Erotic Transference & The Spectrum of Interaction

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Current work in neuropsychology, infant development, and psychoanalysis has directed our thinking away from dichotomous classifications and toward a more fluid, process-oriented understanding of experience. Interaction, too, is best understood as a continuum.

Interaction is a dimension of every human (Katz, 1998) and a core dynamic of the therapeutic encounter. The therapist's ability to make use of interaction is an essential aspect of any treatment. Thinking within a continuum makes it easier to organize, identify and address the interactive opportunities that emerge in the therapeutic process. In addition, this approach facilitates curiosity and guides exploration, encouraging therapists to avoid premature closure.

Our thinking about the Spectrum of Interaction emerged from our reluctance to divide the intrapsychic and interpersonal aspects of therapeutic work into two separate areas of focus.

We believe that the interpersonal dimension of experience is balanced by, and inextricably intertwined with an intrapsychic dimension. These components continuously influence each other, informing and shaping experience. Metaphorically, we can think of the intrapsychic and interpersonal dimensions as the double helix of experience: they exist separately, but they twine around each other, held together always by bio/psycho/social bonds. Both are necessary and essential aspects of therapeutic work.

What makes an interaction therapeutic is the analytic attitude which guides the therapist's involvement in the interaction. An analytic attitude is one that responds to the patient with respectful, exploratory curiosity rather than with conventional reactions. The therapist must be able to toggle between *experiencing* the process, and *thinking about* that process. The Spectrum of Interaction is an organizing schema that facilitates the ***thinking*** part of this oscillation.

Not every interaction is advantageously treated as the center of therapeutic exploration. At times, the primary need is to help the *patient* to reflect and to facilitate the emergence of unconscious material. At other times, when intense feelings in *the therapist* threaten to interfere with the focus on the patient, it is the *therapist* who must self-reflect and attend to his or her own countertransferential impulses. Assessment of the relative strength of intrapsychic and interpersonal activity is crucial to understanding the therapeutic process and determining why, when, where, and how to intervene. This approach is especially useful when confronting erotic transference phenomena.

In our model, then, therapeutic interaction is organized as a spectrum -- a series of bands of distinguishable, yet overlapping, interactive possibilities. The points on the continuum that we will identify are: acting out, transference actualization, enactment, countertransference actualization, and boundary violation.

All experience contains both interpersonal and intrapsychic components which the mind looks to integrate. Notice that there are no clear boundaries between the interactions on the spectrum. We suggest that interactions on either end of the spectrum often (but not always!) profit from an intrapsychic focus – one that opens up wishes, fears, conflicts, and fantasies, while enactments are often (but not always!) best understood through an interpersonal process.

We will illustrate our use of this spectrum with reference to clinical manifestations of erotic transference. In reality, of course, these "bands" of interaction overlap. For heuristic purposes, however, we will separate the bands of interaction to examine them.

Acting out

In his study of Dora, Freud (1905) suggests that the term "acting out" places the behavior in the external world, beyond the awareness and influence of the therapist. Acting out is action outside the treatment situation that relates to what is going on in the treatment. Acting out is ***action*** focused and motivated by an unconscious wish.

Acting out, when it occurs in treatment, replaces verbal communication. Failure to explore the resistance function of acting out can imperil the entire analysis. On the other hand, the exploration of acting out can in some cases rescue a mired analysis.

In the first episode of "In Treatment," Na'ama goes to the pub, drinks too much and becomes involved with a young man. She goes to the unisex bathroom and he follows, with the intention of having sex.

This is an acting out of the erotic transference, in that the patient's effort is to gratify a wish by an action outside the treatment and the therapist's awareness.

Transference Actualization

Transference actualization is the gratification *within the therapeutic process* of the *patient's* transference wish or need. As the transference unfolds, the efforts of the patient are aimed at inducing the therapist to act in ways that tacitly gratify -- or, conversely, defend against -- such a wish. Transference actualization is more *process focused*, unlike acting out which is generally more *action oriented*. During transference actualizations, the patient has the conscious perception of gratification although not a full understanding of the unconscious wish.

In this morning's preview, Na'ama declares her love for Reuven, disclosing that she has been seeing him in treatment in order to satisfy her desire to feel love. This action is a transference actualization, the gratification within the therapeutic process of a wish or need tied to transference activity.

Enactment

The middle range in the spectrum is occupied by the diverse set of phenomena that today are subsumed under the term *enactment*. In enactments, *both* parties are invested in realizing an emotionally rewarding aspect of their involvement with each other. Therapist and patient alike express their often-archaic fantasies, wishes, and needs through actions that aim to achieve gratification. These actions both *conceal* and *reveal* the unconscious dynamics of their relationship. These interactions are forms of

resistance to the process, but they can also expose neglected aspects of self.

Enactments may be verbal or nonverbal. Either way, they are an effort to persuade which may border on coercion. In essence, one party to the therapeutic contract makes an offer that the other can't refuse. In the asymmetric therapeutic situation, the active persuader is usually identified as the patient, and the therapist is the one who complies. But not always. The *therapist* may be very invested in enacting with the patient his or her own core dynamics.

After describing her sexual encounter, Na'ama feels sick and goes to the bathroom -- the therapist's unisex bathroom, in that all patients can use it. Reuven eventually gets up and follows her. He stops short of the door, asks if she is all right, and then makes her a cup of tea.

A caring action, perhaps, but with Levenson, it leaves us wondering: "What is going on around here?" In the course of an enactment, the therapist usually remains unaware of his or her participation, or dismisses its importance. Only after the fact (Renik, 1993) does the therapist realize that he or she has moved away from the therapeutic attitude and strayed into nontherapeutic behavior.

Enactments alert the therapist to something going on in the therapeutic dyad that is not yet sufficiently understood. Their clinical value lies not in the experiences themselves. Chused (1991, p. 617) notes that understanding the meaning of the fantasy, memory, or impulse that is being enacted may lead to an emotional connection that can enrich the process. Realizing one's one role in the process is essential to understanding the broader ramifications of the enactment and can alert the therapist to the multiple functions that enactments may serve.

Countertransference Actualization

Countertransference actualization is the counterpart of transference actualization but on the *therapist's* end of the spectrum. Countertransference actualization occurs when the *therapist* seeks gratification or realization of a wish or need that is tied to his or her own transference process. Disturbances stemming from the *therapist's* countertransference are the driving force _and it is *the therapist* who is invested in substituting gratification for exploration.

Countertransference actualizations rupture the analytic attitude, and make it difficult for the therapist to keep the frame intact. This is especially problematic in *erotic* countertransference actualizations.

For example, we may conjecture that Na'ama's acting out and her revelation were shaped and subtly reinforced by an intense erotic need in Reuven. He may have been seducing her. He may have felt – and indeed, he later acknowledges this to his consultant -- that this was his last chance to "sail…." Although this wish is presented as a conscious desire in the supervisory scene, it might have existed as a powerful organizing erotic wish throughout the therapy as well. A wish like this is more likely to interfere with the process than to facilitate it – the beginning the "slippery slope." If so, it might have stimulated Na'ama's acting out.

In countertransference actualization, the ***therapist's*** attempt to gratify erotic needs or wishes dominates the dynamics and interferes with treatment. As in *transference* actualizations initiated by the patient, countertransference actualizations are generally best scrutinized from an intrapsychic perspective; in this case the therapist must come to terms with his or her own lapses so that a return to the analytic attitude can take place.

Boundary Violation

With boundary violation, the danger of the slippery slope is ever present. Once started down this path, a destructive momentum can build that is difficult to halt. The slippery slope may include much more than sexual offences. Any transgression by the therapist for the pursuit of personal gratification in the emotional, financial, professional or social spheres that derails the analysis to obtain sex, influence, information, money, personal affirmation, etc. involves boundary violation. Gabbard and Lester have shown that boundary violations articulate the collapse of the inner and outer boundaries that secure therapeutic trust.

The maintenance of the frame and analytic attitude is always the therapist's responsibility.

Let's take a look at a boundary violation clip from a later scene in Na'ama's treatment.

[RUN CLIP]

Conclusion

In this presentation we have placed erotic transference in the Spectrum of Interaction. Thinking about interaction on the continuum we developed provides the clinician with an organizing tool that helps to identify and guide intervention strategies. The spectrum of interaction is essentially a road map of possibilities which we consider as we explore the subtle and pervasive between patient and therapist. Object relations, intersubjective, interpersonal, relational, and contemporary Freudian traditions have all made major contributions in expanding our theoretical understanding of interaction. Building integrated understanding helps us to better organize, examine and develop the our work in the therapeutic process.