Review article

Erotic transference

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INTRODUCTION

The erotic transference consists of a quite common process in the clinical practice of professionals that follow either the analytically-oriented psychotherapy or the psychoanalytical orientation, and it comes up as a topic of great theoretical and practical interest. In fact, as this form of transference is a considerable obstacle, it can be used as a valuable resource for the progress of treatment and understanding of parts of the patient's personal history and psychic development and functioning.

The goal of the present work is to review the concept of erotic transference, emphasizing the technical difficulties to manage it, as well as to approach the use of counter-transference and the influence of gender in the transference phenomenon.

TRANSFERENCE

The term "transference" as a meaning of resistance was firstly employed by Freud in 1985.[1] It was considered an obstacle to the analytical process that prevented the access to residuals of the childhood sexuality that remained linked to "erogenous zones"; in a normal evolution, such links should be already disconnected.

Some years later, in the classic Dora's case,[2] Freud pointed out that the patient does not remember anything that is forgotten or repressed, but act it out, reproducing the repressed not as a recall, but as a repetitive and unconscious action. In the post-scriptum of this work, Freud[3] conceptualizes transference saying that transferences "are new editions or facsimiles of the impulses and fantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment. Some of these transferences have a content which differs from that of their model in no respect whatever except for the substitution. These then – to keep to the same metaphor – are

merely new impressions or reprints. Others are more ingeniously constructed; their content has been subjected to a moderating influence – to *sublimination*, as I call it – and they may even become conscious, by cleverly taking advantage of some real peculiarity in the physician's person or circumstances and attaching themselves to that. These, then, will no longer be new impressions, but revised editions." So far, transference had been seen as a clinical phenomenon that could be an obstacle to treatment, later on, however, Freud[4] referred to transference for the first time as a therapeutical agent, and observed that transference was not always an obstacle, it could have an important role in the process of understanding patients.

The specific qualities of transference were assigned an additional meaning when the concept of "transference neurosis" was introduced.[5] This concept emphasized the way how past relationships, which compose the neurosis, affect the patient's feelings towards the therapist. This concept was later widened, when Freud[6] pointed out that "the patient is compelled to repeat repressed contents as something from the present, instead of, as the physician should realize, remember it as something from the past". The theme of such reproductions, which arise with great and undesirable exactness, is some part of the children's sexual life and invariably is expressed through transference that takes place between patient and therapist. When one reaches such phase, we can say that the previous neurosis is replaced by a new one, the "transference neurosis." Repeating the past through transference is a consequence of the "repetition compulsion." The transference itself is only a fragment of repetition, which is a transference of the forgotten past not only from patient to therapist, but to all the other aspects of the present.

The understanding of transference as a source of unconscious communication was very well developed by Melanie Klein.[7] According to her, when the therapeutic relationship is set, the patient recalls feelings, conflicts and defenses he or she experienced in the original situation. Klein understood transference as a reproduction of all primitive objects and objects relations internalized in the patient's psychology, followed by drives, unconscious fantasies and anxieties.

According to Dewald,[8] transference is defined as the displacement to an object from the present moment of all impulses, defenses, attitudes, feelings and responses experienced with the first objects in life . Transference would be a repetition of situations whose origin rely in the past. Greenson[9] defines transference as an unconscious process, as a repetition of an object relationship that took place in the past, usually with people who were important for the child's in his/her first years of life, unconsciously transferred to figures from the present.

Therefore, by analyzing the concept of transference under the light of different authors, it can be defined as a set of unconscious expectations, beliefs and emotional responses that a patient carries to the therapeutic setting. Such responses are not necessarily based on who the therapist is or how he or she really acts, but on the persisting experiences that the patient has during his life with other important figures from the past.

EROTIC TRANSFERENCE:

In 1915, Freud[10] referred to the "transference love" as a serious difficulty in psychoanalysis as a very frequent situation in which the patient declares love for the doctor. Freud points out that the doctor must recognize that the patient's falling in love is not to be attributed to the charms of his own person. Freud intends to demonstrate how much the powers of nature are present in the transference phenomenon and also to call the doctor's attention to what he or she is managing, using the erotic transference to better understand the patient. In this work, Freud classified transference both as positive and negative. The positive transference is then referred to all drives and derivatives related to libido, especially feelings of affection and care, including erotic desires, provided that they have been sublimated under the form of non-sexual love and do not persist as an erotic link. On the other hand, the negative transference concerns the presence of aggressive drives and their derivatives, such as envy, jealous, voracity, destructiveness and intense erotic feelings.

When approaching special types of transference, Sandler[11] reported that there are patients who develop erotic transference and refuse to go on with the usual therapeutic treatment, they can

reject interpretations that relate current feelings to the past and do not search further explanations for the meaning or cause of symptoms they had complained before. Sessions are used to express their love, gratification in the presence of the beloved, and pledges for having their "love" corresponded. Even though Freud[10] acknowledged the resistance of transference, he warned therapists not to confound this reaction with true love, and at the same time he warned them against their attempts to repress patients' love. He said that "to urge the patient to suppress, renounce or sublimate her instincts the moment she has admitted her erotic transference would be, not an analytic way of dealing with them, but a senseless one. It would be just as though after summoning up a spirit from the underworld by cunning spells, one were to send him down again without having asked him a single question." This means it would be as disastrous for the patient to have her love fulfilled as suppressed.

Erotic transferences can be manifested in different ways, following both the neurotic and psychotic patterns. Different authors have differentiated several forms of erotic transference. Bolognini[12] described four types of erotic transference, with their respective dynamic origins and repercussions in the analytical relationship. The erotised transference would be predominantly based on a psychotic modality. The underlying fantasy in the transference erotisation, which would have a defensive function, would be the fantasy of separation and abandonment, which will be an attempt to restore that state of narcissist fusion with the mother. The erotic transference would be based on a neurotic modality, and loving and affectionate transferences would be clinical manifestations that would correspond to a healthier and ameliorated behavior. For many authors, the erotised transference is typical from borderline patients, very disturbed; in the erotic transference there is an excessive anguish to be loved by the analyst, with manifest and conscious demands of sexual gratification, which are direct, exaggerated and persistent.[13,14] It expresses a very primitive mental functioning, in which the object is highly idealized and persecutory. According to Teixeira da Silva,[15] apud Blitzen, the erotised transference is a reflex of pre-genital conflicts in which aspects such as intense violence, fragility of the self and lost of the notion "as if" are

predominant; the therapist is not “as if” he or she were the father or mother, the therapist is the patient’s father or mother. There is a loss in the capacity of symbolizing, and the intensity of this loss shall represent the level of patient’s regression. In the erotic transferences, the capacity of fantasizing is not lost, and the erotic demands remain in the level of fantasy, the analyst is an object of the patient’s fantasy, different from the erotised fantasies, in which the therapist is a concrete object. Saul[16] discusses the role of latent aggressiveness in situations of erotic transference. He points out that this type of transference is associated to real frustrations in relationships that took place in the early years of life, suggesting that hostility and rage triggered by such frustrations could be repeated in the relationship with the therapist. Transference love would be a way of protecting the physician from hostile feelings.

Zimerman[17] considers that two risks may follow the installation of erotised transference in the analytical field: one is that when the patient’s demands are not satisfied by the therapist, the patient acts outside the analytical situation, sometimes acquiring some severe traces of malignity. The second possibility is equally malignant, it is when the therapy can end up perverting the transference, including the possibility of the therapist being involved in it.

In the management of erotic transference, one should take into account that new editions of infantile conflicts result from unfulfilled desires that try to be accomplished in the context of the psychoanalytical treatment. It is the therapist’s responsibility to show the reality to the patient, which can be made through a detailed analysis of transference/countertransference feelings of the dyad patient-therapist. When the therapist makes his or her interpretation, putting unconscious emotions into words, he opens the passage to the symbolic. When interpretation makes the unconscious conscious, it allows the libido to be at the self disposal for healthier investments. It puts the patient in contact with reality and not with the fulfillment of a desire, as the patient requires. Moreover, if interpretation is employed correctly, it frequently reduces the desire and resistance inherent to the erotic transference.[18] Elaborating the transference love implies elaborating the renouncement and the grief that usually follow the resolution of an oedipal situation. At the

same time, the patient must learn that searching for the oedipal object would be a permanent aspect in all his or her love relationships. This does not mean do understand all future love relationships as resulting solely from the oedipal situation, but that the oedipal structure is present and affects the framework of love experiences.

Freud,[10] however, pointed out that there is "one class of women with whom this attempt to preserve the erotic transference for the purposes of analytic work without satisfying it will not succeed. These are women of elemental passionateness who tolerate no surrogates." He goes on saying that "with such people one has the choice between returning their love or else bringing down upon oneself the full enmity of a woman scorned. In neither case can one safeguard the interests of the treatment. One has to withdraw, unsuccessful; and all one can do is to turn the problem over in one's mind of how it is that a capacity for neurosis is joined with such an intractable need for love."

For Kernberg,[19] the most important technical issues in the management of erotic transfer are: first of all, tolerance with the development of sexual feelings towards the patient, either homosexual or heterosexual, which requires doctors' internal freedom so that they can use their psychological bisexuality. Then, the importance of systematically analyzing the patient's defenses against the complete expression of sexual transference, and the risk of becoming invasive through seduction; and finally, the physician's capacity of analyzing the expression of transference love and his or her reactions to frustration, which will inevitably occur. The therapist's task would be to avoid talking about his countertransference feelings and integrate the understanding obtained with his or her countertransference with transference interpretations about the patient's unconscious conflicts.

THE USE OF COUNTERTRANSFERENCE

Initially, countertransference was also treated as an undesirable phenomena of the psychoanalytical treatment, just like transference. Freud[20] coined the term countertransference defining it as a phenomenon that arises in the physician "as a result of the patient's influence on his unconscious feelings." As in the transference, Freud's first reaction was to consider it as something

inadequate and disturbing that should be avoided. He says, with relation to the doctor, that "we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it." Later, Freud[21] was already aware of the potential value of countertransference and recommended: The therapist "must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient … so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free associations."

However, it was after the studies developed by Racker[22] and Heimann[23] that countertransference became an additional factor in the process of understanding the therapist's work. Racker[22] considered countertransference as a set of therapist's images, feelings and impulses during the session that could happen in three different ways: a) as an obstacle; b) as a therapeutic instrument; and c) as a "field" in which the patient can really acquire a live experience, different from that he had originally. He also described two types of countertransference reactions: the complementary countertransference, when the analyst takes on the role of the patient's object; and the concordant countertransference, when the analyst takes on an aspect of the patient's personality (self, id and superego). Heimann[23] describes the countertransference as the set of all physician's feelings towards the patient. He points out that the therapist can use the emotional responses to the patients' projections to understand them. For that end, the therapist must be able to keep his/her feelings for himself/herself, instead of discharging them as does the patient.

Erotic transference usually causes some countertransference reactions in the therapist, and examining such reactions is important to understand the patient. Krenberg[19] considers it is useful that the therapist is able to tolerate his/her sexual fantasies towards the patient, and must let an imaginary sexual relation happen in the narrative, mentally following the patient's erotic transference. This will allow him to progressively realize the antilibidinal, antidestructive and rejecting aspects that can be hidden in the patient's explicit erotic manifestation. According to this author, the analyst that feels himself/herself free to explore, in his/her own mind, the sexual feelings

towards the patients will be able to assess the nature of the transference development and, thus, avoid the defensive negation of his own erotic response to the patient. The analyst must, at the same time, be able to examine the transferencial love without acting his countertransference out in what may be configured as a seductive approach.

Teixeira da Silva draws attention to the role of the therapist's own treatment. He says that the "analyst's ideal didactic analysis would be that in which he/she could analyze with detail his/her pre-oedipal and oedipal aspects and overcome them to develop a natural and true relation with himself/herself. All this would be complementary to practice and theory. This author claims that there is no ideal analysis and that we must understand our work and clinical experience as an endless source of knowledge and development.

GENDER AND EROTIC TRANSFERENCE

There is a growing tendency in the psychoanalytical literature of works considering that transference and countertransference are influenced by the gender and vital cycle of the dyad involved in the analysis. The analyst's and patient's sexual identity does not only stimulate but create specific transference and countertransference resistance and difficulties.[24] As to the erotic transferences, this is not different. Note, for example, that most of the psychoanalytical case reports involving erotic and erotised transferences is about female patients with male therapists.

Teixeira da Silva,[15] points out that both male and female therapists meet difficulties to realize transferences in which they have the role of the opposite sex. This author listed the different characteristics of transference in the therapeutic dyads according to the respective genders. In the male therapist and male patient dyad usually predominates, in the oedipal transference, the situation of an aggressive competition with the father, and, in general, the heterosexual impulses are not realized because they are displaced to external objects. The passive homosexual impulses, when aroused, are sources of great transference and countertransference resistances. In the female therapist and female patient dyad, the arousal of an intense erotisation is more frequent, because the

woman regresses more easily to a situation of fusion with the phallic mother, once the therapeutic situation corresponds to the original situation of the girl's development, in which she must firstly solve her erotic and homosexual development with her mother, then enter the positive oedipal phase, elaborate the oedipus complex and establish her sexual identity. In the male therapist and female patient dyads the erotic transferences – or erotised transference – are more intense. In this situation, the therapist may find difficult to differentiate when the patient projects the rivalry and hostility against the oedipal mother of an anal regression against the frustrating object, that is, against the oedipal mother. In those dyads, when there is a homosexual desire towards the mother, it will be difficult for the therapist to identify it and separate it from the heterosexual desires concerning the father. In the female therapist male patient dyad, there would have an absence of erotised transferences due to the fear of the powerful pre-oedipal mother that generates anguishes of castration that interfere in the development of strong erotic desires for the oedipal mother.

There is a number of other authors that also made important contributions for the understanding of the issue. Lester,[25] for example, stressed that the male patient anxiety towards the female therapist as a phallic pre-oedipal powerful and castrating mother can blur and inhibit the expression of sexual feelings towards the therapist as an oedipal mother, which will account for the few cases reporting this situation in the dyad female therapist and male patient. The author also observed that the passivity engendered by regression in the analytic therapy is dystonic to his active male sexual role. Such point of view was not corroborated by Gornick.[26] He thought that, for certain male patients, it would be much more difficult to be passive and dependant than expressing sexual feelings, which would make men to defend themselves from such feelings, developing erotic feelings towards the therapist in an attempt to restore the sense of male domination.

Pearson[27] points out that the erotic transference is more frequent in women as a form of transference, while men would resist against any form of conscience of an erotic transference. Usually, men would displace their erotic feelings towards the therapist to a woman out of the therapy setting, because recognizing such desires would threaten his sense of autonomy. Person also

considers that the erotic transference in women is more frequently a desire for love, whilst in men it is a sexual desire.

CONCLUSION

The management of erotic transference can pose some difficulties, which can be compared to hostile and paranoid transferences, once they can block the therapist's analytical capacity, at least temporarily.

According to Meurer,[28] such situations challenge the therapist's capacity, demanding a high level of integration with the self, free fluctuating attention and free perceptive sensitivity to be able to detect, acknowledge and interpret what happens in the transference and countertransference. In the erotic transference, the patient is expected to externalize once more his or her intense infantile desire of loving and being loved, and his or her permanent neurotic willingness to fulfill oedipal love frustrations and obtaining unrestricted and exclusive love from the mother-father therapist. A delicate issue is the possibility, and even necessity, of using countertransference to identify the nature of feelings and fantasies present in the transference. Thus, countertransference does not need to arise as an obstacle but as a factor to understanding. As a consequence, the patient's transference will not be only resistance and drawback, but also a valuable form of communication, which will bring contributions to treatment.

Wallerstein,[29] in an analysis of the "Observations on transference love"[10] stresses that Freud: 1) Identified the high prevalence of erotic feelings evoked in the psychoanalytic treatment and the "dangers" of such feelings; 2) observed that a small part of patients would develop a form of transference love that would act as very intense resistances and could not be analyzable; and 3) established the main technical foundations to cope with such transferences, as the rule of abstinence and neutrality.

The fact that erotic transference is a common process that can cause technical difficulties when being managed was always stressed in the psychoanalytical literature. Following

the basic principles of psychoanalysis postulated by Freud, acknowledging the phenomenon of resistance and adequately using countertransference are necessary conditions for understanding and solving it, which brings precious benefits for the patient's treatment.

The therapist's personal treatment is a fundamental instrument, which can make him able to understand his own psychological functioning and the processes that take place in the patient's mind, as well as the mechanisms that influence the erotic transference and countertransference phenomena. Other required resources can be learning through clinical and theoretical seminars, selected readings and individual supervising.

According to Zimmerman,[17] although the patient has an absolute conviction and determination in his game of seduction, in his or her inner deep he is afraid the analyst makes some mistakes, as remaining cold, indifferent and distant from the patient's appeals and erotic fantasies; getting disturbed and defensively replacing interpretation by criticisms, accusations, moral lessons and apology to good behavior; the patient can even have repressive actions that include the fear of having the treatment interrupted, use of medication or being referred to other professional; and the real possibility of the therapist getting involved in a sexual intimacy, which would characterize a total perversion of transference and of the psychoanalytical process.

The theoretical and technical difficulties in the identification and management of the erotic transference can get worse, when they start to cause ethical and legal problems beyond clinical ones. Bad sexual behavior in the patient-therapist relationship is potentially harmful to the patient and therapist, destructive in relation to the therapeutic work and negative to the profession.

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ABSTRACT

Erotic transference is a relatively common process in psychotherapy and psychoanalysis. In spite of its difficult management, when appropriately understood and managed, erotic transference may become a useful tool in the therapeutic process. In this review, we will address the concept of erotic transference, with emphasis on the difficulties faced in the technical management of the process, as well as the use of countertransference and the influence of gender in this situation.

Keywords: *Psychoanalysis, psychoanalytic psychotherapy, transference, erotic transference, erotized transference.*

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