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The Place of Erotic Transference and Countertransference in Clinical Practice

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Patients who express intense, erotic attraction to their therapists pose special treatment challenges that may not respond well to the interpretative effects of the therapist. The wish that the therapist demonstrate love for the patient and the therapists' own erotic feelings toward such patients can create misalliances as well difficult technical moments. Furthermore, some patients expressing their love for their therapist may have physiological manifestations while others would not. At the same time, therapists may not experience erotic feelings toward the patients' expressions of love. The purpose of this paper is to try to answer the following questions: How do we conceptualize our patients' erotic manifestations? Are those expressions of Oedipal or preoedipal pathology? What are the countertransference reactions of the analyst? Two clinical examples will highlight these issues.

Some patients experience sexual feelings toward the analyst. When these feelings predominate in treatment, the patient may feel driven by an intensity that both demands satisfaction and yet engenders shame and humiliation within the patient, as well as rage at the therapist. Unlike other transference phenomena, the wish for sexual contact, as a repetition of past trauma, requires the therapist to rupture an area of illusion in the transference and to foreclose the fantasy in favor of promoting boundary formation and repairing ego deficits **(Stern, 1991)**.

Messler Davies (1998) states that we can no longer conceive of the idea that sexual feelings in treatment are about unresolved infantile desires, as if they exist only for the patients and not for the analyst. Sustained intimacy on the psychoanalytic process often leads to an erotic dimension that cannot be automatically pathologized. Such feelings can be strong for the patient and the analyst; the effect of these feelings ranges from disquieting to dangerously overwhelming (p. **752**). Lack of awareness or intolerance of erotic countertransfrerence in ourselves may result in enactments of it through

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mothering responses or in arrested feelings that are kept out of awareness, bringing about an altered therapeutic process.

The purpose of this presentation is to try to answer the following questions: How do we conceptualize our patients' erotic manifestations? Are those expressions of Oedipal or pre-oedipal pathology? What are the counter-transference reactions of the analyst? Two clinical examples will highlight these issues.

Review of the Literature on Erotic Transference and Countertransference

Transference

Erotic transference is inevitably emotionally difficult, reflecting a variety of dynamic and defensive meanings **(Gabbard, 1994)**. **Freud (1915/1959)**, in "Observations on Transference Love," concluded that the quality of love expressed by patients in treatment was for the most part the same as love that is expressed in everyday life. What primarily differentiated the two types of love was that love expressed in analysis was closely tied with resistance. In other words, the patient's expressions of love for the analyst were used defensively against remembering painful experiences. Freud's conclusion was that a subgroup of these patients was untreatable because they concretely needed to actualize the transference. He stated that among others, there are certain common factors, which make a person more likely to develop an eroticized transference. These are: sexual seduction in childhood while in the oedipal phase; instinctual over-stimulation combined with parental deprivation in terms of lack of appropriate protection and support; intense masturbatory conflicts; and family toleration of incestuous/homosexual behavior.

In **1973** this idea changed with the publication of Blum's "The Concept of Eroticized Transference." Blum described a

continuum of responses from the patient that on one end he labeled “erotic” transference (positive expressions of affection from the patient to the analyst that were analyzable); on the other end, were eroticized transference responses characterized by “an intense, vivid, irrational erotic preoccupation with the analyst, characterized by overt, seemingly ego-syntonic demands for love and sexual fulfillment from the analyst” (Blum, **1973**, p. **63**).

Unlike Freud, Blum suggested that patients who express even the more intractable forms of erotized transference might be analyzable, depending on their ability to test reality. Also, unlike Freud, Blum, together with many other therapists (Hirsch and Kessel 1998; **Mann, 1994**; Saul, 1962, and Searles, 1959; in **Stirzaker, 2000**) consider erotic transference to be a fundamental part of therapy, which occurs to different degrees in many therapeutic encounters.

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This belief dominated clinical thinking about erotic transference for many years.

Since **1973**, and particularly in the 1990s, many works have appeared considering different explanations. **Schafer (1993)** emphasized the adaptive dimension of erotic transference viewing the patient's erotic material as a form of communication and an attempt at creating something new. Wolf (**1994**, in **Odgen, 1999**) described how the erotic transference can reflect the patient's attempts to maintain self-cohesion in the phase of severe empathic failure. **Wrye and Wells (1994)** explored primitive expressions of erotic transference describing patients who operate primarily from a nonverbal stance and convey themselves through enactments. **Chessick (1997)** exemplified the dangers of eroticized transference in his paper entitled: “Malignant Erotic Counter-transference.” He used malignant because it has the potential for destroying the therapy, harming the patient's life, and destroying the career and harming the life of the analyst (p. 119). **Akhtar (1996)** also discussed the malignant erotic transference (see discussion below).

It is worth noting here that there is controversy in the literature about the gender of the pairs on erotic transference/countertranferece. **Slochower (1999)** states that most of the literature on this topic is between female patients and male analysts. On the other hand, **Rosiello (2000)** states that female analysts wrote most cases reported, and they have concentrated on erotic feelings between female analysts and male patients. Overall, however, there is agreement in that there are fewer papers on erotic feelings on same gender dyads **(Sherman, 2002)**.

In terms of the developmental nature of these erotic longings, clinical reports tend to emphasize the Oedipal nature of erotic transference in the female patient-male analyst constellation. Nevertheless, when those feelings develop within the same sex or male patient-female analyst dyads, those feelings and wishes are an expression of both Oedipal and pre-oedipal maternal longings **(Lester, 1985)**.

Wrye and Wells (1994) describe a particular type of erotized manifestation. They call it the pre-oedipal maternal erotic transference-countertransference: Both analyst and patient may experience simultaneously terror of, and longing for, fusion with the other. Wrye and Wells (**1989**, **1994**; **Wrye 1999**) posit the maternal erotic transference and countertransference as a potential playground which must be made and kept safe for the emergence and exploration of the patient's very primitive early preverbal longings and fears of the early mother's voluptuous and essential body.

Countertransference

Except for a few pioneers (Field, 1989, and Samuels, 1985, in Solomon, until recently the **1997**), professional literature has been outstandingly silent

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on the subject of erotic countertransference. Typically, when therapists wrote about or discussed their own sexual feelings for patients, they received the traditional advice to control their feelings, go back to analysis, and/or terminate treatment if those feelings were out of control and there was a possibility of acting out. While erotic and sexual emotional reactions have negative ethical implications when they are realized in action, this does not mean that those reactions are invalid. Even though the therapist wishes to maintain therapeutic neutrality, his/her feelings are part of the relationship. The problem is not in the emotions themselves but in their unconscious, unhealthy enactment (Solomon, **1997**, p. **73**). **Mann (1994)** states that many therapists, even though they say they work using transference, have never experienced erotic feelings toward their patients. His view is that “the twin dangers are on one hand to repress, deny, split off feelings, this leading to displacement or projection onto the client, or, on the other hand, to be overwhelmed by feelings, thereby leading to acting out with the client” (p. 350).

Countertransference responses, sometimes physiological, provide clues to what cannot be said in words. The therapist, then, can focus on physiological sensations, and at times, attune his/her own internal signals that may be connected to erotic feelings (Solomon, **1997**, p. **74**). **Koo (2001)** discussed the erotized transference of a male patient toward her. She described her reactions as feeling acutely uncomfortable when faced with his declarations of love. Those statements on the patient's part interfered with her ability to explore those issues in a neutral, constructive way. Fear of the

patient's anger and potential violence as well as Koo's desire to be caring made it difficult for her to confront his erotized transference. As she became more at ease with the patient's declarations of love and his angry outbursts, "I was able to assert reality more clearly and to explore his feelings in an accepting manner" (p. 35). Allowing countertransference feelings to unfold, understand, and admit may uncover core issues.

These comments lead us to the topic of self-disclosure of erotic feelings from the therapist. In recent years discussion of this subject has been an important controversial theme in modern psychoanalytic literature. There are those (Gorkin, 1985; Maroda, 1992, and **Gabbard, 1994**, in **Messler Davies, 1998**) who would refrain from pathologizing the analyst's response, seeing it as important countertransferentially derived information to be understood and processed, but never shared or openly explored between patient and analyst. **Mann (1994)** believes that the therapist's erotic feelings toward the patient should not be shared with the patient, much like the parent would not expect the child to deal with his or her parent's incestuous feelings.

However, other analysts (Knoblauch, 1994, **1996**, in Messler Davies, **1994**, **1998**; Slavin, Rachmani, and Pollack, 1998, in **Messler Davies, 1998**) have argued that judicious and tactful disclosure of the analyst's sexual response

can facilitate demystification of infantile conflicts and a deepening of the analytic work (Messler Davies, **1998**, p. **748**). In that paper, Messler Davies shared her sexual feelings toward a young man who retreated teasingly from any acknowledgment of his attractiveness. She used his horror to explore his relationship with his mother, who was seductive but avoided him when he responded. I think that Messler Davies had probably burdened the patient with her frustration and attraction, at the same time. She further told the patient that she had fantasies about the patient both inside and outside of the sessions. She explored what those fantasies were, before he accepted that she was attracted to him. **Russ (1999)**, commenting on this interaction, stated that inviting the male patient to consider his analyst's sexual engagement is necessary, and "we have to know if doing so is disorganizing, yet there is room for deep contact in the aftermath. A worse mistake, however, is avoidance" (p. **611**).

Recent analytic literature indicates that the erotic transference and countertransference feelings are altered through the analyst's interpretations into a more workable or sexually neutered transference alliance **(Sherman, 2002)**, or that treatment is ended by either the patient or the therapist **(Rosiello, 2000)**.

Maternal Erotic Transference With Physiological Manifestations

Kathy is a 45-year-old married woman with two adolescent children. She came to therapy because of difficulties in dealing with her children and problems in the marriage. She presented as a patient with paranoid features with poor self and object representation. Since she appeared paranoid, she was in face-to-face therapy for 2 years; however, she wanted to use the couch "like in the movies," which she did when the paranoid defenses lessened.

From the beginning of treatment, issues of trust came up. For example, I knew that she was well off and she asked: "Are you going to charge me more?" She had trouble recognizing that I was available to her. The concepts of object constancy came to my mind and I initially focused on interpretations based on being a "real" object instead of a transference object. Due to the lack of consistent self and object representation, parameters were set in that she could call me to check on me. We worked on her understanding was that I did not disappear when she left the office and she could maintain our relationship inside her, when I was not physically present.

As our contacts continued, Kathy remembered having been sexually molested many times by her father. She became agitated with this memory that had remained unconscious for many years. During those sessions she described her anger at her father for what he did and at her mother for not protecting

her from her father. Since our working alliance was strong, we talked about those issues without her fear of my leaving her as her mother did. In the past she had described her mother as critical, cold, distant, and being arbitrarily angry at her. Berating her mother became more intense in this period. Shortly afterwards, the initial rage at both parents became muffled. Something was happening. Kathy appeared resistant, more reserved, and distant. I could not understand that sudden change. I was confused, not sure what to do or say. Finally I decided to question her about what was happening. Kathy said that she started to realize how much she loved me, that I was so special, that I had changed her life, that she needed me so much. Kathy started to talk about her love for me, and wanting to take me physically with her when the session was over. These and other expressions of love were repeated over and over again. I started to feel uncomfortable. Her love for me felt different than with other patients, I felt intruded upon. Her expressions of love evoked feelings of anxiety and helplessness in me. Additionally, I did not feel the erotic resonance one might expect with opposite sex and even same sex patients. Thinking of her history of sexual abuse and lack of affection and protection from the mother, I

wondered if there were erotic components to these responses.

As time went on, she persisted in talking about those manifestations of love and affection toward me. I was not sure what to do with her statements. One day, I decided to ask her how she would express her love for me. Her response was that she wanted me to lie next to her, to caress me, and to touch me and that she was feeling sexually aroused when talking about it. At this point she was using the couch. I continued the exploration and Kathy said that she wanted to be one with me, to have me inside of her so that she would not lose me; she could possess me and have me with her all the time. Her insistent expressions of love were accompanied by bodily sensations on her part. While this was taking place, my inner feelings were of discomfort. I felt that she was going to eat me up, to swallow me. I felt angry and I wanted to run away. I experienced her expressions of love as someone who was insatiably hungry. In hindsight, my discomfort about Kathy's resistance to talk instead of acting the transference, had its origin in her sexual feelings toward me that I had probably unconsciously anticipated. During that period, I was not looking forward to her sessions. At times, I had the fantasy that she would cancel her appointment. When all those thoughts, fantasies, and feelings were occurring within me, I became aware of the impact her erotic feelings were causing in my clinical judgment. I could not return her expressions of erotic love because I did not have them. How could I help us and her understand what was happening? I questioned myself about it. I became aware of a few situations in my life when I felt verbally intruded upon.

It was then that I recalled Kathy's experience of sexual abuse and intrusion

by her father and lack of protection and love of her mother. I also thought of her neediness and her wish to swallow me. I became aware that it was possible that those memories motivated the sexual feelings in the transference. I came to comprehend that her need for the mother of symbiosis was missing when growing up. She was projecting those wishes in the relationship with me. With this point more clear in my mind, I started to feel more comfortable, and my anger and discomfort started to recede. After all those inner struggles, I made my first interpretation on her need for a mother. Kathy was furious. She wanted me as a lover, not as a mother. She felt I did not understand her love for me and after all this time I did not understand her at all. In retrospect, perhaps my interpretation was premature; however, I repeated it in several ways at different times. Her wish to focus only on her love for me was a significant resistance to deal with in the treatment. She desperately wanted me to be the mother she did not have. At the same time she was fighting this awareness. The deep desire to merge with me physically and fear of losing my love was in her mind most of the time. This was interpreted over and over again. We worked on that storm. Behind Kathy's expressed frustration at failing her to seduce me, there was later a relief that I did not get involved in that fantasy. She started to feel safe: Her father had seduced her but she could not seduce me. I started to think of my need to alleviate the pain of the loss of the mother she never had. As time went on, however, Kathy comprehended her need for a primary object, a caring, loving mother to soothe and comfort her. We came to discuss how her sexualization of those feelings toward me had its origin in her father's seduction. I started to see the sexualizing of her feelings as a way to enliven her deadness inside. I also began to understand her paranoid defenses against trusting, closeness, and intimacy. Accepting that she needed a mother was too infantile, expressing her need sexually was, in her eyes, more adult-like.

Erotic Transference Between a Male Patient and a Female Therapist Without Physiological Manifestations

Peter is a 58-year-old professional, married man who came to therapy because he was unhappy with his wife. In his professional work he deals with international people and in the past, he had an “affair” with one of his contacts. This affair did not involve a sexual relationship; however, he fell in love with this woman and his wife noticed a change in him. Even though this had happened some years back, and he has had no contact with her, he had been thinking about her again. At the time he told his wife about it.

His relationship with his wife was not what he wanted at this stage in his

life. She was very involved in her work and appeared somewhat compulsive about it. He wanted to spend more time with her. Their sexual life was sporadic and he wanted more. When he would sexually approach his wife, she was not interested.

Peter's mother died when he was a child. His father remarried a divorced woman who was loving and caring of him. In recent years he did not have much contact with his stepmother.

In the initial stages of treatment we dealt with his emotional needs that were not fulfilled. We associated those feelings with the loss of his mother and the implications of that loss when he was growing up. Since he had not been in touch with

his stepmother, his father's illness and then his death made him be aware of the importance of his stepmother and other relatives in his life. Those issues were dealt with and he began to have more contact with his family. Remembering his adolescence, Peter stated how “nerdy” he was and how much trouble he had going out with girls because of that.

In treatment he was involved, came punctually, and talked freely; how-ever, he was very intellectual and rigid in some assumptions and expectations, and about his life in general. There were some obsessive compulsive aspects of his personality. Even though he complained about his wife's rigidity, he had not allowed himself to enjoy certain things in life that gave him pleasure, like poetry. Slowly, Peter began to get involved as a sponsor to a poetry reading group. As a result of this, he starting attending poetry events, mostly alone (most of the times his wife did not accompany him), and reported to me on his outings. At those times, when he told me about the pieces he had heard, he would frequently recite some of them. At that point, he expressed more intense emotion than at any other time in the past. Those were powerful emotional experiences that he shared with me. He felt that he was allowing himself pleasures that he had not before. I also felt that he was allowing his deep feelings to come to the surface. In one session, following a poetry event, I made a comment about poetry and he picked up that I also liked that art form. After that, he started discussing more topics about literature. I thought he was trying to seduce me with that. I later realized that whatever I had said made me feel that I had given something away about me and that he was using it, but I had to admit that I enjoyed hearing his tales and his comments about poetry.

In one session, talking about his wife, who had not gone with him to one of those events, he stated: “If you had been there you would have liked it.” On another occasion he talked about being angry at his wife for being uninterested in what he liked, and resented her for being somewhat cold. He said “I am telling you this and I feel funny. I am complaining about her. I feel that am cheating on her.” When I tried to explore further this “cheating,” Peter started to talk about our relationship—how he wished we could go together to

a reading and how many things we had in common. I questioned him regarding other fantasies about me, even outside of the session. He chuckled, remained silent, and then he started to talk again. He expressed his wish of sharing more things, being more intimate, holding my hand, and taking me to a poetry reading. He wanted to spend time doing that, then we would go to dinner and then speak forever. These themes were repeated many times. He talked about getting old and not enjoying his life to the fullest. When I asked about sexual feelings toward me, he appeared very uncomfortable. He said that he had not thought about it.

The following session, he only talked about work and other unrelated subjects to our last sessions. I asked him about his change in topic. He said that he did not want to talk about it. Moreover, he stated that he was afraid of those thoughts and feelings because he was fearful of acting them out. I explained to him that talking about feelings did not mean that we were going to act upon them. He seemed relieved and spoke about this person (me) that was giving him support and encouragement to do things he never thought of in the past, and that we shared many things that he was feeling very close. He compared me to his wife. This relationship was different from his past affair since ours was more than sexual, it was also intellectual, even though sexual feelings were there. He started fantasizing about the possibility of falling in love with me and began to panic at the idea of losing me because of that. I assured him again that talking did not mean doing it. He seemed so afraid of his emotions that my reassuring him gave him some freedom to talk, even though cautiously at times. We continued our discussions and after a great deal of work, he realized that I was a fantasy, that he could not have me. During this period, I did not feel sexually aroused by his remarks but I was fascinated by his intellectual comments and his knowledge of literature and poetry. I remember waiting for his hour with anticipation: What was he going to bring “me” this time? I also questioned his idealization of me and was concerned about what would happen when I disillusioned him. I worked through my contertransference and started to accept the possibility of disappointing him.

Working through the erotic components of the transference (and my feeling more comfortable with that), helped him feel more at easy with his feelings. With time, he began to experience relief and gratitude toward me for protecting him from his impulses. He learned to tell his wife what he needed from her and she had begun to be more responsive to his needs.

Discussion

Many patients are motivated by the urgent desire for actual bodily contact, a desire for maternal envelopment along with the terror of being lost, engulfed,

or smothered within the maternal orifices. What the patient desires is bodily contact in which there is no boundary between patient and therapist, in essence share the same skin. There is the longing for oneness and yet a terror to be one

(**Solomon, 1997**; **Wrye & Wells, 1994**); however, the analyst may not reciprocate those sexual feelings. This description is what Kathy wanted from me, however, I did not have any erotic feelings; I felt engulfed and wanted to run away from her. My non-sexual feelings reminded me of **Akhtar (1996)**. He described four aspects of the "malignant erotic transference": (1) predominance of hostility over love in the seemingly erotic overtures; (2) intense coercion of the analyst to indulge in actual actions; (3) inconsolability in response to the analyst's depriving stance, and (4) the absence of erotic countertransference in the analyst, who experiences such "erotic" demands as intrusive, desperately controlling, and hostile (p. 143). This last one is how I felt with Kathy.

I also connected my experience with Kathy with that of Slochower's **(1999)** work with her female patient. She stated that her coldness toward the patient's expressions of love was related to something about the content, intensity, and explicitness of the patient's desire toward her, and her own inability to use her subjectivity. Finally, Slochower remembered one childhood experience that helped her understand her sense of scrutiny and penetration. She understood that her patient's erotic transference represented a re-enactment of a symbolically penetrating, but mostly non-erotic dynamic. Later on, she realized that her patient's idealizing erotic transference reflected an unconscious need to redress a sense of badness through the patient's connection to her as a maternal Angel (p. **1126**). Like Slochower, a personal memory helped me deal with the patient's erotictransference. Also, as with Slochower, I felt more comfortable in the role of idealized-other than as a sexual partner (p. **1122**).

Khan (1979) and **Stein (2000)** wrote about sexualizing an experience. **Khan (1979)** described how children libidinize the body in response to deficiency in maternal care and how sexual behaviors are prematurely developed to serve nonsexual needs and to obscure the person's hungry, primitive parts. This libidization of the body is an attempt to concretely recreate, and some-times redefine, the original unity with the omnipotent, nourishing breast-mother. **Stein (2000)** wrote how sexuality transforms overstimulating pain into (sexual) excitement and that sexualization can enliven the patient's deadness. She further stated that sexuality has the capacity to overflow the entire field of human experience so that everything can acquire sexual connotations (p. **169**). I agree with both Khan's and Stein's statements, since they clarify and define Kathy's conflict. Kathy's sexualization of our relationship was a re-enactment of her trauma with her father in the transference, evoking anxieties and primitive bodily sensations. It was a manifestation of pre-oedipal

needs that had not been fulfilled. Kathy's close and deep ties with an inconsistent and ambivalent loved object (mother), who she needed and persecuted her, were projected in the person of the analyst by sexualizing them. She used sexualization to transform pain into a stimulating pleasure.

As mentioned before, **Wrye and Wells (1994)** use the phrase *maternal erotic transference* to denote erotic wishes directed toward concrete parts of the analyst's body, which they attribute to the sensual bond with the pre-oedipal mother as early as the preverbal period. Often this maternal erotic transference-countertransference duet evolves only late in the analysis after the patient has developed the capacity for self-reflection and the deepest resistance to trust has been analyzed **(Wrye, 1999)**. This is not what happens in more regressed patients. Kathy is a case in point. I believe that the development of an erotic transference can happen at any time in the treatment process, particularly with patients with severe psychopathology or sexual trauma.

The connection between sexual or erotic transference and sexual abuse, sexual trauma or sexual seduction in childhood has been described in the literature (**Bernardez, 1993**; **Davies and Frawley, 1994**, in **Messler Davies, 1998**; **Droga, 1997**; **Freud, 1915**; **Miller, 2002**; **Stein, 2000**; **Wrye and Wells, 1994**). For further literature on this topic, see **Wolf and Albert, 1991**.) **Droga (1997)** describes the somatic manifestations in the emergence of memories of childhood sexual abuse. She states the appearance of these memories are accounted for as follows: (1) the trauma was somatic in nature and was encoded, stored, and retrieved in memory along somatic-sensory channels; (2) the physical dimension of the trauma was an intensive foreground experience; (3) the original experience was never articulated in words; and (4) the somatic nature of the memories concretized and validated the reality of the traumatic experience (p. **190**). This was the case with Kathy. She had repressed the sexual trauma for many years and it appeared in the sexualized transference with the physiological components attached to it.

We worked on the maternal erotic landscape with my non-erotic feelings; however, what if I did have erotic feelings? As mentioned before, some clinicians have written about this issue. **Messler Davies (2001)** raised the clinical question of when and why one might draw the analysis of erotic transference-countertransference issues into the here and now of the analytic relationship, and when and why one might choose to deal with these issues first by maintaining a focus on the patient's life outside the treatment setting (p. 258). Her view was that analysts have to remain secure and comfortable, working on their own issues and resistances. **Ehrenberg (1992)** stated that in some instances willingness to let the patient know what the analyst is experiencing, even if the analyst may not at the time understand his or her own reaction, can facilitate the analytic work, simply because of the kind of collaborative possibility it structures (p. 17).

In my work with Kathy, my personal impression about sharing my erotic feelings is that if I had them, I would probably have not shared them with her due to her pathology. It would increase her wish for me and her devastation that we would not act upon them. However, I would acknowledge them to myself and would try to find ways to still help her without jeopardizing our relationship.

With Peter the erotic encounter was different than with Kathy, because we are of different gender, because of the personality dynamics, his longings, and his developmental needs. My work with Peter confirms Karme's **(1979)** viewpoint that the reality of the female analyst's gender can be a determining factor in the transference at the oedipal level. The fact that we were of different gender stimulated his sexual longings. I agree with **Koo (2001)** that the age of this male patient may indicate a life stage, midlife, during which there is an increased need for external confirmation of attractiveness and sexual vitality (p. 35). He needed a companion that can share with him his newly found interests. Having felt as a "nerd" in his adolescence, that I, therapist-female was interested in him, was a facilitator for the development of the erotic transference.

Bonasia (2001) talks about eroticized transference at the beginning of treatment. This transference is seldom accompanied by a corresponding countertransference. Such a crude idealization triggers feelings of greater or lesser irritation in the analyst, associated with the patient's invasion and distortion of his identity (p. **257**). Even though with Peter, the erotic transference did not develop so early in treatment, it stimulated my fear of disappointing him with his idealization of me. Actually, it was the intellectual seduction that stimulated my curiosity. That we know our patients and that we consistently make efforts at enhanced intimacy; that we offer certain provisions missing in their earliest object relationships; that we promise a kind of understanding and enlightenment—all this and more can render us objects of intense excitement and allure. This leads to the idea that the psychoanalytic encounter per se is a seductive process (Messler Davies, 1991, p. 761).

If I conceptualize Peter's erotic wishes at the oedipal level, we can understand that the oedipal parent, the object of the oedipal child's emerging sexuality, is an adoring and idealizing figure. Peter's disappointment from the early abandonment by his mother set the stage for a need of somebody idealized to fulfill his developmental process and fill the gaps produced by that loss. Recognizing that Oedipus is not a complex capable of resolution but only the beginning of what will be a lifelong, post-oedipal process of containing, enhancing, and elaborating, it can ultimately help enjoy one's sexual subjectivity in different situations despite the obstacles that can impede this journey.

The fact that I made clear that there were not going to be boundary violations,

helped the development of the positive transference and Peter's ability to talk about his fantasies about me. As Stern **(1991)** told his female patient: "In order to protect you and the treatment, you need to understand that I will not, now or ever, take sexual advantage of you in any way, recognizing as we do that this is terrifying and yet a longed for fantasy" (p. **475**).

One question that arises is why Kathy had somatic manifestations of her erotic longings while Peter did not. The answer to this is the nature of the pathology that each patient had. Kathy presented with a more borderline pathology at the pre-oedipal level with sexual trauma, while Peter functioned at a neurotic level with oedipal issues. He had received enough consistency and reliability to reach the oedipal stage with fewer traumas.

One wonders how the body worked for these two patients. **Freud (1923)** stated that "The ego is first and foremost a bodily ego; it is not merely a surface entity, but itself a projection of a surface" (p. **26**). The ego, then, is not part of the body; it is not a somatic but a mental structure; it is a somatic representation of the body (Rangell, **2000**, p. **187**). Talking about the body's erogenous zones, Rangell comments that the affective, cognitive, and somatic significances of the erogenous zones spread to other more diffuse and related bodily parts, ultimately involving the entire body in the service of reacting to psychic stimuli. Psychic meanings spread from one orifice to another interacting with objects from the environment (Rangell, **2000**, p. **186**). These objects can be personal interactions including traumatic experiences. The body acting as a unit with the mind, is utilized to convey the mind's wishes, as discharge or defense. Pines (1993, in **Mo, 2000**) explained that a psychoanalytic dialogue consists of listening to what the patient is not saying, not able to say, and noting how the body has been forced to act out feelings that could not be consciously known or transmitted. Following this line of thought, **Gedo (1997)** considers that bodily functions may communicate symbolic meanings, in which case they are capable of being translated into discursive language. They may also occur as incidental, albeit dramatic concomitants of some persistent affective state. This being the case, communication takes place through the music of affectivity itself, and the accompanying somatic by-products are of secondary import (p. **196**). The body, then, is able to induce a variety of disturbing (and visceral) experiences; dread, horror, and nausea reactions which typically characterize the confrontation of

discursive limits, arising at particularly those moments where signification and words fail, and meaning collapses (Hook, **2002**, p. **682**). At those moments Kathy's language failed and her body started to tell what was difficult to utter with words whereas Peter was able to attach his bodily ego to ego integrity and hence symbolic integrity that allowed him to articulate emotions in a verbal way (Hook, **2002**, p. **706**).

We can include here the interpersonal understanding of bodily experiences.

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Diamond (2001) argues that while certain psychodynamic formulations view bodily impulses and sensations as developing from innate internal sources, contemporary psychobiological theories emphasize the interdependence of the body with the environment. Bodily experience and processes are formed in interaction with the caretaker, initially, and with interactions with others throughout life (Diamond, **2001**, p. 42). From this viewpoint, bodily instincts, sensations, and fantasies all develop in an interpersonal context. In other words, the interpersonal tie between persons is primarily bodily in nature. As Merleau-Ponty (1964, in **Diamond, 2001**) indicated, internal sensations are always in relation to an environment and to an interaction with an-other (p. 50).

Exploring our experience of erotic feelings with one patient and not with another can help us understand the nature of the interaction, the type of pathology involved, and the repetition of a trauma. Such countertransference, if correctly used, may be extremely valuable to both members of the dyad in terms of their capacity for transformation and integration. Brenman Pick (**1985**, in **Bonasia, 2001**) states that the ultimate problem is how the analyst can allow himself/herself to have the "sexual" experience, to digest it, to formulate it, and then to communicate it as an interpretation (p. **260**).

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