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EROTIC TRANSFERENCE

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This article presents some reflections on the delicate and complex phenomenon of erotic transference (and of correlated countertransference issues), a particular form of transference that compels the subject to convert the object into an erotic phantasy. It must be noted that the adjective 'erotic' is a bridge concept between 'pleasurable' and 'sexual'. It follows that erotic transference can have various tonalities that range from loving to sexualized and from a dream state (benign) to a drugged or delusional state (malignant). Some writers distinguish between various types of erotic transference, which, however, can be placed on the 'pleasurable↔sexual' continuum, and which can in turn be superimposed onto the 'preoedipal↔oedipal' dimension.

KEY WORDS: EROTIC TRANSFERENCE, EROTIC COUNTERTRANSFERENCE, IDEALIZATION, EROTIZATION, SEXUALIZATION

In this paper I will offer some reflections on the delicate and complex phenomenon of erotic transference, a particular form of transference that compels the subject to attempt to transform the object into an erotic phantasy. It should be clarified that the word 'erotic' is a bridge concept between 'pleasant' and 'sexual' (Rycroft, 1968). Consequently, the erotic transference can modulate from loving to sexualized, from a dream state (*benign*) to a drugged or delusional state (*malignant*) (De Masi, 2011). Some authors (cf. Bolognini, 1994, 2005) distinguish different types of erotic transference. However, they all seem to be able to fit into the 'pleasant↔sexual' *continuum*, which, in turn, can be superimposed onto the 'preoedipal↔oedipal' dimension.

Our clinical activity provides a privileged perspective on the everyday life of our patients. From this vantage point, we see that many of them (as well as others who do not consult us) tend to fall in love with something that does not exist rather than something that does – a circumstance that involves idealization. Obviously I am not referring to normal idealization, or creative illusion, fundamental to the process of falling in love (followed by a gradual disillusion that leads to mature love), nor to our normal need to attribute special values and powers to the people on whom we are somewhat dependent. I am talking instead about an excessive use of the mechanism of idealization that spreads through all the various significant object relations that characterize the life of a given adult. The problem is that idealization is a primitive defence mechanism, in that it corrupts the perceptual process, produces an alteration of perceptions in terms of compromising the process of reality testing, as well as in terms of a

'confusion' of self-object boundaries. All this implies that these particular individuals cannot establish real and mature object relations because they are always relating to an ideal image, namely to something that is not there. Moreover, we must remember that the fate of idealized objects is that of being ultimately devalued. The greater the idealization, the more radical the devaluation. Once again, I would like to emphasize the difference between the process just described and the gradual disillusion that follows the creative illusion typical of the process of falling in love – disillusion, precisely, and not total delusion (which is closer to devaluation).

More generally, it is possible to claim that many people try to defend themselves through idealization. Numerous patients (neurotic, borderline and even psychotic), once in treatment, can often develop an erotic transference specifically in order to maintain the idealization. Therefore, erotic transference as defence, or more precisely manic defence, is often accompanied by acting in and/or acting out. I say manic defence because there is a close connection between mania and idealization (Klein, 1935, 1940): mania comes from the feeling of an internal possession of a perfect love object – one that is idealized. In this mania, the idealized object is experienced as exciting and desired (the patient's attempt to fulfil his/her erotic phantasies in the transference is perceived by the object-therapist through his/her countertransference). So it could be said that erotic passion is fuelled by desire which is looking for 'completion': it has to do with something that the subject lacks and that the object owns (or at least the subject is under the illusion that it is so). In some way, eroticism and desire are the representatives of the subject's personal history, of his/her two-way relationship between his/her internal and external worlds, two realities that pervade and influence each other.

More than 100 years of clinical practice (Stefana, 2015, 2017a) show that the erotic transference (loving↔sexualized) and its correlated countertransference are temporary phenomena that we find in many kinds of psychoanalyses and psychoanalytic psychotherapies. However, it happens that in some treatments this type of transference, which we have been describing, acquires a more permanent character, impregnating with sexualized erotic colouring everything that emerges in the here and now of the session. In these cases it is more appropriate to talk about erotic transference neurosis (Britton, 2003). It seems to me that when a non-psychotic patient develops an erotic (sexualized) transference neurosis, the analyst has almost always played a crucial role because of his/her technical incapacity to handle the situation or his/her unconscious collusion with the patient. However, there are cases when such circumstances occur independently of the clinician's analytic functioning. It is therefore important to consider the possibility that our attitude and behaviour towards a specific patient could be an expression of our needs more than a useful contribution to the analytical process.

If a therapist experiences his female[1] patient's 'falling in love' with him as narcissistic appreciation, then he has not understood that such an occurrence is part of the dynamics of transference–countertransference (meant as an intersubjective process) – a transference that implies that what happens in the patient–therapist relationship is a repetition of the patient's overinvested and unresolved relationships with his/her

significant childhood figures. Furthermore, such an analyst would not understand that what the patient perceives are her own projections and not the actual characteristics of the object. In addition, he may have been less than diligent in his attempt not to 'confuse the tongues' (Ferenczi, 1933); that is to say, he might have misread the declaration of tender love from the patient as impregnated with an erotic component.

Such an analyst may have also missed another important point: the lack of the 'as if' nature of sexualized erotic transference (and countertransference): to the patient, the analyst does not 'stand for', but 'is', that specific phantasy[2] that the patient has in mind – a symbolic equation (Segal, 1950, 1957) that makes it possible to deny the absence of the ideal object and/or to control the persecutory object. This is the character of concreteness at the origin of the saying 'erotic transference . . . psychotic transference'. Thus, in the presence of an erotic transference the patient unconsciously tries to fulfil a transference phantasy, or rather, the patient ceaselessly tries to turn the therapist into the object that she has in mind: the therapist must become the object of the patient's phantasy! Thus, it becomes clear that in the erotic transference, the object is a partial object. It is depersonalized, and the subject tries to turn it into an erotic phantasy ('You are this!'). The driving force that fuels the desire of the patient, in order to make her phantasies come true, completely cancels out the perception of the real object (with its qualities and defects). In this sense, the erotization of the transference is a denial of both internal and external realities. It is an escape from the reality that leads her to attribute only positive and ideal qualities to the object, and it may become a veritable delusion.

Sometimes the erotic transference, especially the loving type (a clinical form that is based on a mature level of the Oedipus complex), is a way of defending the object-analyst from aggression, hatred, hostility, ambivalence and devaluation – feelings that are rooted in early-childhood traumatic experiences of deprivation, loss, depression, seduction, and manipulation, and which are all typical of patients who develop an erotic transference during their analytic treatment. The erotic transference is thus an expression of the pain originating in early frustrations, but it is also a benign attempt to hark back to these needs. This pain represents a once-repressed emotion that can finally find expression in the here and now of the analytical session. Underneath the erotic transference lies the desperate need to establish a vital link with the primary object and to regress to a narcissistic object relation or to a state of self-object (ideal object) fusion. Regression and fusion are defences against the narcissistic wound, a sense of inferiority and of exclusion. They chase away the spectre of separation and abandonment. In other words, for some patients, erotic transference is an attempt to go back to their non-separation, to reach that 'new beginning' (Balint, 1949) that requires the achievement of a 'primary love' state, from which one can move on to independence, and to a new separate identity of one's own; this implies the original experience of a mother who was unable to maintain a good-enough illusion (Milner, 1952; Stefana, 2017b; Winnicott, 1953, 1971). The erotic transference is an 'illusion'. In order for it to lead to desirable internal changes, it is necessary for it to move towards a disillusion (and the consequent mourning of the lost illusion), not towards complete delusion. It is important to specify that the more serious the

early deprivations of the subject, the more sensitive he/she will become to the clinician's affective responses. Establishing this new real relationship with the clinician, absorbing the emotional impact which it entails, acknowledging feelings without running from them, and thinking thoughts that are known but previously unthought-of (Bollas, 1987) can initially transform the internal world, and then – at least potentially – the external world of the patient.

In the case of sexualized erotic transference, sexualization can also perform the function of pseudo-autonomy: it provides a defence from feelings (anxiety, hate, desperation . . .) that are evoked from having been deprived of both a healthy analytic dependence and the need for fusion with the primary object. It represents a form of self-protection from the possibility of being hurt by not receiving, even from us, that emotional investment that was insufficient in the patient's primary relationship in terms of quantity and duration: 'I'm not here for my problems of when I was a kid . . .' (passive position; child of the mother-therapist); '. . . I have come here to seduce you' (active position; wife of the father-therapist).

This is the case of R., a young woman who started analysis for some conversion disorder symptoms, and – as would later emerge in her analysis – for an internal conflict between a part of herself that wanted to die, and another part that wanted to continue to live. After some time in therapy, R. developed an erotic transference that appeared only in some parts of the session (regularly announced by sexual excitement in the countertransference a few seconds earlier), which soon became intense and diffused. I felt disturbed by this massive projective identification that forced its way into my mental state, and I worried about the acting out that put R. in dangerous situations. It is within this charged atmosphere that the following session took place: after some minutes of silence, R. started to simulate sexual intercourse and lay on the floor near my feet, and started to show parts of her body. Shortly thereafter she went into an altered state of consciousness and began to beat her head against the floor violently and repeatedly. My interpretations did not have any effect on her, so I decided to take a pillow and put it under R.'s head, but she moved it away. While trying to gently support her head, I said to her that all that 'head banging' was her desperate and provocative attempt to make me sense how difficult it was for her to be understood, and to communicate her states of excitement (sexuality, anger, desperation, guilt etc.) and her being in need of help. In the same way that she discarded the pillow, R. tried to push my arm away, so that she could continue to beat her head against the floor. She did this and then held onto my arm and stroked it, but this time I did not perceive anything sexualized in her gesture. Instead it reminded me of the case of a 3-year-old girl, a former patient of mine, who had suffered from abuse – a girl who lived with a mother who neglected her completely. This little child reciprocated my affection, by stroking me, or by getting a special ointment that she had, and gently rubbing it into my skin.

This session with R. represented the beginning of the resolution of the erotic transference: the sexuality began to be symbolized instead of enacted, just as her dreams, too, emerged during our sessions. There was one in which a big, white boa snake appeared from under the grass of her garden and began to climb onto her, spiralling around her child-self, until it reached her throat.

It is clear that if the seduced object reacts – perhaps because the analyst yields under the continuous pressure of the projective identification, through which the patient aggressively tries to create within him a mental state of excitement, and he, in turn, enacts that seduction in reality (e.g. a sexual enactment) instead of within his imagination – the patient experiences a new trauma, the failure of her underlying narcissistic intentions, and the formation of the sexual couple becomes the death of the mother–infant couple represented by the analyst-patient (Britton, 2003).

Only through abstinence is it possible to analyse the deep meaning of the erotic desires communicated by the patient through the transference; that is, the meaning of those past relationships that can be re-experienced through the transference in the here and now of the session. Thus we will discover that, underneath the erotic imprint gleaned from the transference, there exist past emotions of a totally different nature (anxiety and anger are always present). The result is that the erotic transference is not just a defence. It is also a window onto the internal world of the patient. In this way, the erotic conscious phantasy (see note 2) can potentially become a way to gradually and carefully connect with the unconscious. It should however be noted that the process of understanding the non-erotic meanings conveyed by sexualized erotic transference is contaminated by the particular involvement of the analyst's countertransference (Bollas, 1994).

The patient's possible (probable) 'erotic transference curiosity' as well as her jealousy towards other people in our lives, must not be suffocated. One of our tasks is to help this curiosity, instead, to come to light. For example, the phantasies that a patient has about us, about our love and sex life, are important issues for the analysis. It is good to know them. We can be most explicit on this point. (It must be clear that one must not encourage the establishment of an erotic transference neurosis.) We could thus discover, among other things, that there is an idealization of our personal, emotional and sexual life, and this might mean a splitting of the 'self' and the impossibility, at least for the moment, of accomplishing the integration of the 'good' and the 'bad' (aggressive and transgressive aspects, guilt and violent passions), of infantile and adult aspects etc. At the same time, this work will allow our countertransference to take shape.

Earlier on I mentioned acting out and acting in (of a markedly sexual quality). These are quite common within the psychotherapeutic process of patients who develop an erotic transference. Regarding the acting out, let us simply remember that during a treatment, the patient may establish some lateral transference (which usually modulates the intensity of the erotic transference). She may enact promiscuous sexuality and have occasional sexual intercourse only when psychotherapy is temporarily interrupted (usually during the holidays) etc. In these cases it is essential to report such communications within the analysis, where they will be understood. It should be clear that enactments are not just a kind of communication. Usually, they are a communicative necessity (Giannakoulas, 2010).

The acting in takes different forms, ranging from the simulations of sexual orgasms (through sighing, groaning and body shaking) to performing a strip-tease, from masturbation to an attempt at real physical contact with the analyst (searching for sexual

gratification). In these cases of erotic transference with sexual acting in, a highly relevant technical problem is that the patient does not hear what is said to her. Our interpretations do not reach her, in the sense that she eroticizes the language and completely misinterprets the meaning of each and every intervention we make.

Thus, in the cases of sexualized erotic transference, interventions like 'This is not taking us anywhere', 'Now you have to go back to your place' or 'You are somehow trying to tell me that . . .' do not help and do not reach the patient because she does not want to hear them. Indeed, these kinds of interventions may even prove harmful and lead to the interruption of treatment because the patient may feel rejected and humiliated. In the same way, interpretations that aim at bringing what is currently happening within the therapeutic relationship back to the patient's past, risk causing new wounds instead of beneficial results. This is because the object-therapist is experienced only as the object of erotic desire. More useful are interventions like: 'You don't want to hear me, you only want to do to me what you want', interventions in which the analyst has some space to add 'you are furious if I don't do it' or 'you will feel furious if I am not seduced by you'. Obviously even these kinds of interventions do not eliminate the feeling of anger. My patient R., for example, had railed against me because I did not succumb to her seductiveness, calling me a 'fucking faggot'. It is not only the form and content of the interpretations that count, but the timing as well: interpretations should be appropriate, well-timed, and continuous if we want to prevent the patient's psychotic nucleus from invading her entire personality (Rosenfeld, 2001).

It is also important, during an acting in, to be careful not to look at the patient and everything she does, as if we were witnessing something extraordinary. On the other hand, it is equally important not to look away as if we were facing something sinful or too disturbing. We must not give signals of eroticism or disturbance.

Clearly, one of the essential tasks of therapy is to try to construct a space for symbolization where thought (including phantasies) and actions are quite distinct from each other. This path inevitably relies on the symbolization and verbalization skills of the analyst.

It is necessary here to briefly mention the other side of the relational dynamics with patients that develop sexualized erotic transference: erotic countertransference. Often it becomes paranoid and persecutory, and one is afraid that other people (colleagues, hospital staff, other patients) might hear, see or realize that the patient is masturbating, groaning or doing a strip-tease during the session. The countertransference may take on a sexual quality, and in this case the excitement felt in the countertransference may prove to be so intrusive as to seriously tax the therapist's ability to think. Often, due to the continuous attempts at seduction and the projection of excitement, the countertransference takes on a negative quality. Feelings of anger, discomfort, and helplessness in response to the obstinacy and power of extra-analytical and sexual demands on the part of the patient are, in fact, quite common. Neither is a wish for exclusivity rare – namely that phantasy of being the only good object in the patient's life[3] (particularly in the case of hysterical patients). All these countertransference experiences usually alternate and interweave during the same course of psychotherapy. Moreover, it is important to keep in mind that it is not strange for erotic

countertransference to precede the emergence of erotic transference. If the analyst is not too disturbed, he has an extremely useful and valuable working tool available to him, one that will allow him to get in touch with a patient's deep inner life experience, an experience that, according to different cases, might be complementary rather than concordant (Racker, 1953). In this way, for example, a countertransference that leads the analyst to perform a primary (maternal) function could be helpful in getting in touch with the patient's needs concealed behind the erotization (this occurrence is more frequent in cases where the patient has a phantasy of fusion with the pre-oedipal object). It is also conceivable that a countertransference feeling of desperation could be similar to the one experienced by the patient. Taking all of this into consideration, I do not mean to suggest that the existence of a certain degree of congruency between the analyst's countertransference reactions and the patient's transference reactions indicates a complete identity of thoughts and feelings. Rather, it indicates that they are moving in the same general 'ballpark of emotion' (Eagle, 2000).

I wish to conclude this short paper on the erotic transference phenomenon with a question: what helps the analyst to keep an analytic position when he finds himself immersed in the dynamics of an erotic transference–countertransference? A review of the literature on this subject shows that multiple factors on various levels come into play, levels that range from the superficial and impersonal (for example, professional deontology) to the deep and personal. This entails having one's very own code of ethics, and having and continually enhancing a good theoretical-clinical training. It is also crucial to bear in mind that the erotic transference is a patient's illusion, and not an objective perception. I would also suggest that we, the analysts, take the opportunity to discuss professional difficulties with colleagues, and try to achieve, through our own life experience and personal analysis, a healthy enough emotional development, all of which will hopefully lead to the development of a secure analytical identity, as well as a satisfactory private life.

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NOTES

1. In this paper, I am describing a female patient and a male analyst only for the sake of simplicity. The considerations I have made in this article are valid also for situations in the reverse, as well as for cases of homosexual transference.
2. 'Phantasy' 'refers to a specific imaginary production, not to the world of phantasy and imaginative activity in general' (Laplanche & Pontalis, 1967, p. 314).
3. In these cases, one of the risks might be that, while at a conscious level the therapist feels he is the only good object in the life of the patient, at an unconscious level he looks for love and dependence from the patient. This would then be a defence of the therapist, aimed at protecting some of

his traits (mainly the narcissistic ones), the as yet unresolved and painful ones, of which he may be in denial. This type of defence not only blinds him but also makes him enact (Joseph, 2003).

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