

Love in the Afternoon A Relational Reconsideration of Desire And Dread in the Countertransference

Jody Messler Davies, Ph.D.

The psychoanalytic exploration of the analyst's erotic countertransference has remained a subject rarely addressed in open collegial dialogue. This paper addresses this professional reticence as a manifestation of two interwoven resistences. The first, an avoidance of the physiologically based substrata of self and object organization growing out of certain preconceptions derived from a structural-drive model. And the second, an unwillingness to view the parent/analyst as a full participant in the child's romantic oedipal struggles. An alternative formulation based on a reconfigured, relational model of mental structures is suggested. Here the physical experience of self in relationship to a host of significant internalized others becomes a meaningful organizing component for both the patient and the analyst, one that must be incorporated into the ongoing exploration of transference-countertransference manifestations. Likewise, the unfolding oedipal situation between parent and child, patient and analyst, is viewed from the perspective of a two-person model within which the shared symbolic participation of both becomes a necessary prerequisite for the kind of resolution that lays the groundwork for mature love. A clinical example in which the analyst felt it necessary to disclose the presence of erotic countertransference is explored from several perspectives.

Jody Messler Davies, Ph.D. is Adjunct Associate Professor of Psychology at The Derner Institute of Advanced Psychological Studies; and a supervisor and faculty member at The National Institute for Psychotherapies. She is coauthor (with Dr. Mary Gail Frawley) of *Treating the Adult Survivor of Childhood Sexual Abuse: A Psychoanalytic Perspective*, published by Basic Books.

LOVE AND PASSION, the favorite and timeless topics of poets and philosophers, have been subjects assiduously avoided in the psychoanalytic literature of our day. Especially when such pressures begin to exert their influence on the countertransferential experience of the analyst, we become measured and cautious in our response to patients and in the openness of our dialogue with each other. Patient and therapist together appear to lose sight of the distinction between thought and action. The universality of incestuous oedipal fantasy and boundaryless, preoedipal erotic terrors is lost within the horror and incomprehensibility of actual incestuous enactment. One inadvertent danger of the current interest and concern with early sexual trauma and with the equally real issue of actual sexual contact between patient and therapist is that it will further foreclose this already constricted arena for symbolic interpersonal dialogue, experimentation, and play.

The Recent Literature

The literature on countertransferential desire is sparse. Most recent contributions focus on the area of erotic transference, particularly the ways in which gender differences affect the development of the positive and negative oedipal transference within a female analyst/ male patient dyad. The controversy centers around the question of whether the fear of regression, raising the specter and threat of fusion with the omnipotent preoedipal mother, essentially inhibits the full intensity of more erotic desires (Lester, 1985; Goldberger and Evans, 1985; Goldberger and Evans Holmes, 1993; Person, 1985; Kulish, 1984, 1986; Karne, 1979, 1993; Diamond, 1993). Though several of these authors touch on the question of the analyst's countertransferential resistance to the development of an erotic transference, none move it to the center of clinical inquiry. There are, to my knowledge, four notable exceptions.

Searles (1959) is the first analyst to explore his erotic experiences, and his reactions to those experiences with both male and female patients. Searles believes that the experience of being in the oedipal situation is as important as its ultimate resolution and that although the renunciation of oedipal wishes becomes internalized via the superego, the internalization of mutual loving desire between parent and child becomes an important ego function. This, of course, would be replayed in the transference-countertransference processes between patient and therapist and would be present as a final stage in all successful treatments. He states:

To the extent that a child's relationships with his parents are healthy, he acquires the strength to accept the unrealizability of his oedipal strivings, not mainly through the identification with the forbidding rival-parent, but mainly, rather, through the ego-strengthening experience of finding that the beloved parent reciprocates his love—responds to him, that is, as being a worthwhile and lovable individual and renounces him only with an accompanying sense of loss on the parent's own part [pp. 301–302].

Searles goes on to state, however, that the analyst's awareness of such feelings is enough, that the patient will "sense" them, and that overtly expressing such countertransference experiences puts the analyst on "shaky" ground (p. 291). He does not comment extensively on the patient's oftentimes intense resistance to becoming aware of this transference but does imply that the stumbling block might be a countertransference one.

According to Kumin (1985), the reaction to a growing awareness of erotic transference or countertransference can include feelings of such intense dysphoria, frustration, shame, humiliation, and disgust that it might best be termed "erotic horror." Kumin believes that it is not the patient's desire that serves to inhibit the development and elaboration of erotic transference but the desire of the analyst. Wrye and Welles (1989; Welles and Wrye, 1991; and Wrye, 1993) go a step further. In their work a separate developmental line, "the maternal erotic transference and the maternal erotic countertransference," stresses the movement from an early preoedipal dyadic, bodily sensuality to a more narrowly defined, triadic, oedipal, erotic mutuality, to an ultimately "adaptive and creative transformational attempt to view the mother/analyst as a more dimensionally integrated whole object" (Wrye and Welles, 1989, p. 675). Here, too, the need for the analyst to work through her own countertransference resistances to this kind of mutual experience in the therapeutic relationship is stressed. Wrye (1993) states:

We have posited that in the preoedipal transference–countertransference situation, the countertransference problem may be less of behaving oneself than of allowing oneself to participate. Where even speech can be erotized, yet experienced as strangely inadequate, what is longed for is contact with the analyst's body or with bodily products; both participants may face the longing for and terror of the wish to be one being in the same skin. Not only the patient but also the analyst will have to recognize and deal with this wish [p. 243].

Implications of a New Psychoanalytic Model

Ironically, psychoanalysis proper began with the recognition of infantile sexuality, incestuous wishes, and their impact on the organization of childhood fantasy. The treatment process became a focused attempt to untangle the intricately intertwined threads of identifications, erotic desire, and murderous hatred, as they gave shape and unique coloration and texture to the organization of each individual's internal object world. As the theory of technique became organized around an understanding of the transference (the patient's fantasies about, and wishes in regard to, the analyst, as they reflected earlier and unconscious aspects of relationships between patient and significant objects), a dual emphasis was placed on maximizing these transference experiences and on keeping them "pure," immune to suggestion and influence by the specific person of the analyst. Intense, one-sided experiences of transference distortion (the patient's distorted reconfiguration of the present in accordance only with her own pathological relationships of the past) became the analytic ideal. The mode of analytic action came to rest upon the elaboration of such distortions and the insight born of interpretive clarification of their historic and essentially pathological roots. As such, the Gemini twins of abstinence and neutrality became the *sine qua non* of precise analytic technique. Within such a model the analyst existed only as the object of the patient's desires and counter desires; and only complete frustration of transference oedipal wishes would result in an interpretable transference neurosis.

Certainly psychoanalysis has come a long way in its deconstruction of such fundamental analytic tenets. Many of us have come to view the psychoanalytic encounter as a two-person process in which both the patient and analyst bring to bear a unique perception of their shared experience, not only informed by the realistic perceptions they hold of each other but colored, shaped, at times distorted by the unique system of internalized object relations that each participant projects upon the other and with which each comes to identify in the other. Within such a revised model the traditional understanding of analytic neutrality becomes untenable. We assume—indeed, we rely upon—the hope that analyst and patient together will become enmeshed in complicated reenactments of early, unformulated experiences with significant others that can shed light upon the patient's current interpersonal and intrapsychic difficulties by reopening in the analytic relationship prematurely foreclosed areas of experience.

As we move within a field defined by analytic participation reenactment and, ultimately, understanding, so, too, the classical notions of

abstinence and nongratification are called into question. It would appear to follow logically that if reenactment within the transference-countertransference experience is to be understood and integrated as anything more than an iatrogenic retraumatization of the patient, something essentially different must happen in order to render this reenactment only a partial one. The analyst, by dint of her very presence and ability to provide certain protective, holding, and containing functions, fundamentally changes the patient's earlier experiences of anxiety, sadness, envy, rage, and erotic hyperarousal. In so doing, the analytic space provides the backdrop against which previously foreclosed experiences can be reopened, mastered, and more effectively integrated within an internal system that no longer views such moments as overwhelming and dangerous. The analyst herself becomes both the magnet that draws out the reenactment of unconsciously internalized systems of self and object and the architect of the transitional arena where such self and object experiences become free to play and reconfigure themselves in more harmonious ways. Magnet and architect, as they volley between foreground of active interpretive work and background of containment and holding, bring into focus the necessity of discovering an optimal tension between interpreting the past and cocreating the new. It would, indeed, be naive to assume that within such a model, the particular history that shapes the analyst's subjective experience of the analytic encounter can be ignored or that the experience itself, subjective though it may be, is anything less than a conduit via which we gain access to as yet unarticulated aspects of the patient's experience.

Thus, comes our current fascination with the analyst's countertransference: how to know it, how to use it, when to disclose it; what represents dangerous, countertransferentially induced acting out on the part of the analyst, and what represents what Aron (1991), in a beautiful clinical application of Benjamin's (1988) important work, has defined as the patient's understanding of, and fantasies about, the analyst's subjectivity. Within such a climate, the essential absence of any informed discussions of the analyst's sexual and erotic experiences becomes even more mystifying. It is my hope that a sober reflection upon the unconscious processes that have kept such a dialogue out of the professional literature may shed light on certain parallel processes at work in the psychoanalytic encounter.

A Relational Reconsideration

In my personal attempt to untangle these rather tenacious resistances, I focus on two specific areas of countertransferential pressure that I believe

to be related to our professional reluctance to explore the boundaries of the analyst's sexual subjectivity. First is the fact that an understanding of oedipal dynamics remains rooted in the soil of drive theory and ego psychology. As such the almost exclusive focus has been on the child's need to come to terms with the concrete impossibility of such desire. The renunciation of the incestuous wish, the implementation of ego defenses, the establishment of sublimatory outlets, and ultimately superego internalization itself all rest upon what Freud termed the "dissolution of the Oedipus complex." As such the power of the experience itself, the symbolic significance of idealized oedipal love as it moves both parent and child to experiences of power, surrender, and physical desire, comes to be first circumvented and then overshadowed by the formidable task of moving beyond what are viewed as essentially phase-specific wishes seeking healthier forms of sublimated expression. Likewise, the erotic, bodily aspects of the oedipal experience, somatically encoded in a system parallel to the mental configuration of self and object matrices, is often ignored, summarily dismissed as belonging to the realm of primitive mental functions, significant only where "pathological states" prevail. The mental consequences of drive renunciation take precedence, therefore, over the actual experiences of relational frustration and gratification, as well as over the physiological, more purely erotic analogues of such experience, in the uniquely mutual throws of oedipal romance.

Clearly, contemporary analytic thinkers have expanded our notion of the complex processes unfolding in the experience and resolution of the classical oedipal configuration. Fast (1984), Benjamin (1988), Dimen (1991), and Ogden (1991), to mention only a few, all pose a phase of what might be called "transitional oedipal play," in which the young child experiences primary identifications and erotic exchanges with parents of both sexes. Such a phase of boundaryless erotic and identificatory experimentation presumes that the child needs to experience what are too often viewed as incompatible polarities of gender-dominated potentialities before there can be a final consolidation of gender identity, a renunciation of what Ogden (1991) terms "bisexual omnipotence" and Fast (1984) terms "overinclusive gender definition."

But even here, the emphasis is surely on the identificatory processes that set the stage for such renunciation and for the ultimate realization that, what we are forced to renounce in our coming to terms with gender differences may be rediscovered in the erotic discovery of the other. Missing, even in these expansive and bold reinterpretations of classical developmental theory, is that they still speak more to the mind of the developing child than they do to the body; and it is my belief that essential erotic experience occurs at the interface where mental and physio-

logical experience comes together. I suggest that within this transitional arena wherein the child sorts out all that she is, all that she may yet come to be, and all that must ultimately be sought out in intimate and erotic contact with essentially different others, there is a physiologically based and somatically encoded substrate of experience that runs parallel to, but remains in most cases essentially dissociated from, the more cognitive, verbally encoded operations. It is my belief that the early template for both the adult's potential to experience erotic passion as well as the particular difficulties inherent in achieving such states of physical intimacy and desire is formed during this phase of transitional oedipal experimentation.

Let me elaborate. I am certainly not suggesting a return to the impersonal and endogenously organized drive theories of Freud. What I am suggesting is, perhaps, more in keeping with Fast's (1992) statement that "the basic units of experience are bodily interactions between self and other" (p. 396) or Bollas's (1988) view of the early object as "enviro-somatic transformer of the subject." I suggest that as the child reconfigures her experience of what it means to live within her own body, as she comes to understand the separate subjective experience of the other because such preliminary trial identifications allow her to transcend her own physical definition, there will be a moment-to-moment, virtually uninterrupted flow of bodily states, in specific relation to each experience of self and other as they become internalized into increasingly more organized matrices of self and object representation, a separate yet parallel organization of self-experience, symbolically encoded in a language of somatic sensation and countersensation: arousal, hyperarousal, inhibition. I believe that it is misleading, an unfortunate derivative of drive theory, to regard this aspect of self experience to be important only in early development or where primitive mental states prevail. I also believe, however, that in our efforts to move beyond a conceptualization of sexuality based primarily on an organization of depersonalized drives, we have in large measure cast aside the reality that sexuality is still an outgrowth of shifting physical sensation as it occurs in relation to specific fantasied and interpersonal relationships. In fact I would suggest that this particular aspect of self organization and experience grows increasingly elaborated and differentiated with time and assumes a position of particular centrality in any attempt to understand the individual's erotic life—an organization of the experiences of self in relation to other in which love, shame, idealization, envy, and rage are not just words but systems of physical sensation, elusive, ever-shifting, and rarely, if ever, verbalized in normal interpersonal discourse.

If we are to enter the clinical realm of erotic desire, confusion and inhibition, it would seem imperative that we gain access to this essential subtext of interpersonal relatedness as it effects both patient and therapist. Often this aspect of experience provides access to repressed and dissociated states of erotically charged experience, otherwise unavailable in the verbal discourse that dominates clinical inquiry. Yet, we are often taught to avoid such immersion in physicality, for the very reason that it is viewed as too primitive, too arousing, and therefore potentially too gratifying to the patient. We are taught to presume, instead, that silences are neutral, though we must know from our own life experiences that such meaningful and uncomfortable silences are the very foreplay of erotic enactments.

If, ultimately, we presume a developmental progression from the physiological to the purely or near purely mental, if we view such states as out of control impulses or primitive modes of expression, there is another danger; here, the theory will in fact encourage a premature foreclosure of erotic experience rather than an enhanced capacity to contain the progressive elaboration of such experience as a normal substratum of increasing development and differentiation. We lose an entire aspect of self-organization and a different language by which we may come to understand highly conflictual aspects of the patient's relationships with significant others. Only by integrating these often dissociated aspects of experiencing self in relation to other, i.e., the purely physical and the purely mental, can we forge the much needed integration of mind and body so necessary in impacting upon the patient's capacities to experience erotic desire.

How, then, can we enable the patient to hold on safely to and sustain anxiety-ridden somatic states long enough to know those moments from within, from the subjective experience of both the self and the other, to incorporate into our psychoanalytic explorations an ego, a containing, symbolizing, knowing constellation of capacities that incorporates physicality and sensation as well as language and other forms of mental definition? Surely, we cannot as clinicians interpret the unconscious or unformulated aspects (Stern, 1983) of physical sensation, which we have not first enabled our patients to reopen and sustain. We cannot, as individuals, come to know an experience that we have not first felt. Nor can we integrate an experience of erotic desire until we have been able to explore it comfortably with another in an atmosphere safe from both intrusive overstimulation or silent humiliation.

The answer to such a question lies in what has been already described as the analyst's ability to move fluidly between her role as magnet for reenactments of past object-related experiences and her function as a

container for both experiencing the old and facilitating the new. As patient and therapist together reimmerse themselves in specific object-related experiences of the past, the physiological substrata of experience described will certainly reemerge. As a full participant in the analytic endeavor the analyst must be willing to feel and process her own somatic states accompanying the interplay of self and object in the erotic counter-transference, as well as recognizing those states inherent in the patient's unfolding erotic transferences.

The second point of resistance to exploring the analyst's sexual subjectivity comes, I believe, with the unwillingness to view the parent and, by extension, the analyst as a full participant in the erotic oedipal situation. It is by now familiar analytic terrain to view Freud's renunciation of the seduction hypothesis and adoption of a belief in the centrality of oedipal dynamics as the cornerstone of formal psychoanalysis, one that turned the emphasis of clinicians from the realities of early sexual trauma to the vicissitudes of oedipal fantasies and configurations. This shift, however, had another, less explored result. It forever shifted the focus from that of the out of control parent, moved to extremes of traumatic transgression by experiences of aggression against, and erotic longing for, the child, to an exploration of the sexual fantasies and desires of children whose parents are cast in the immutable stone of dispassionate objects of desire. Any exploration of the analyst's sexual feelings for his patient, in the analytic setting, will reveal the repressive derivatives of this defensive shift, the parent/analyst as an active participant in his child/patient's erotic oedipal experience and the reactivation of the analyst's own conflicted oedipal struggles under the sway of this compellingly unilateral romance. How much easier to engage in a collusive denial of the parent's sexuality or, better yet, a defensive devaluation of such romanticized oedipal love as immature, idealized, adolescent, or pathological—easier yet when the analyst's own training analysis predated many of the changes in psychoanalytic conceptualization that enforced the value of renunciation and resignation over the symbolic powers of transitional play and the need to maintain certain essential paradoxes in the psychoanalytic situation (Winnicott, 1971; Ghent, 1992). Here the analyst can retreat to a defensive reliance on an asymmetrical, one-person model, which presumes to isolate the erotic fantasy life and related physiological sensations of the patient, as if such an experience could, in fact, be separated from the concordant and complementary fantasies and sensations of the analyst.

I would suggest that ultimately, though with careful timing, the patient must come to know the analyst as subject of her own erotic sensation and desire. When a traditional analytic frame is used defensively by the patient to shield himself from acknowledging the sexual

subjectivity of the analyst, I would suggest that certain countertherapeutic boundary confusions ensue. The patient, not unlike the overstimulated oedipal child, bears the guilty weight of his own erotic longings, as well as the burden of maintaining in denial an awareness of the parent's reciprocal interest and involvement. When such confusion is then supported by the analyst's own, theoretically reinforced unwillingness to regard her sexual responses as a significant aspect of the countertransferential process, I believe that a perverse scenario, rather than an increasingly intimate one, is reenacted, at least in part on the basis of an almost universal defense against the awareness of the parent's own erotic fantasy life as it relates to that of the child. It is my fear that what masquerades as analytic neutrality may in many cases represent the reenactment in the transference of a countertransferentially induced gratification of the patient's eroticized masochism, rather than an enhanced capacity for intimacy and erotic mutuality.

Indeed Masud Khan (1979) introduces his first book, *Alienation in Perversion*, with the following: "The basic argument of this book is that the pervert puts an *impersonal object* between his desire and his accomplice; this *object* can be a stereotype fantasy, a gadget, or a pornographic image. All three alienate the pervert from himself, as, alas, from the object of his desire" (p. 9).

A Case Example

Let me conclude with a brief clinical vignette, which I hope will illustrate the importance of (1) the analyst's not defensively denigrating the centrality of physiological and sensational correlates to erotic fantasy and (2) the analyst's need to acknowledge her own participation in the erotic fantasies of the patient and at times to reveal her view of that participation within the treatment.

Mr. M was a 27-year-old graduate student in mathematics who lived most of his life from within his world of numbers theories and abstractions. He had a history of developing intensely eroticized, fantasied relationships with female colleagues and fellow students, though he never acted on these feelings in reality. Whenever he attempted to approach a woman, he would become anxious, sweaty, and overwhelmed by what he described as "a rather urgent and threatening nausea," thus ending any romantic initiatives on his part. If a woman approached him in anything resembling a seductive manner, the patient would become cold and rejecting. He somatized a great deal and in fact had a long history of physical illnesses and complaints, which merely reinforced his sense of himself as weak, sickly, and decidedly unattractive to the opposite sex.

It was somewhat surprising, therefore, that the patient quickly developed an intense and highly eroticized transference, complete with compelling, almost poetic descriptions of his sexual fantasies involving the two of us. I was for him, he claimed, "the perfect woman, warm, sensual, perhaps the only person who could lead him out of his life of sexual inhibition and loneliness." The fantasies themselves were vivid and compelling, somewhat at odds with the patient's experience of extreme sexual awkwardness, and I found that I was beginning to warn myself of the dangers of taking them too seriously, that is, enjoying them too much. Yet there was more than a small thrill, that under this deadened mathematically abstract persona, I had somehow stimulated the heart of a most truly poetic lover. How shocked I was one day, to find myself thinking, rather jealously, of the real lover who would someday be the beneficiary of the patient's sensuality. I began to regret never having had a son. That felt like a betrayal of my own daughters. The guilt of betrayal brought my own mother into focus, along with the uncomfortable recognition in memory of some of my own more grandiose oedipal desires and experiences. Clearly, I had left the real world behind and had entered with my patient a shared illusion of oedipal passion, victory, triumph, and remorse, as much a subject of my own resurrected struggles as I had become the object of his. I felt confused, not exactly sure what kind of state I was in, but all the while painfully clear that whatever state it was, it was a long way from the comfortable states of abstinence and neutrality.

In the meantime an interesting pattern was emerging in the rhythm of each session. The patient would enter somewhat shyly, and despite the always varied content, a mood of some intimacy and intensity would soon be established. Sometimes this experience could be verbalized by the patient; at other times I would be alerted by my own sense of inner tension and arousal, physiological states that became necessary clues to hearing the erotic subtext of the sessions. I would struggle for a way of responding to both the manifest and latent content of the process in a way that would be perceived as neither anxious and rejecting nor eager and overstimulating. Regardless of how long it took to formulate such an impossibly measured response, it became apparent, over time, that the patient's attitude and persona would change dramatically at the precise moment that I was about to intervene. Clearly, I was being permitted to observe, take in, and reflect the process of the session, but the patient seemed to have an uncanny sense of the exact moment at which I was prepared to step inside and become a more active participant in the process between us.

At that exact moment he would appear to implode upon himself,

slumping down in his chair, his voice whining and somewhat grating; he had no right to these feelings about me. Of course, it was impossible that I shared any of his sentiments, and therefore I must be secretly laughing at him, describing to my friends how paltry and pitiful he was. I could only assume that the experience of such symbolic, yet eroticized, mutuality was being experienced by the patient as a consummation of sorts, a traumatic boundary transgression that would instantly precipitate a realignment of the self and object constellation at work in the therapeutic reenactment of the moment. It was clear that he no longer felt like the same person to me. My sense of warmth and growing arousal would dissipate instantly, and in its place I felt enraged, seduced, misled. I was aware of feeling sick to my stomach, and there was an experience of dread that became physically palpable and frightening. Where I had initially made it safe for the patient to experiment with a more active, seductive, and sexual side of himself, it was apparent that within a certain aspect of our clinical reenactment he made that experience feel safe for me too. As I attempted to follow my own states of arousal, desire, jealousy, counterarousal, and inhibition, followed by fear and dread, it became obvious that these experiences in the countertransference had the potential to serve as a road map of sorts through the shifting matrices of self and object representation as they played themselves out with rapid shifts and transitions in the specific transference-countertransference matrices at work in the clinical endeavor.

There also came a time in the analysis when the patient needed to confront me as a sexual being, and to deal with the very intense reaction that he had to this realization. As we followed the signposts of our emotional and physical reactions to each other, as they gave way to the reenactment and interpretation of particular aspects of his internal object world, it became increasingly clear that the patient's mother had been extremely seductive, romantic, and erotically stimulating, although never in an actually physical way. He remembered long, languid afternoons in which he would lie curled up next to her while she read to him; always epic poems or stories of romance, passion, and adventure, the stories of Odysseus, the legends of King Arthur and the Knights of the Round Table. He recalled the recurrent fantasy of mother and him as Guinevere and Lancelot, with a benign, yet asexual father, Arthur, looking on from the background.

As we struggled to understand my repetitive experience of sudden danger and dread, followed by a deadening of erotic experience in the countertransference, other aspects of the patient's experience with mother began to emerge. He recalled that all would be well between

them as long as he was careful not to respond too overtly to her intimate cuddlings. If he rubbed or cuddled too eagerly, or as he put it one day:

Even if I sighed too deeply or longingly, she would change, virtually transform before my very eyes. She would look at me in horror and disgust, as if I was the most hideous person in the world. It was like she knew how I felt about her, and she was revolted by me . . . revolted by the thought that I could have those feelings about her. I know that must be why I can't stand it when women respond to me sexually. I'm afraid that they will change suddenly and find me disgusting. And I can't take that risk. It's too humiliating.

Though this represented a partial working through, the patient was never able to accept the interpretation from me that perhaps his mother had been revolted by her own sexual urges toward her young son, during these most intimate times, that perhaps when he responded in particular ways, it was she who became more highly aroused, surpassing even her own threshold of denial. Mr. M would become enraged at these suggestions, claiming, with controlled anger, that I knew that to be impossible; mothers weren't allowed to have sexual feelings for their children anymore than analysts were allowed to have such feelings for their patients. His admonition worked well and indeed kept my sexual responses well in check for some time, much as his mother's had controlled his. When I did experience such feelings for the patient, they were accompanied by a sense of some kind of professional misconduct or shame. Here, I believe we remained more or less embedded in a rather perverse scenario, which, in fact, made it impossible for the treatment to move into the experience of real erotic desire and understanding. Between the patient and me I placed allegiance to an impersonal theory, which taught that such countertransference was to be understood and worked through on my own, that it could be used to enhance my understanding of the patient, but, particularly in this area of sexual arousal, it could not be shared without committing an act of symbolic incest. The patient placed between us the stereotyped fantasy, rigidly adhered to, that parents felt no sexual arousal for their children, and likewise that an analyst had no such feelings for a patient. By relying on these stereotypes and maintaining what would have appeared to be a position of neutrality, I believe that I was, in fact, sadistically gratifying the patient's fundamentally masochistic assumptions about the nature of our relationship and his relationships with women in general.

Moving beyond this treatment impasse involved a commitment to working through a host of formidable countertransference resistances of

my own: the dreaded fear of becoming for the patient an overwhelming, preoedipal, chasmic mother; my fear of reencountering my own overwhelming and intrusive memories of being so physiologically and erotically enmeshed; the dangers of resuscitating the struggles to transcend idealized oedipal romance and find mature love. In part the struggle was pushed along by this young man's adamant need to deny the reality that he could be the object of a woman's sexual desire. He saw himself only as the victim of unrequited love after unrequited love, and such stuckness in the treatment defied all other interpretive avenues that felt "safer" to me. Feeling that there was no other honest alternative, I said to the patient one day, "But you know I have had sexual fantasies about you, many times, sometimes when we're together and sometimes when I'm alone." The patient began to look anxious and physically agitated. I added, "We certainly will not act on those feelings, but you seem so intent on denying that a woman could feel that way, that your mother might have felt that way, I couldn't think of a more direct way of letting you know that this simply isn't true." The patient became enraged beyond a point that I had ever seen him. I was perverse, not only an unethical therapist, but probably a sick and perverted mother as well. He thought he needed to press charges, professional charges, maybe even child abuse charges; how could I help him when my own sexuality was so entirely out of control. He was literally beside himself. Unaware of what he was saying, he could only mutter, "You make me sick, I'm going to be sick. God, I'm going to throw up."

Though set off course by my own visions of professional ethics reviews and child welfare investigations, I was refocused more by the patient's physical reaction of intense nausea, one of his presenting symptoms, in reestablishing the operative transference-countertransference than by anything else. I was able to say to him, "I don't think that there's anything sick and disgusting about the sexual feelings that either of us have had in here. . . . In seeing your revulsion and disgust with me, I think I'm understanding how your own sexuality made you feel sick whenever your mother withdrew from it with such horror. You felt perverse and criminal and fearful of retaliation. King Arthur was a powerful guy." The patient added, "And Guinevere was very beautiful." "But," I added, "Guinevere knew that her sexual feelings began inside of herself; she didn't hold anyone else responsible." The patient began to weep, he punched his fist into his palm repeatedly. I said, "I think you're just enraged, that you were forced to carry these feelings for your mother for so many years, her revulsion, disgust, and shame about her own erotic sensations, that she made you believe the shame rested with you." At a later time: "You felt sickened by my sexuality, just like you want to throw

up whenever a woman begins to respond to you in this way. You must have felt sickened by your mother's arousal and enraged by her rejection . . . so you become sickened and then reject the woman who is seducing you." At a still later time, perhaps with the greatest difficulty: "Perhaps you are also angry with me for allowing you to carry the responsibility for all of the sexual feelings in here."

This vignette is, of course, collapsed, covering many sessions. But I hope that it does illustrate first, how the therapist's use of her own bodily states of awareness served as a map through a veritable minefield of potentially explosive and disorienting transference-countertransference reenactments, and second, how recognition of the therapist's sexual subjectivity in the clinical setting enabled at least this patient to break through into an area of inquiry that had remained up to that point debilitatingly dissociated.

Clinical Implications

Surely the response to this clinical material will in large measure derive from the model of therapeutic action held by the individual reader. Some will dismiss it outright, convinced that such involvement and revelation on the part of the therapist must point to serious unresolved countertransferential pressures. Others, more comfortable with the centrality of the analyst's countertransferential experience but nonetheless uncomfortable with the specific content of this vignette, might still accept it as a "last resort" kind of intervention, one that became necessary when the "safer" alternatives, alluded to earlier, failed to work. "You assume, then, that I could have no sexual thoughts about you." "Why do you think you make that assumption?" "Do you ever think that I might have such feelings about you?" "Could you imagine a situation in which I might have such fantasies?"—these are all alternatives that come to mind with far less anxiety and dread than the path ultimately chosen.

Despite the reality that my choices in this case were dictated by a sense of clinical frustration and the failure of those alternatives mentioned above (as well as countless other variations on the theme), let me here play devil's advocate. I wish, for the moment, to take what might be considered the theoretical "high road" and consider, indeed, argue, the possibility that from the vantage point of a relational model of psychoanalysis, the ultimate course of events, in this case, represented one of the most therapeutic alternatives. Why is that?

If we work within a relational two-person model of psychoanalytic discourse and wish at the same time to hold onto the notion that psychic pain emanates at least in part from the irreconcilability of conflictual

internal experiences, we are often impelled to shift the focus of our analytic attention, steeped as it is in illusions of neutrality, from the structural model of conscious, preconscious, and unconscious thought as it exists solely within the patient's inner world, to that of a mutually constructed, intersubjective playground of transitional potentialities where meaning can be constructed only in the throws of recognition, destruction, and perpetual interaction between two actively engaged participants.

Here it should become clear that experience that seeks to avoid meaning can lodge itself well within the unconscious or unformulated experiences of either the patient or the analyst. Where, via projective identification and other projective mechanisms, meaning is subjected to such defensive extradition, it becomes incumbent upon the analyst to represent actively—even embody—that aspect of the split-off internal self and object world of the patient that so elusively defies acknowledgment and integration. It becomes a part of the analyst's essential function to recognize and maintain such disavowed experiences until such time that the patient can know them and integrate them without the threatening precipitation of debilitating anxiety and psychic regression. Within such a scenario, the analyst oftentimes must speak the dangerously charged words for the first time.

When we ask the patient to take such a risk, to venture forth with a shared description of his physical states of desire, dread, and arousal, despite the threat of frustration, humiliation, and denial, the analyst's failure to embrace an equal risk can, as in the case described, serve to reinforce the patient's fundamentally masochistic assumptions, thus foreclosing again on the potential for enhanced intimacy and mutuality. When, because of personal or theoretically reinforced reticence, aspects of the analyst's unconscious participation in the therapeutic drama remain unexpressed and therefore unexplored, whole areas of the patient's unconscious experience may be kept out of a full participation in the interpersonal arena of reconfigured meanings.

In coconstructing with the patient a current interactive dialogue that seeks both to unlock the unconscious symbolic equations of the past and to create personal meaning where cognitive operations have failed, we hope to maximize the potential for newly constructed meaning within the present therapeutic space. When an awareness of erotic desire toward the analyst triggers the terror of either overwhelming preoedipal danger or the reactivation of an overly stimulating oedipal configuration and when such dangers are experienced somatically, because verbal encoding has yet to occur, awareness and meaning may first emerge in the countertransferential experience of the analyst, including, as has been described in this case summary, all manner of physical sensation. Here the analyst

must communicate to the patient that the body, dreaded though it may have become, also creates and interprets meaning, responding to such meaning even before these processes can be cognitively encoded. Only if both participants listen to the language of shifting physical sensation can the necessary process of symbolization proceed and the gulf between somatic experience and expressible cognitive operations be bridged.

It is, after all, only when such experience can be put into words, that it can be openly shared between two people. It is only when such erotically charged material can be spoken of, changed, modified, withdrawn, renewed, when it can become the substance of all forms of symbolic and illusory play; that the patient can both "have" and "not have" (Benjamin, 1993) the experience of oedipal success. Here the patient can revel in an experience of oedipal potency and desire, in an atmosphere free from any traumatic transgression of the incest barrier. He can learn to play with, and enjoy his sensuous, sexual desires without the threat of penetration, humiliation, or overstimulation. I believe that it is in the successful negotiation of this particular developmental paradox that a groundwork is set down, that will ultimately enable the patient to mourn successfully what cannot be, maintaining, at the same time, a hopeful investment in all that is yet possible. Here, the mutual pleasures of a fully reciprocated oedipal love can be experienced, enjoyed, and taken in as a permanent template for the mature love that will, with a little luck, ultimately fill the future.

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666 West End Avenue, #1A
New York, NY 10025