that, in fact, what is sought is a highly collaborative relationship with clients where there are two experts present. The client is seen as an expert on his or her own experience, thinking and feelings, and the therapist is an expert in general patterns and strategies that have been found to be helpful. The task, as seen by CBT therapists, is to engage with the client in a joint effort to work on those areas of living identified by the client as problematic. CBT, on the whole, also tends towards a short- to medium-term intervention with sessions ranging anywhere between 6 and 24 sessions.

**Brief Encounters: Does Sexual Attraction Show Up in CBT?**

The previously mentioned, admittedly brief and incomplete, characterization of standard CBT serves to provide some context for understanding how sexual attraction may show up or, perhaps far more frequently, may not show up (explicitly) in CBT. It is possible that dilemmas around sexual attraction between therapist and client are far more likely to become
activated in therapies that are of a long-term duration and in which the therapist takes an explicitly relational focus. It is possible that the highly focused and structured nature of CBT functions to prevent sexual attraction from coming to the awareness of the therapist or the client, or, at most, serves to keep such phenomena safely in the background. It is possible but, I suspect, highly unlikely. Any consideration of one’s own experience of the vagaries of sexual attraction indicates that this can show up in a wide range of contexts and does not require a specific time context. Where would the field of romantic literature be without the concept of ‘Love at first sight’?

I am unaware of any research that reports on incidents of CBT therapists experiencing sexual attraction in therapy (either client attraction to therapist or therapist towards client) or data on how CBT therapists respond to and manage such experiences. Rodolfa et al. (1994), however, report on a survey of over 900 members of the American Psychological Association. While they obtained a typically low return rate of 43%, the findings are striking in that only 12% of respondents indicated that they had never experienced sexual attraction towards a client in therapy. These authors do not report on the theoretical orientation of the respondents; however, it is reasonable to suppose that at least some of these practising psychologists will have been working from a CBT orientation. If we assume that CBT therapists are as likely to encounter the phenomenon of sexual attraction in therapy as are other therapists, it is also reasonable to assume that this experience provokes for them the same anxieties and concerns as that which has been reported in the literature for practising therapists more generally (Pope, Sonne, & Holroyd, 1995).

The experience of anxiety (as well as a wide range of other emotions) is highly understandable when encountering phenomena of sexual attraction in therapy. There is now a very widely shared understanding among psychological therapists of all orientations that actual sexual contact between therapist and client is likely to be highly damaging to the client, is an abuse of the power relationship between therapist and client, and, in addition, is in direct violation of professional ethical codes. While CBT training in the United Kingdom will routinely cover the ethical dimension of practice, it would be unusual, in my experience, for the topic of sexual attraction in therapy to be delivered as part of formal lectures or workshops. The result, particularly for beginning CBT therapists, is likely to be the activation of anxiety when this phenomenon is encountered as it will be experienced as ‘This is not who and how I should be as a CBT therapist!’ A particularly useful concept in contemporary CBT is the notion of ‘thought–action fusion’ (Wells, 1995). This concept refers to
the beliefs clients (or therapists) may hold about the operation of their own minds. This can refer, for example, to beliefs such as ‘if I experience a thought, image or feeling, this must mean something about me, it means that I must want to do this thing and am in danger of doing so’. Such beliefs have been found to be particularly important in obsessional difficulties. While it will be understandable to experience a degree of anxiety in response to sexual attraction for a client (or being the recipient of sexual attraction from a client), this anxiety is likely to be that much stronger and distressing to the degree that the therapist’s reactions demonstrate thought–action fusion. Efforts to avoid or suppress thoughts have also been found to have a counterproductive effect in that this serves to increase the salience and frequency of the avoided thoughts (Wells, 1995). Of course, as will be discussed further, sexual attraction may not be reducible to thoughts.

It is likely to be beneficial for CBT therapists that the topic of sexual attraction is more frequently raised in training in order to support therapists to respond appropriately and effectively if and when this is encountered. In my view, a range of recent developments within CBT have extended the range and flexibility of this model and provide a framework that may allow for theoretical and research work to be conducted on this topic.

Developments in CBT: Integration and Expansion

As the theoretical and research base of CBT has continued to be developed, and as the approach has been extended to work with clients presenting with more complex and enduring difficulties (such as clients experiencing difficulties that result in them being diagnosed as having ‘personality disorders’), there has been significant reconsideration of some basic principles. Perhaps the most significant of these has been a deepened appreciation for the role of the therapeutic relationship and emotion.

While CBT has maintained its perspective on the therapeutic relationship as being necessary but not sufficient for beneficial change, the emerging research, from within CBT, has indicated that the therapeutic relationship holds far more variance in terms of outcome than had been appreciated (Waddington, 2002). Contemporary CBT can be seen to be moving beyond a somewhat ‘black and white’ approach that contrasts technique with relationship to a perspective that acknowledges that all technical interventions can also be seen as relational interventions. There is a recognition also that the appropriate application of CBT strategies can also help to support the development of optimally supportive (and
challenging) therapeutic relationships. Additionally, contemporary CBT has placed a greater emphasis on emotion in therapy such that the ‘cold and intellectual’ discussion of cognition is seen as insufficient and that, instead, the focus of work must be on ‘hot cognition’, that is, cognition that is closely tied to client emotion. A related development has been those efforts directed to integrating a more interpersonal perspective within CBT. Safran and Muran (2000), for example, have argued convincingly that the core beliefs and schemas highlighted by CBT as being implicated in forms of psychological suffering are inherently interpersonal and concern self–other relationships as much as self–self relationships. The purpose of this chapter is not to review these or a range of other equally relevant developments in depth. However, it does seem to me that theoretical and clinical developments that open the possibility for CBT therapists to consider the therapeutic relationship, emotion and interpersonal experience in more depth also open the way for a consideration of sexual attraction in therapy.

While current developments in CBT may potentially make room for thinking about the phenomena of sexual attraction in therapy, might it not also be that doing so in any depth may also provoke further challenges for CBT theory and practice? In my view, the development of a CBT perspective on sexual attraction in therapy challenges CBT to consider in greater depth its perspective on ‘embodiment’ and the relative emphasis it has placed on the ‘computer metaphor’.

**Computer Love**

A primary metaphor for CBT has been the ‘mind as computer’ as it has also been for cognitive science more broadly. Clark (1995), for example, asserts that a fundamental postulate of CBT is that all acts of perception, learning and knowing are the products of an active ‘information processing system’ that selectively attends to the environment, filters and then interprets the information impinging upon the organism. Such ‘processing’ of information is seen as evolutionally adaptive. In psychopathological conditions, aspects of the information processing system are seen as having become ‘distorted’, biased or maladaptive, leading to experiences of emotional, behavioural and relational distress. The role of the CBT therapist is seen as assisting the individual to clarify their current patterns of information processing and to modify this through a range of strategies that encourage individuals to take on a more ‘scientific’ stance towards their own experience. Clark further states that in CBT:
The therapist and patient collaborate to identify distorted cognitions, which are derived from maladaptive beliefs or assumptions. These cognitions and beliefs are subjected to logical analysis and empirical hypothesis testing which leads individuals to realign their thinking with reality (Clark, 1995, p. 155).

As Safran (1998) has noted, the mind-as-computer analogy has been a highly productive one in cognitive psychology; however, this should not detract from a consideration of the ways in which the mind, and interpersonal experience, is not computer-like. I would suggest that troubling or disturbing instances where a therapist encounters sexual attraction in therapy are likely to be one of those occasions where the person-as-information processing system is likely to be found seriously wanting (reports of individuals who appear to develop attachment relationships with their computer equipment and hand-held devices notwithstanding). Indeed, in situations such as this, and many others besides, the therapist is likely to be confronted with the irreducible embodied nature of human interpersonal existence. Consider the following.

Collaborative Colin (CC) has been working with an older female client on her long-term problems with recurrent depression. He has taken an evidence-based approach and emphasized behavioural activation as well as cognitive disputation strategies, all of this to good effect. The client, who has been single all her life, has responded well to the emphasis on increasing her socialization; however, this has also brought to the fore her long-term anxieties and disappointments about relationships with men. Colin has noted that, as therapy has progressed, her self-presentation has improved. He has noted her wearing perfume and has complemented her on her improved self-care. Towards the end of a particularly productive session she looks CC directly in the eye and states ‘I wish I could just take you home with me.’ This statement and the look in her eye have an immediate physical effect on him. It feels like her statement is a physical caressing of his face and he experiences himself as both attracted and repelled at the same instant and is unable to say anything. In response to the attraction he feels shock and disbelief, and to the repulsion he feels a sense of guilt and struggles not to express either emotion in his bodily gestures or gaze. He mutters something about the value of her learning to become her own therapist and the session ends.

While in the previous example there are clear indications of interpretative processes or cognitions, can the interaction or experiences described be reduced to the operations of information processing without something central being lost? Sitting with a client in CBT is not an experience of one
information processing system encountering another for the purpose of some form of reprogramming, it is rather an embodied experience of being in the presence of another. The embodied nature of the therapeutic encounter is primary; the statement ‘I wish I could just take you home with me’ may indeed be offered and experienced as a caress of the face.

It is possible that a CBT perspective on sexuality and sexual attraction in therapy could be advanced by considering an integration of insights and perspectives from a wide range of sources. Some mainstream CBT practitioners, for example, have asserted the need to develop cognitive models of transference and countertransference (Guidano, 1991). Others have drawn upon insights from attachment theory and evolutionary biology and neuroscience (Gilbert, 2010). In my view, an alternative source to both challenge and develop a CBT perspective is that of existential phenomenology, and it is to a consideration of this possibility that I will now turn.

**Existential Insight on Sexuality**

Why seek to draw upon the insights of existential–phenomenological thought to clarify and expand a CBT perspective? Why not draw instead upon psychoanalytic thought and practice or some other form of psychotherapeutic thinking? As Ottens and Hanna (1998) state, at first sight, existential thinking, and the existential versions of therapy inspired by such, seems at opposite ends of the therapeutic spectrum to the behavioural and cognitive psychotherapies. However, there are, in fact, many points of potential contact principally surrounding the focus on ‘meaning’ in understanding psychological distress; in fact, Clark, Beck, and Allford (1999) have suggested that CBT finds its most compatible philosophical base in the field of existential phenomenology. Thus, it seems entirely reasonable to consider what an existential–phenomenological perspective on sexuality might provide for CBT practitioners wishing to consider the phenomenon of sexual attraction in therapy.

The contribution of existential–phenomenological philosophy, and existential therapies derived from this, to CBT practitioners is, in my view, the foregrounding of the inevitable aspects of human existence itself, or the ‘givens’ of existence. This includes the inherently ‘interrelational’ basis of human existence (the centrality of context), the unavoidability and indeed centrality of anxiety for human existence and, as is most relevant for the present discussion, that human existence is always embodied and sexual (Cohn, 1997; Spinelli, 2001). Admittedly, existential therapists
themselves, such as Spinelli (2001), have noted that an existential perspec-
tive on sexuality has been curiously neglected (again perhaps due to a
sense that this field is somehow owned by psychoanalysis). Nevertheless,
a consideration of the work of one existential philosopher, Merleau-Ponty
(1982), seems to offer avenues for development. As Spinelli writes, in
taking a phenomenological approach to sexuality, Merleau-Ponty is setting
aside analyses that principally focus on issues of gender and socialization
as well as analyses that might focus on biological imperatives such as
developmental or evolutionary theory. The question for existential phe-
nomenology is ‘what is the essence of human sexuality?’ Merleau-Ponty’s
philosophy places particular emphasis on the embodied nature of human
existence. In this perspective, the body is not regarded as a ‘thing’ to which
a consciousness is somehow attached or which acts as the vehicle for an
encapsulated mind (or information processing system), but rather human
existence is irreducibly an ‘encarnated consciousness’. The body, for
Merleau-Ponty, is the configuration through which our dialogue with the
world is manifested. Sexuality, in turn, rather than being something that
can be reduced to the effects of physiological or biological drives, is inher-
ently ‘intersubjective’ in nature. As Spinelli writes:

How we are, sexually, and what we enact sexually, therefore become state-
ments not of reproductive drive but of our willingness, hesitation, delight
and anxiety to explore the ‘being-with’ of self and other (2001, p. 8).

From this perspective then, sexuality and embodiment are ‘givens’ of
human existence, an inevitable aspect of the context for human existence,
implicitly present, if not explicitly clarified, in all psychotherapeutic
encounters. Thus, ‘sexual attraction’, just as much as experiences of ‘sexual
repulsion’ or ‘sexual indifference’, can be understood as a relational
expression concerning, for example, ‘who one wishes to be’ in the world,
and who one believes ‘one cannot or should not be’ in relation to self and
other, topics discussed more fully in Chapters 3 and 5. How might such
an existential perspective on sexuality inform a CBT perspective on sexual
attraction in therapy?

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2 This in no way should be taken to mean that such considerations as gender and sociali-
ization should be considered of less importance for the present topic. The fact that the
overwhelming number of instances of actual sexual contact between a therapist and a
client occurs between a male therapist and a female client is sufficient justification for an
in-depth and critical look at this aspect.
‘Emotion Schemas’ and Responding Flexibly or Inflexibly to Sexual Attraction in Therapy

Earlier CBT models have stressed the experience of emotion as being primarily an outcome of cognitive processing. Emotion is thus seen as, in some sense, secondary to, and consequential to, interpretative processes. Contemporary cognitive models, such as the ‘metacognitive’ model of Wells (1995) and the ‘emotional schema’ model of Robert Leahy (2002), have sought to extend this perspective. Leahy’s model, for example, has sought to integrate insights from emotion-focused therapy (Greenberg & Paivio, 1997), which itself draws upon insights from existential philosophy as well as the humanistic models of Rogers and Fritz Perls. In this perspective, emotional experiencing and emotional processing in therapy is prioritized as it is argued that emotions are in themselves a form of information processing in which the experiencing of emotion allows an individual to access the meaning of events. Here, emotion is regarded as a ‘prime mover’ of cognition and not just a consequence of ‘cold cognition’. Leahy’s model attempts to integrate this insight into CBT and stresses various forms of cognitive and emotional processing, as well as behavioural coping styles, which come ‘online’ once an emotion becomes foreground for an individual. Emotions, including those centred on sexual attraction, thus become a ‘given’ of experience that an individual will subsequently process via ‘emotional schemas’ or beliefs, rules and action plans regarding what emotions may mean and how emotion should be responded to. Thus, once an individual experiences sexual attraction in a specific context, for example, they may then respond to this experience in accordance with a range of rules, beliefs and action tendencies. The model stresses both adaptive and maladaptive processes of emotional regulation and processing that may allow individuals either to experience their emotions as valuable, if at times distressing and disturbing, windows to insight about what is important, true or needing attention in their lives, versus anxiety- and distress-provoking experiences that are responded to with strategies of distraction, suppression and avoidance. How might such ‘emotion schemas’ and associated processes play out in instances of encountering sexual attraction in therapy? Let’s consider the following.

Rational Ray (RR) has been a CBT therapist for over 10 years and comes from an impeccable academic background. He prides himself on the technical proficiency of his work and is fully convinced that
therapeutic outcome is driven by the therapist’s adherence with specific intervention protocols and procedures. RR has been working with a young female client presenting with a blood injury phobia. She is a postgraduate physics student. Highly verbal and intelligent, she understood the CBT model and treatment plan very quickly and was highly motivated for treatment. RR found himself looking forward to the therapy sessions as a highlight of his working week. He felt more alert and awake in sessions with her and worked in a particularly focused way to help this ‘ideal client’ overcome this one area of difficulty in her life that seemed to be holding her back. He was vaguely aware that he gave additional attention to how he dressed on her therapy days and he always managed to find the time to prepare for her session. He found himself thinking about her between sessions but quickly dismissed these thoughts other than to note ‘ah yes . . . maybe we should try this new CBT strategy that I read about recently’. Therapy was very successful and the client left very happily. RR also felt very pleased and yet was aware of a sense of loss at the end of therapy and experienced a depressed mood for several weeks afterwards that he found difficult to conceptualize or communicate.

Perfectionistic Pat (PP) is a trainee CBT therapist. She loves CBT for its structure and evidence-based procedures and has worked incredibly hard in her training. She always prepares for therapy sessions and is also always well prepared for supervision, frequently bringing audio recordings of her client work for the supervisor to provide feedback on. She has been working with Bruce, a man in his mid-30s working in banking. He is a well-dressed, well-spoken and high-achieving individual with high expectations of CBT and his therapist to help him overcome a recently developed difficulty with social anxiety during work presentations. PP has received lots of positive feedback from her supervisor about the work that she has done with Bruce, and there has been significant progress. In a group supervision session PP states that she would like to bring back Bruce for discussion again and prefaces this with the statement ‘You know . . . my guy . . .’. The supervisor notes this statement, and then during a playback of the last session, the supervisor (male) asks PP about her personal response to Bruce. It seems clear to the supervisor that the interaction between the two had bordered on being flirtatious. Presented with this feedback, PP experiences embarrassment but, not wanting to seem an ‘avoidant’ supervisee, acknowledges that she does indeed find her client ‘a little’ attractive and was aware of trying really hard to be a perfect therapist for him. After this supervision session, PP ruminates a great deal about this. She is flooded with negative thoughts along the lines of ‘How
can I be attracted to my client? This is just awful. I must be some sort of immoral individual in danger of acting out’. Her work with Bruce becomes bogged down as she attempts to rigidly adhere to the protocol and gives little room to enquiring how Bruce is experiencing their work together. In subsequent supervision sessions, she avoids speaking about Bruce, is notably withdrawn and her performance in training seems to decline. The supervisor struggles to understand what may be happening to this previously bright and engaged student.

Undeniably Straight Stan (US) is a CBT therapist in a primary care setting. He enjoys CBT but prides himself on having something of an ‘integrative attitude’ and likes to feel that he is person-centred and offers an authentic relationship with his clients, even when doing technical work like exposure. He has been working with Joe, a gay man with a degree of obsessions and compulsions around sexual thoughts. Joe is a very athletic and handsome man who shares US’s interests in Rugby. US enjoys working with Joe and often feels that, had they met outside therapy, they could have been friends as they share many values and interests. During one session, where US had asked Joe to say out loud a range of sexual fantasies that Joe often responds to by forms of ‘neutralizing’ thoughts, US, to his surprise and alarm, finds himself becoming sexually aroused in a direct and undeniable fashion. US quickly brings the exposure work to a close, suggesting instead that Joe do this as a written assignment rather than live in the therapy. After this session, US goes home and has several glasses of beer and watches the Rugby but finds himself becoming irritated with his team’s performance. In subsequent sessions with Joe, he becomes far more directive and structured, and therapy is brought to something of an abrupt ending several sessions later.

Enlightened Arnold (EA) has been a CBT therapist for over 10 years working often with highly distressed individuals, many diagnosed as presenting with ‘personality disorders’. He feels himself to be ‘burnt out’ and is aware that his relationship with his partner has been suffering for several years and that they are disengaged from each other. He has struggled with his experience of burnout as he has always believed in the importance of providing therapy to this client group and he feels himself still committed to his high ethical standards. He has also over the last few months stopped doing many of the nonwork activities that he used to enjoy and has socialized less with friends. He has been working with Justine, a young woman with many features of borderline personality. She has been openly flirtatious with him in sessions and has sent provocative emails and text messages to him between sessions. He cannot now remember why he had thought her having access to his work mobile would be
appropriate. Despite his high ethical standards, he finds himself thinking of her between sessions and has even had several obviously erotic dreams about her. His daytime fantasies have sometimes featured this client and involve themes of ‘running away’ as well as ‘rescuing her from all this’. His is aware of finding her flirtatious remarks enjoyable, especially her remarks about him being a ‘special therapist’. EA starts to recognize that this situation is now complex and risky for himself and his client. He takes the step of speaking to a trusted female colleague who listens carefully but also strongly confronts him about his need for much closer supervision of this case (he had not brought the case for supervision for several months). He also takes the risk of talking with her about his sense of burnout and his concerns about his relationship with his partner. The conversation is anxiety provoking for EA and he asks his colleague to recommend him to an individual therapist as he thinks this might be helpful both professionally and personally.

The above-mentioned examples illustrate several of the processes highlighted in Leahy’s emotional schemas model. For example, RR demonstrates difficulties in ‘emotional comprehensibility’ whereby he shows deficits in an ability to recognize and make sense of his experience. This is also demonstrated with PP, who reacts to her experience with cognitions such as ‘I should not be feeling this way, my feelings don’t make sense’. PP also responds with processes of rumination that effectively block her ability to learn from her experience as well as cognitions that provoke guilt and shame responses that express the stance ‘This is not who I should be, who I am allowed to be’. The case of US can be seen to illustrate the dimension of ‘controllability’, which refers to the degree to which individuals experience their emotions as something that could potentially overwhelm them. UC experienced the novel experience of homosexual arousal both as a challenge to his self-concept and also as an experience that could be overwhelming and needed to be managed with avoidance, suppression and substance use to numb his experience. By contrast, in the last example of EA, the factor of ‘validation’ is evident, where the therapist has the expectation that ‘my emotional responses are understandable and will be received and understood by others’. This also illustrates the factors of ‘acceptance’ and ‘simplicity versus complexity’, whereby EA is able to both be open to his emotional experience of sexual attraction, rather than attempting to dismiss or ‘get rid’ of this, as well as a sense that there is a degree of complexity in his emotional response that requires reflection rather than impulsive action. Leahy also introduced into his model a concept derived from the existential model of Viktor Frankl, that of ‘higher values’. In Leahy’s model, this refers to the possibility that through
the clarification and validation of emotional experience, individuals are also able to clarify what for them are important life values. This could potentially be seen to be operative in the case of EA, where he is willing to take the anxiety-provoking step of disclosing his experience to a colleague and being willing to experience her challenge of him, a challenge that would result in him needing to take further steps to address avoided areas in his life, in the interest of him staying true to the high ethical principles that he has chosen for his work.

The cases of RR and US discussed earlier are ones that might never have been discussed or considered in supervision or in an alternative consultative process. In the case of RR, it might also be that the experience of sexual attraction, which remained always a background one, did not in any way impede the effectiveness of the CBT intervention. The other cases, with the exception of EA, illustrate varying degrees to which the therapists’ difficulties of ‘staying with’ and processing their experience, impacted upon the therapy in potentially unhelpful ways. Ideally, these would be experiences that the therapists concerned would feel able to bring to CBT supervision in the expectation that the supervisor, and the model itself, will have helpful things to say. Such explorations in supervision could include, for example, the clarification of how the experience of sexual attraction in therapy has confronted the therapist with ‘possibilities of being’ that are a challenge to the therapists’ currently maintained view of themselves and others or are expressions of ‘who and how I would like to be or be seen as being’. Contemporary third-wave approaches to CBT such as acceptance and commitment therapy (ACT) would also offer the therapists strategies of becoming mindfully aware of such experiences as well as being able to effectively ‘defuse’ from such thoughts and emotions in the service of staying committed to the values of providing safe and effective therapy for the client under challenging circumstances.

In order to promote this, in my view, there is more work to do in the field of CBT training and supervision research and theory development to support this. Potentially, this work will also further challenge and open up CBT to insights from sources outside of the current model.

**CBT Training, Supervision and the ‘Person of the Therapist’**

Over the last several years, there has been a rapid expansion of CBT training. At the same time, there has been recognition within the field that
there has been insufficient research and theory development in the areas of CBT training and supervision. What are the best training methods to develop effective and interpersonally skilled CBT therapists, and what supervision models and methods best support this development both for novice and experienced therapists?

A notable recent contribution towards developing a CBT perspective on how effective therapists develop has been Bennett-Levy’s ‘declarative–procedural–reflective’ model (Bennett-Levy & Thwaites, 2007). Consistent with other models of therapist development, this model has stressed the centrality of ‘reflection’ and the necessity of therapists being able to both be open to, mindful of and accepting of their own experience as a potential source of learning. This model also distinguishes between what are referred to as ‘declarative skills’, which are skills and knowledge related to theory and models and techniques that can be learnt from reading, books and research, and ‘procedural skills’ that refer to, often implicit, ‘when–then rules’ for how to apply knowledge and skills in practice. According to Bennett-Levy, the key process that allows for the transition of declarative knowledge to procedural skills is reflection.

An additional novel contribution of this model is the emphasis it places upon ‘the person of the therapist’. In this model, the training and supervision of CBT therapists also need to attend to the emotions, beliefs and ‘rules for living’ that are expressive of who the therapist is apart from their professional role. Bennett-Levy also argues that a key set of skills that has traditionally been ignored in CBT training is that of ‘interpersonal perceptual skills’. This again refers to the embodied presence of the therapist and his or her relative level of skill in being able to perceive and process, in a thoughtful manner, the embodied presence of the client and the impact that this has upon them as they are interacting.

In my view, this model opens up the possibility for CBT therapists to pay far greater attention to phenomena such as encountering sexual attraction in therapy than has previously been the case. This move towards a more interpersonally attuned and embodied understanding of therapeutic practice is also consistent with Bennett-Levy’s suggestions for far greater attention to be paid in the training of CBT therapists to processes that focus on the person of the therapist. Bennett-Levy has suggested a process of ‘self-practice/self-reflection’ that involves CBT therapists employing CBT strategies to explore, open up and challenge their own beliefs and experiences.
Clinical Strategies for the Management of Sexual Attraction in Therapy

Should CBT therapists, introduced at the very beginning of this paper, practise a form of self-practice/self-reflection on their briefly experienced encounter with attraction, they could potentially do the following:

1. Complete a self-monitoring record on the experience in which they clarify and describe the thoughts, feelings and behaviours that emerged in this incident.
2. Submit the various thoughts clarified, and possible implicit meanings within these, to various forms of reflection and questioning including, for example:
   i. What were the qualities expressed by the other in this encounter, and in this context, that were associated with the experience of attraction?
   ii. To what extent do these qualities express possibilities and challenges for me in terms of ‘who I would like to be/not be/should not be’ in the world?
   iii. What was my response, cognitively, emotionally and behaviourally to the experience of attraction? What did I ‘do with it’? Did I attempt to avoid, distract and get rid of this, or did I elaborate, ruminate or focus on this experience? What does my response to this experience express in terms of my beliefs of concerning what is allowable, proper, appropriate, irrelevant, and so on?
   iv. What might the possible effect of this experience be on how this relationship is experienced by the client as well as me? How might I respond in the way that both facilitates engagement with my client, client safety and my own consistency with my chosen values for my work as a therapist?
3. Consider discussing these reflections and challenges in clinical supervision in either a peer or consultative framework.

There are indeed a wide range of potential forms of reflection and challenge for therapists to consider that can support them in considering factors related to the context for this experience, factors related to their clients and factors related to themselves. Additionally, this opening up of CBT to consider the value of working on the ‘person of the therapist’ also makes some room for considering the possible value of personal therapy for CBT therapists.
Most definitely, this provides some support for CBT supervisors to pay increasing attention to supervisees’ relational experiences that emerge in the course of their practice. In the case of ‘perfectionistic Pam’ discussed earlier, we saw the possibility of the phenomenon of sexual attraction in therapy becoming clarified in supervision. Contemporary CBT approaches would recommend a form of ‘interpersonal formulation’ as an appropriate response, particularly in instances where some form of relational phenomenon is experienced as ‘blocking therapy’. For example, Leahy (2007) has suggested that such instances can be formulated in terms of therapist–client schematic matching and mismatching. In this example, it could potentially be the case that Pam and her client present with matching schemas around needing to appear ‘efficient, effective and hardworking’, and the experience of mutual attraction can be contextualized and understood in this light. Unfortunately, the understandable responses of guilt, shame and embarrassment, combined with processes of worry and rumination and avoidance, shut down the possibility of further exploration. In my view, such a shutting down of exploration would become less likely should CBT practitioners continue in the project of advancing the model towards a more relational perspective, even if such an exploration may provoke uncomfortable experiences of anxiety expressing the dilemma ‘Is this who and how we should be as CBT therapists?’.

In sessions on ‘Ethics in CBT’, I sometimes ask trainees to imagine that CBT was a person. What sort of person would they be? What values and virtues would they embody? This generally leads to much laughter and some ‘venting’ of current frustrations regarding their relationship with CBT. Words such as ‘cold’, ‘rational’, ‘structured’ feature strongly as well as words such as ‘committed’, ‘scientific’ and ‘collaborative’. I usually end this exercise by asking them that if they indeed met such a person as CBT, would they care to go out on a date with him (CBT is usually but not invariably imagined as male)? Mostly, our man CBT ends the session without a date. To be fair, the same question asked regarding all the other known forms of psychotherapy also leads to a dearth of date possibilities as each is found to be an unstable and unsuitable character. The characteristics attributed to CBT would be understood by the philosopher Friedrich Nietzsche as expressions of the ‘Apollonian’ character type (Nietzsche, 1993). This he contrasted with the ‘Dionysian’ character that embodies such qualities as ‘spontaneity’, ‘chaos’ and ‘passion’. Potentially, the move towards some of the so-called third-wave CBT approaches such as ACT opens the model towards a more Dionysian perspective. CBT is unlikely to lose its Apollonian values or character; however, finding a place to reflect upon and to work with
the Dionysian aspects of existence appears as a potentially enriching, if challenging, path for CBT to take.

References


