

The Spectrum(s) of the Erotic Transference:

Wrestling with Ambivalence

Wrestling with Erotic Transference requires us to work with a degree of unavoidable ambiguity and confusion. This ambiguity reflects the fabric of the phenomena itself which includes a wide spectrum of analytically inferred as well as observable behaviors and feelings organized at various levels of integration ranging from well organized, interpersonal/object- related loving and sexual feelings to experiences which are poorly understood and articulated-the oceanic, pre-symbolic- concomitant with distressful emotions with an inchoate pull toward the analyst and fears of the loss of self. We need to ask ourselves if we are talking about fully formed but repressed infantile sexual feelings (Freud), unformulated and bodily based tensions (Sullivan), symbiotic/hypnotic states, obsessions, infatuations, yearnings, etc. Indeed to call them erotic may be a projection of the analyst in an effort impose a certain level of organization that is premature. As Edgar Levenson warns that we must be careful of imposing meanings on the material. As with most of our concepts, it is hard to talk about this one outside the context of a specific clinical data from an analytic dyad. As Rapaport (in Gill, 1967) cautions, “there is a temptation to mix up terms denoting *empirical observations* with those denoting *theoretical constructs*... Transference and resistance are not empirical observations...they are concepts, which *condense* (emphasis mine) a set of dynamic variations of phenomena into a theoretical construction” (p.202). Thus to heed Rapaport’s advice, we need to unpack these constructs and explore the questionable assumptions of the Erotic Transference, forcing us to a more detailed inquiry as to “What kind of erotic transference?”

The erotic transference is often and incorrectly equated to the manifest presence of sexual feelings and more importantly is viewed in a one-dimensional perspective. I suggest that the transference should be considered in its complexity as a *mélange* of thought, feelings, including often contradictory or ambivalent dynamics as best summarized by Loewald p.264 ; “... neither love nor hate can ever be unambivalent. (and) that inherent ambivalence pervades all relationships... in the struggle between individual existence vs. narcissistic union.” This ambivalence is born out of a dual relationship with the parental figure; “... a positive libidinal and a negative dread of regressing to unstructured state of identity with mom). This is echoed in Ferenczi who informs “...*there lies hidden an ardent desire to get rid of this oppressive love. If we can help the child, the patient ...to ward off the over-burdening transference, then we may be said to have reached the goal of raising the personality to a higher level* p.203

What is often referred to as Erotic Transference may be thus too restrictive if it doesn’t include the full range of conflicts as cited above and we must be on guard from de-coupling of one set of affects from the matrix.. I am aware my approach may be model driven by my tradition which includes safety and security as essential determinants of behavior in that we need to not limit the analytic inquiry to the incestuous wishes or the sexual feelings but to continue to look **beyond** and **beneath** the manifest and immediate emotions. Furthermore, as most of us know, erotic/sexual themes may be the easier issues to tackle compared to other attachment fantasies and wishes. The overarching mandate of the questions raised in this conference can be summarized by the mandate as to how best do we guard against the patient becoming a narcissistic object for the analyst-with the erotic as simply the most extreme form. When the analyst loses attunement or becomes disinterested in both sides of the ambivalence, trouble may begin.

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An important spectrum of the erotic transference would be a temporal dimension characterized by ET reactions that occur very quickly in the course of treatment. This early appearance ET would be suggestive of diagnostic issues (such as hypomania of the psychoses, trauma, obsessional patients prone to early infatuation etc.) and less related to the analysts' participation, reminding us of Freud's earlier conceptualization of ET in which we must treat it as unreal "*...not a single new feature arising from the present situation, but is entirely composed of repetitions*". (P.167) Working with these reactions seems easier for the analysts in that our roles would be clearly defined to intervene in thoughtful ways to set limits and reassure the patient.

The more complicated ET would be those that develop over time as they would be more object-related affects which include a range of strong affectionate and sexual feelings or fantasies developing out of a maturing relationship specific to the analyst. These might be in Loewald's terminology, occurring at higher levels of modulation or integration. We might find admixtures of repetitions along very new and unique manners of relatedness with the analyst, a type of hybrid relatedness- part transference and part real.

I would also suggest an intrapsychic spectrum as well in which the therapist should be sensitive to the patient's degree of awareness of the range of transference reactions (including the ambivalence) as well as the degree to which the patient can put these feelings to words and actually talk about them. There is also, in my experience, a paradoxical effect in that talking about the erotic transference per se may create distress rather than any benefit (reminding us of the unanalyzed positive transference). I could offer the provocative statement that it may be quite therapeutic to not talk about ET at times in the analysis.

Inflaming the Erotic Transference

It is obvious that our approach to working with transference love is related to our mode of therapeutic action. This raises the difficult question as to whether or not our style may lend itself unwittingly to fueling (or discouraging) the ET. As first cautioned by Freud, we "*...must not suppress nor gratify the patients erotic feelings...the analyst must take care not to steer away from the transference-love, or to repulse it or to make it distasteful to the patient.*" (p.166)

This issue was beautifully reviewed by Clara Thompson in her sensitive but critical commentary of her own analysis with Ferenczi as she challenges his creative notion of mutuality. What I find poignant about her review is that it is probably one of the first balanced critiques written in the history of psychoanalysis. Prior ones often serve to de-legitimize the other. Though Ferenczi emphasized that the analytic situation is a real human interaction and that we must give the patient love, Thompson challenges, p.80. "*And, I think he harbored confusion as to what was meant by giving the patient the love he needs....he sometimes mistook the love demanded for the love needed....(not the love missed from parents).*" (I would add here that he failed to differentiate the patient's consciously expressed needs vs. their unconscious ones). Thompson's most cogent point is that the patient is "*...no longer in a condition to receive it.....*" Thus, though Ferenczi was correct in thinking that the patient needs love, he failed to take sufficiently into consideration the complications in the neurotic character structure which prevent the patient's making use of love when it is available. For me the genius of her commentary from fifty years ago underscores the problems appearing today between character defenses and therapists who advance the case of mutuality.

Similar difficulties may arise with approaches that encourage an overly empathic approach or efforts to promote idealization (a close cousin of Eros). For example Kohut (1971), (1985) argued that idealizations are necessary and an essential part of the treatment. These idealizations he asserts revive developmentally arrested needs of the patient and, therefore, should be allowed to unfold in the

treatment without interpretations. (This is contrasted to Kernberg (1975), (1976) and others who maintain that idealization is in the service of defense of aggression towards the analyst.) The technical implication of this approach is that idealizations are not to be analyzed. Not only are the idealizations left un-interpreted, but some self psychologists (e.g. White and Weiner, 1986) suggest reinforcing the idealization. (Self psychologists further argue that early interpretations of idealizing material reflect a countertransference problem of the inability of the therapist to accept the idealization.)

Assuming that all idealizations should be left untouched can be quite limiting and, as Sullivan (1965) proposed, allowing idealization of the analysts can be too costly to the patient's self appraisal. I recall one patient, a middle aged woman with severe depression and bulimia reported that she was praising me to her friend. The last time I heard her reports of praise was when she was describing an alcoholic, ex-convict boyfriend and before that, in her references to a small town faith healer who promised to cure her of her weight problem. If I were to accept and even reinforce her praises I would be perpetuating a fraud and promoting an illusion. Rather than say nothing I inquired as to what it meant. She quickly responded that, "*if you are perfect, then when I'm with you I can feel that and feel better*

"And when you're not here?" I asked

"*I then feel like a smelly rotten blob just a large mass.*"

Failure to be curious with her about idealizing statements, however, may lead to a sham analysis in which split off aspects of the patient's self remain outside the discourse of treatment. Many interminable analyses may be a by-product of unanalyzed erotic transferences resulting in pseudo-mutual alliance with patient.

Freud considered success at love as well as work to be indicators of mental health. I suggest we also apply this two-fold criterion to therapy. Perhaps there developed a confusion of tongues when therapy is mistakenly thought to be exclusively in the service of simply repairing affairs of love and attachment rather than including the analysis of the patient's adaptation to the milieu- how they characterologically relate to their family, their careers, their bodies, etc. Therapy as "work" implies the patient participates with some degree of commitment to struggle beyond just sharing feelings or assuming a passive-receptive stance with the therapist.

CASE: Working with Eros: Making it safe for the Emergence of Transference

The patient is a 40 year old Catholic woman from the Midwest. She has never been married but is desperately seeking a husband. She is a very bright executive and very psychologically curious. Her father deteriorated emotionally as she entered adolescence and he was repeatedly hospitalized for chronic depression. Her mother was described as somewhat stern but emotionally available when the patient was in crisis with peer relationships during her school years. The patient would rarely talk about her father and dreads speaking to him. She admits that she rarely even thinks about him. If I did not occasionally make note of her lack of material about him it is possible the treatment would have gone on without any mention. My initial thought about her relationships with men is that she quite early in life learned not to expect much from them. Men, like her father, would sooner or later become disappointments. I had seen her three times per week for three years at the time of this session. Two efforts to use the couch, once in the beginning of treatment and another time a year later, led to acute distress after a few sessions. We agreed to have her sit up. (By the way, I have found over the years a familiar pattern that patients with parental loss frequently do quite well in treatment but find the couch to distracting or distressful to be useful)

At the beginning of the session she had mentioned that her friend had asked her if she ever had sexual feelings toward her therapist. The patient then raises her hands as if to ward off an attack and averted her eyes saying "*I don't want to have those feelings, don't want to go there*".

Several questions cross my mind: Does one hear her comments as a simple denial or a seduction to

draw in the analyst.? Is my goal to help “go there” to facilitate the uncovering of her suppression or repression by alleviating her fear or should I simply help her feel safe and have her experience me as more interested in her security than her exposure or her confessions? If I do not address her reaction would she think I was afraid or unsure? If I did address it would she experience me as intrusive? I hear that she, at one level, has some awareness but feels that she cannot let herself “know that she knows”. I could ask her directly “How do you know what is it you don’t want to know?.” but for me at that time I wanted to let her know that I was interested in her distress and not in the hidden affect. Thus with a collaborative inquiry I wondered out loud with her and said, “You appear distressed about this, what would be most helpful to you? “. My focus here is not on the content or the anxiety- laden affect but rather on letting her know she could think about what to do next. She could join me at whatever level felt comfortable thereby making her a participant and helping me figure out what was next rather than I having to assume the role of analyst who would know what would be the next best thing for her. She continued on the topic and replied that if she had sexual feelings it would be too painful if the feelings were not reciprocated- she would feel too vulnerable and it would be too disruptive.

She continued. “*Well, I am not repulsed by you*” and then caught herself and started laughing at what she just said and declared “*I don’t mean it that way.*” Which triggers a laugh in me. She continues, “*I just need to keep you the right distance...or struggle over confusing the relationship and the limits of it..wouldn’t want to lose myself completely... need to protect myself.* “

Inviting her to speak more about it she continues, “I can’t imagine if I were sexually attracted to you...it would feel overwhelmed.... I don’t know, **it would be a distraction from the feelings I have**...it could jeopardize or make more confusing....(I inquire, “ In what way?”) “ I just can’t imagine”

There is an analytic paradigm that suggests that it would be helpful if she could become more fully conscious of her sexual feelings and perhaps play with a sexual fantasy free of distress and fears of regression. On the other hand in reviewing my patients’ treatment over the last twenty- five years and taking an informal survey of several female colleagues of various Institutes, they have reported that conscious sexual feelings (one component of the “Erotic Transference”) was not really a significant role in their treatment with male analysts. My decision thus was to simply maintain a curiosity about her felt experience and not “go there”. In other words the analytic tendency and pull toward privileging the latent / erotic material could inadvertently diminish the patient’s current experience. I could imagine if I said to her, “You have alluded to the lack of awareness to sexual feelings but are distressed, what holds you back from feeling them? Or I could say, “The intensity of your fears suggests that you have intense sexual feelings”. Both of these statements would not be respectful of her struggle to secure her boundaries and feel safe. She might experience me as uninterested in her as a person in real time but more interested in her in theoretical time/space. If we review the session we can catalogue her consciously felt emotions by listing her exact words: “repulsion”, “confusion”, “loss of oneself”, “overwhelmed” By expanding our lens from simply focusing on the sexual we were able to help her express an array of her distressful feelings as well which seems to have helped her modulate her affect and help her feel more secure.

During the following week she brought in the following dream:

DREAM

“ I was walking down Broadway, had an appointment with you at 10 PM. Went in the store to buy you some dark chocolate. I picked up the package and saw it was nine dollars. As I examined the chocolate I saw it were just some dark cocktail napkins. as I was examining them they became a package of chocolate colored napkins.

What comes to mind?

“Well 10 o’clock is a little late for a session it is more like a date “(I see her 3x/wk- at 10:30 AM; 4 PM; and 4:30 PM)

She puzzled about why the chocolates became napkins. Rather than interpret I wondered out loud with her about how puzzling that imagery was and asked her if she had some thoughts about why it changed. She was stumped. My message to her was that I didn’t know either. I try to communicate to her that I was interested in how her mind would tackle this puzzle rather than exclusively focusing on her connecting the dots to simply be aware of sexual feelings. I observed to her, *“that it is curious having the number nine and ten but what stood out for me was that things turn out differently than they appear in the dream, how frustrating that was”*

She then associates- “I wondered as to whether if we would be friends if I knew you outside of here. or would we ever date...how safe is this relationship?”

In reviewing the dream the second time, and it is quite fascinating to have the patient retell a dream since invariably new imagery and associations are produced. She said *“well napkins are associated with cocktail napkins; maybe I just wanted to have a drink with you”*

This I heard as a shift from the anxiety of being overwhelmed by sexual feelings to more moderate feelings of friendship that she could put to words for the first time. We see the associations to a realm of possibilities- friends or dating. Still not quite sure of the limits but she was allowing herself to experiment with some ideas that were previously traumatogenic.

She continued “ I met someone on the way walking down Broadway, I was disappointed, I wanted to give you chocolates- I had gone out of my way to get you the chocolates”

In the second telling of the dream the word “disappointed” stood out and a much more clear negative feeling emerged in her declaring *“I had gone out of my way”*

I inquired: *“Maybe this would be a good time to talk about disappointments?”*

She replied, “I don’t like going out that late (10 PM) maybe I was worried I would disappoint you when the chocolate turned to napkins”

I think this may be the point of countertransference vulnerability since if I needed to stay focused on the positive, the eroticized, the exciting aspects of her feelings I may have run the risk of not inquiring about the negative-the disappointments. What originally appeared in the manifest as a struggle with anxiety ridden sexual feelings begins to develop into a wonderfully more elaborate and complicated experience allowing a new range of possible relations with me, real or imaged. We see evidence of movement and mastery as she approaches that which was initially quite scary. For me the guiding principal technique was detailed listening and the method of inquiry. Inquiry is not the same as asking questions for an inquiry has to track the patients affect quite closely rather than a question that might originate from the analyst’s favorite theme. The method is in the service of helping the patient elaborate what is being said and may be seen as a bridging technique, compatible with several models of analysis. It keeps the analysis open to discovery beyond our theories:

*A patient tells me the obvious and I wonder what he means, and ask further questions. ...he begins to see ...that statements which seem obvious to him may be remarkably uncommunicative to the other person. (and worse than that)... they may permit the inexperienced (therapist) to assume that he knows something that is not the case. ..(only to later realize) that he has been **galloping off on a little path of private fantasy** (Sullivan (p.8)*