

RESPONDING TO THE EROTIC TRANSFERENCE

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Much can be said about Ruven Dagan's ways of responding to his patient's erotic pressures and the different contexts they come from. I articulated some thoughts on this for today, but given the short time I have, I decided to leave the commentary on Ruven's dilemmas and his way of working, and talk from my own experience.

I share the view, gaining ascendance today, that the erotic transference can be a bid and an opportunity for growth and self-enhancement, that when well attended to, it offers a transitional space to experiment with one's love and sexuality. I consequently share the view that the erotic countertransference is one of the crucial tools to work with. What the analyst gleans and feels from the ways she emotionally and sometimes physiologically responds to the patient's erotic transference is an important part of the work.

A nice visual representation for such a good state of affairs came from a patient whose erotic transference together with my resonating

countertransference I was able to handle in a free and playful way (unlike the case I will present soon). This patient dreamt that I was holding him by the very bottom of his body, that is, the small (relatively “calm”) area between his anus and his penis. My physical holding of him felt loving, energizing, but not disturbingly exciting. We felt that it stood for a sexual-nonsexual holding and loving that represented making peace with relentless sexual tensions yet did not renounce them; the physical meanings and body connection with me were sustained.

We have made much progress since the days of total analytic restraint. Classical psychoanalysis posited an idealized process of renunciation of infantile strivings toward unavailable oedipal objects. Since then we have seen more complex ways to deal with renunciation, prohibition, and the impossible, although the pain involved in these experiences should not be minimized. To put it somewhat simplistically, I would say that we added to a discourse of **renunciation** the discourse of **mourning**. We supplemented the ideal of giving up infantile wishes with the mourning of impossible loves. Still, it is interesting to note that the classical model is vexed by the contrast between *inviting the patient to feel and say “everything,”* and the *lack of ways to conceptualize the mutual impact of the subjectivities* of both patient and analyst. This leads to a situation in which

the analyst's sexual subjectivity that ought to be part of the analytic process – even if it is not explicitly disclosed to the patient – falls away, and some difficult moments in analyses conducted in the classical spirit are created.

This difficulty, the difficulty that comes with the analyst's restraint, the other side of the analyst's sexual acting out, leads me to the story of an analysis, undertaken when I was a very young therapist. Many years ago, a patient came to therapy because of difficulties in concentrating in his academic work as well as difficulties in his love life. In relations with women, he invariably rejected the woman when she was interested in him but pursued women who rejected him. His mother had an incestuous affair with him throughout his childhood. Inviting him to “suck” at her breasts until he was 11, was just one aspect of it. His father, an eminent scientist, was described as quite benign but aloof and removed. My patient had been a moody, unhappy, whining child who used to throw tantrums and gyrate into frequent crying spells. Later he became an unusually cultured schizoid man, who seemed to regulate his depressive and narcissistic vulnerabilities through his wide-ranging intellectual and aesthetic interests.

The power of the nonverbal communication that immediately established itself between us became clear to me when, in our first session, I had vivid visual images of him, such as a plant in pot hanging in mid-air, with no soil. Soon the patient developed an idealizing and sexualized transference toward me. I reverberated to his feelings inwardly, physically and emotionally. I sensed a deep affinity between us in terms of ideals, preferences, and emotional sensibilities. Being a very young therapist, and having been trained in a classical framework, I adopted an analytic restraint, which I felt was required in this case, with its mutual emotional intensities, even more than usual. At the same time I was partially aware that my careful stance was guarded and withholding. But I did not fully realize then that my “brave” abstinence could be experienced as taunting and tantalizing, that the classical analyst’s enigmaticity and her distance may paradoxically increase her enthralling qualities. The more restrained I was, the more provocative, intrusive and aggressive he became. Thinking back on this case (as I have done so many times), it seems to me that, knowing myself, there was no way I could be wholly withdrawn, and I assume he sensed it, even if unconsciously, and this stimulated him all the more to “get to my

core,” or to “subvert my hermeticism,” accusing me of being cold and unfeeling. On a deeper level, there was the sense that he tried to invade me, colonize my psychebody, and destroy me. This was represented by another disturbing image I had when he came, that of him being lodged in my body with only his head popping out of my mouth.

My patient focused all his energies on my person, and his unsatisfied desire, his excited, frustrated efforts to get into me, and his depressive anger grew from day to day. As his condition worsened so did my anxiety, guilt, and excitement.

My attempts to interpret the patient’s intense feelings toward me as a repetition in the transference of his excitement and his megalomaniac sense of possibility offered by his mother’s incestuous seductiveness were of no use and angered him further. I strongly felt I needed to deal differently with the perspective that recommended past-oriented, transference-interpretations. Such past-oriented perspective needed, my intuition told me, to be “**pulled**” **toward the present**, toward something that needed understanding and repair **between us**. But in those days – I’m talking about the early 80s – and even today in some quarters, there was no path where this could be done directly. Even in less charged

areas there was no ready discourse about what is happening in the here and now between patient and analyst. I felt my patient should be empathized with, and his feelings toward me should obtain recognition as to their positive, growth-enhancing and self-stabilizing value, not just their incestuous, resistive, or even wish-fulfilling aspects. After all, my patient was a schizoid, withdrawn man, who had difficulties with intimacy and emotional relating. I then proceeded to interpret to him his longings and idealization of me as a developmental need and as a manifestation of his courage and ability to love, given his animosity and wariness of women. I tried to convey to him my empathic resonance with his experience. I would find words to portray the nuances of his experiences and to affirm them, and him. But I still could not encompass the fact that his experience was poignantly and most personally directed at me, *even if* it echoed past experiences with internal objects and with living women. At that time, I could not make use of my sexual feelings toward him, as I learnt to do later. My patient kept insisting on my returning his love and threatened to commit suicide if I did not respond in kind to his feelings.

I began seeking consultation with one supervisor, and then with another. I chose first the most conservative, patriarchal training analyst around. This person tried to help me basically by indicating how sick my patient was, diagnosing the patient's transference as psychotic, quoting Rapoport's ancient 1956 paper to that effect. But other than a diagnosis, I did not feel helped. I then went to another supervisor, who was in many ways the opposite of the first. This analyst was a maverick and the *enfant terrible* of the Institute. With this supervisor, I felt safe enough to talk about my feelings for my patient. The supervisor told me some useful things, and even tried to help me concretely by warning me that the kind of person this patient was would make me unhappy should I contemplate being with him In my desperation to get help I consulted with my fellow-"candidates," but to no avail. Everything I heard seemed either wrong or ineffective at that point.

The situation got worse for various reasons, some of them having to do with the patient's past experience and trauma, but also with my own (countertransference) feelings toward him. His powerful seductive ploys, acquired through a long training with his incestuous mother, what he represented in my inner world, and some objective factors, such as taste,

looks, age, and so on, and, all compounded matters, I was at a point in my life where radical changes (in great part promoted by my own analysis) swept me into a tumultuous time. Furthermore, the very changes I was undergoing now created for me the freedom to embrace the very things that he and I felt passionate about. The thought that returning his love would bring us both happiness passed through my mind more than once. At the same time, I knew I would never be capable of acting on these feelings; I believed in psychoanalysis too much. Conscientious and well-trained in Freudian analysis I kept my countertransference to myself and made tremendous efforts to function as a good (Freudian-Kohutian) analyst, that is, to hold him safely, to accept his idealizing transference, to empathize with what *he* felt towards me, and to interpret *his* experiences and motives.

After two years of stormy and painful sessions, my patient eventually left the therapy, to embark on another analysis with an elderly male analyst, at that point still hoping to realize his long-range fantasy of approaching me later in life. There is no doubt in my mind that my inexperience and my life situation played a role in the outcome of this analysis. Yet it is possible that had I possessed some of the analytic tools at our disposal

today, and I mean relational and intersubjective ways of working, the outcome could have perhaps been different. I would have been enabled to accept my countertransference in a more benign, less anxious way. I would have understood that in order to be of help to my patient under these difficult circumstances, I would have had to make use of my feelings toward him to help him – and myself – acknowledge and mourn this kind of love, and perceive the ambivalence and the hostility, the mutual narcissistic stakes we held for each other, and the intense rage (at me, at women) behind his passion. I knew I did not really want a relationship with him in reality, excited and aroused as I was in the sessions, but had I known then the intersubjective truths and imperatives I know now, I might have been freer to feel and work with what I felt and to present it to him in a more honest, even if mitigated and processed way. I would have given my feelings the same high degree of reflection and presented it to him in a similar way to what I did with his feelings. Such exploration would have included questioning his view of me as cold and aloof, it would have included addressing his aggression and defensive sadism, expressed through his repeated acts of emotional blackmail, and contacting our more accurate perceptions of each other. Such an attitude would have enabled us to open up further exploration,

possibly using humor and sublimated erotic feelings in the process, as I would do with a patient I treated some years later. My interpretations would have included not only transference analogies and pointing to his needs for idealization and merger experiences – they would have included as well the articulation on my part of what was going on between us. I would have worked through and worked out a highly processed version of my feelings toward him, of his defensive blindness, and of our aggression and coerciveness toward each other. I would have to face the disavowed seductiveness, and the violent, manipulative parts not only in him, but also in myself. And I would have to mourn a love that, even if it were true, was not possible. These intersubjective and interpersonal understandings and the psychic energy that needed to be spent in areas different from that of defenses and concealment might have – though this is by no means certain – might have moved the analysis out of its impasse. I would have assumed a more dialogical stance, in which I would have placed myself not only within my patient's experience (as is supposed in self-psychology), but I would have judiciously expressed my understanding of both my patient's and my own experience, thereby creating a more mutual, intersubjective space, even if it is, as Gabbard calls it, a “romantic space,” in which to

articulate more of the here-and-now unfoldings. The two years we spent together were often filled with deep insights and powerful experiences. They taught me many things, including what I learnt from his analysis of this analysis (which he wanted me to read). But what was lacking in these analysis were intersubjective dialectics, that would hold the tension and eventually overcome the splits and complementarities of doer and done-to. The manifest version was that he was the doer, I was the done-to: he loved me, I rejected him. Alternatively, there would have to be recognition, not only of his feelings toward me (which I was quite good at articulating to him), but also of my responsibility in what transpired between us. Instead, we had on our hands an incomplete and truncated version of an analysis, a version which disavowed my love and his hostile rejection of my choice, to “love” him analytically, a version which hid my active emotional participation and his spiteful and anxiety-propelled need to deny it. I did not possess the knowledge that would have set me free to work better and be of help; but neither did the two supervisors I turned to with the hope of getting help with this case.

[I forgive Ruven (or Dr. Paul Westen) who has been intensely criticized by psychotherapists for the numerous mistakes he makes. We know that

this fictionalized character had to fulfill the exigencies of dramatic suspense, and therefore had to be compressed, dramatized, simplified. This is why I grant him a margin of credibility that is wider than in real life. But with all his errors, with all denials and dissociations he uses (such as his utter surprise when Naama tries to tell him she is in love with him and has been cheating on her boyfriend with him). He makes mistakes and he transgresses thresholds. But if we transpose his entering his patient's bedroom into a fantasy level and regard it as his wrestling with his temptation, then the last episode of the series, that of his confession to his supervisor/therapist and that of her confession to him, comes into its own. The last episode finds supervisee and supervisor taking stock of their life choices and their inner wars, and the conclusion is clear. They are both revealed to us as having overcome the temptation and mourned the fantasy of finding their happiness with a patient: they reaffirm their integrity and their allegiance to their real objects as well as to their analytic values.

Ruven Dagan is an aging, increasingly angry and isolated man, whose taste buds for life and whose joy with his body are alarmingly declining. Ruven is considered an excellent therapist and he is trying his best to help his patient Naama deal with her erotic feelings towards him. He has

been notably oblivious to the nature of Naama's transference, to the point where she needs to go into wild acts of maltreating her boyfriend, courting anonymous sex, and turning on the pressure of her seductive ploys on him to get him to become involved in a sexual-romantic relationship with her. The details and constant shifts of their interactions are fascinating to watch. As a culmination of the dramatic events she is recounting of the night preceding this particular session, she confesses her love for him, at the same time as she declares that he too is in love with her. All this information is packed in swiftly morphing little pulls and tags in what Naama says from one moment to the other. She replays, we learn later, her deeply conflicted position, in which she wields her female power, at the same time as she tries to satisfy her fatal attraction to becoming once again a victim of abusive exploitation. In later scenes we learn that Naama desires to repeat with her analyst the relation she had with her love object, her paternal substitute, her uncle, but also, we might speculate, her dead mother. As a girl unable to mourn mother's death, she "seduced" this uncle who then exploited her sexually instead of giving her the care and warmth she needed. She runs away from her loving boyfriend (in object-relations language: her needy, dependent part which she repudiates), and she almost succeeds in running

away from an enactment of humiliating sex (a reenactment of a past trauma) – into therapy. Her analyst responds to her dramatizations, cajolings, provocations and incursions as valiantly as he can. Consider his sensitive, differentiated responses to a pair of questions she asks him. When she asks him, anxiously, “Do I disgust you?” he replies, simply, “No,” but when she then asks him, teasingly, “Do I excite you?” he says, “Go on.¹”

But with all the analyst’s efforts, Naama resonates too readily, too deeply, in too thoroughgoing a way, to his deteriorating intimate life, the existential crisis of his aging that engenders his melancholic desire to experience “love for the last time,” as he later tells his supervisor. On another level, this transference-countertransference love reflects the therapist’s desire to enliven his dead mother and be enlivened by her, and most terribly, his attraction to compulsively repeat, that is, enact, the trauma of his father’s abandoning his wife and son and going off with his patient, leaving Ruven to care and sustain a destroyed mother.

¹ We know that the series is a compressed, hyperbolized fictionalized rendition of the more mundane, laborious therapeutic process, but I found some of his responses decent and “not bad.”

Thus, instead of a seasoned therapist who withstands the temptations of a young attractive female patient through processing the countertransferential feelings and desires evoked in him by her erotic transference, we are privy to two “lost souls” who abuse their closest kin (she mistreats her boyfriend, he neglects his family) but who act as if bewitched to find the repair of themselves and their damaged objects in the other, thus actualizing a symmetrical picture of each in relation to the other. Beyond and against the therapy, Ruven and Naama long to go back to places of destruction, betrayal and exploitation, and **this longing is what excites their mutual attraction** their erotic love, (their “false love”) and their hopes for redemption. With all his faults, I was deeply relieved to see that Ruven does not succumb to the awful damage that would have followed upon his giving in to his desire and that of his patient. There will be a brief phase in the narrative when Ruven relinquishes his “surprised”, paralyzed, anxious stance and speaks to his patient more directly. This short interval separated his more rigid earlier stance, where he bluntly says “I’m not a real option for you,” and his later tumbling into an uncontrolled acting out, though he never reaches the bottom of the pit. In this short interval (which we didn’t see today), he was able to assume a stance that feels “right” to me, a rough

combination of openness, authority, and an analytic understanding of the situation. Later he will fall from grace, but will then catch himself and engage in a gripping dialogue with his supervisor, where the two will reflect – as much as a media frame such as a TV series allows it, on life and love choices. Had Mr. Dagan been a better therapist, we may imagine him transcending his private troubles and working more effectively with the positive and growth-promoting aspects of the erotic transference, and cultivating its promises for a kind of (Balint’s) “new beginning.”]