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The origins and management of erotic countertrasference and its impact on the therapeutic alliance : a critical investigation of the psychoanalytic literature.

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1. CHAPTER ONE: INTRODUCTION

1.1 Overview and Rationale

This study concerns and addresses both the origins of erotic countertransference as well as the erotic countertransference responses of psychoanalysts [(1)] to their patients. The rationale for this research is compelling in that it engages with the feelings, thoughts and decisions of psychoanalysts who provide therapeutic services to a vulnerable sector of society, namely the disturbed, emotionally distraught and mentally ill. This research aims to contribute an understanding of the source of erotic feelings that analysts may experience with patients and furthermore recommends what actions should be followed in the therapeutic context of dealing with patients.

There is uncertainty about where the erotic countertransference comes from, and how best to manage it, which is evident in the psychoanalytic literature. Within the pages of many a journal article and book, analysts recount their own personal experiences of the erotic countertransference within the analytic relationship, and why they chose to handle the experience in a particular way. There is no consensus on this issue and no guideline or rule that could help the analyst know what to do should they encounter the erotic countertransference. No single theory has been put forward with any degree of certainty that is not countered by an opposite recommendation.

This is disconcerting for a number of reasons. Firstly, how the origins of erotic countertransference is understood has a bearing on the analyst's way of engaging with his or her responses to the patients concerned. While theory is necessary to understand this erotic responsiveness to patients, it also has implications for how this is addressed. This calls for an in depth look at how professionals are dealing with this controversial psychoanalytic issue.

There appears to be much debate over whether or not the origins of erotic countertransference can be accounted for by psychoanalytic explanation alone.

[(1)] For the purpose of this research report the term 'psychoanalyst' includes all practitioners of psychoanalytically informed psychotherapy. The terms analysis and therapy will also be used interchangeably.

If the origins of erotic countertransference cannot be accounted for exclusively by psychoanalytic explanation then a specific debate arises concerning whether or not it is permissible for the analyst to engage in intentional self-disclosure of erotic countertransference (a non-psychoanalytic technique) versus maintaining analytic abstinence with the patients concerned. However, one may argue whether understanding erotic countertransference psychoanalytically necessarily implies whether or not this has therapeutic implications for self-disclosure or non-disclosure of erotic feelings. The author will argue that an understanding of erotic countertransference in psychoanalytic terms in deed does have implications as to whether it is ethical to disclose such feels to patients.

The uncertainty of the origins and handling of erotic countertransference has important implications for unethical sexual enactments with patients. According to Bridges and Wohlberg (1999) sexual enactments between psychoanalysts and patients is a very common occurrence and neither ethical nor legal prohibitions have managed to eradicate such incidents. It is important that one looks at how to address this problem in light of the negative impact such enactments have been found to have on patients in treatment. Lundgren, Needleman and Wohlberg (2004) have researched the impact of patient-analyst sexual relations on patients and have discovered a number of negative psychological states occur in these individuals.

Patients who have had sexual relationships with analysts have been found to have increased levels of depression, anxiety, suicidal thoughts and attempts, emotional lability, cognitive dysfunction, as well as dissociation (Lundgren, Needleman & Wohlberg, 2004; Pope, Tabachnick & Keith-Spiege, 1986). Other negative psychological repercussions include the patient's inability to trust others as well as themselves, accompanied by feelings of self-blame, shame and guilt (Lundgren, Needleman and Wohlberg, 2004). Wohlberg (1997) states that patients tend to blame themselves for lacking judgment and present with a unique set of subsequent treatment problems (Wohlberg, 1997). The violation of trust with the previous analyst impacts upon the patient's experience of forming a new therapeutic alliance, which is felt to be both frightening as well as compelling. It is also likely that whatever caused the patient to initially seek psychological services will not have been therapeutically addressed (Wohlberg, 1997).

Analysts fulfill an essentially healing role in the life of a distressed patient, and inevitably become transference figures. In light of this, whether or not it is ethical to disclose one's erotic countertransference will be discussed. Self-disclosure of this nature introduces an element into the therapeutic alliance which has implications for treatment efficacy. "The analyst may intend a specific therapeutic impact" using self-disclosure, but "how the patient hears and experiences this at an unconscious level" (p. 3) is not knowable in advance and this may damage the therapeutic alliance either temporarily or permanently as "it confuses what the patient wants with what he or she may need therapeutically at the time" (Ivey, 2008, p. 3).

1.2 Research Method

The researcher has sourced information and literature by searching various psychology data bases with the aim of accessing a range of psychoanalytic journals and books. The electronic data bases that were accessed to search for psychology journals and articles included: PsychInfo; EBSCO Host; JSTOR and ProQuest Psychology Journals. Search terms included the words erotic countertransference, sexualized countertransference, countertransference, psychoanalysis, sexual abuse in therapy, countertransference love, ethics in psychotherapy, and therapeutic relationship and alliance. Sources of information included both clinical and empirical data. The researcher has also been mindful to include a broad coverage of the existing psychoanalytic approaches in order to include the theoretical perspectives of various schools of thought on the issue of erotic countertransference. In order to do this information was also sourced from psychoanalytic books in print.

1.3 Research Questions

The researcher had three main research questions in mind when undertaking this theoretical research project. Firstly, the researcher wanted to know what accounted for the origins of the erotic countertransference in the context of the relationship between analyst and patient. Secondly, the researcher wanted to look at how the erotic countertransference could best be managed, including whether or not self-disclosure as espoused by relational psychoanalysts could be used ethically and effectively as a psychoanalytic technique. The third research

question was concerned with what the impact of erotic countertransference and its management could potentially have on the therapeutic alliance that exists between analyst and patient.

1.4 Outline and Structure of the Research Report

This research report has six main sections. The first section looks at the possible origins of erotic countertransference (Chapter Two). In this section the researcher looks at how erotic countertransference has been defined and a brief discussion of analysts' typical internal reactions to their own erotic countertransference is discussed. Chapter Three includes a review of possible sources of analysts' sexual feelings for patients. After extensively reviewing the literature, it was found that the origins of erotic countertransference can be placed into six individual categories and each of these will be individually discussed and debated. In Chapter Four the question of how erotic countertransference can best be handled in the therapeutic setting is investigated, focusing on whether analysts can ethically make use of the therapeutic technique of self-disclosure. Chapter Five includes a discussion on alternative methods of handling erotic countertransfernce to those suggested in Chapter Four. Chapter Six provides a summary and conclusion to the investigation.

2. CHAPTER TWO: EROTIC COUNTERTRANSFERENCE

2.1 Defining Erotic Countertransference

Comprehensive definitions of erotic countertransference are few, as this seems to be a specific area that has not been paid much attention to in the psychoanalytic literature. Gorkin (1985) defines erotic countertransference as the analyst's fantasies and feelings of a sexual nature, which arise in response to the transference of the patient.

If one accepts Gorkin's definition as valid then one needs to place the onus of the origins of countertransference more on the patient than the analyst. This definition is problematic as this research paper will highlight that it is not merely the patient's transference, but at times it seems that the analyst's own psychological make-up plays a definitive role in the occurrence of an erotic countertransference. In addition to this analysts may also exert an influence on the patient's transference (Gabbard, 2004). The therapeutic setting as well as analysts' behaviour towards patients, both contribute to patients' experiences of their analysts and transference is, therefore, not merely shaped by patients' own subjective worlds (Gabbard, 2004). This implies that analysts need to remain aware of how they are influencing interactions and development of countertransference experiences with patients (Holmes, 2005).

Freud stated the analyst experiences a countertransference because of "unresolved personal conflicts" (cited in Gabbard 2004 p.132). He further suggested that analysts needed to overcome their countertransference reactions through regular periods of self-analysis and thus countertransference was viewed as a phenomenon that needed to be eradicated as quickly as possible (Holmes, 2005).

The prevailing view of most psychoanalytic schools is that countertransference feelings involve a joint creation with contributions from both patient and analyst. The analyst "brings his or her own past into the dyad, but the patient also induces feelings in the analyst" (Gabbard, 2004, p. 132). One of the central notions of psychodynamic therapy is that there are "two subjectivities" (p.132) in the analytic dyad. The analytic dyad is viewed as

comprising two multifaceted human beings who are mutually influencing and evoking a variety of feelings in one another all of the time (Gabbard, 2004).

Ogden (2004) re-conceptualised countertransference as comprising a 'third' space between analyst and patient. Transference and countertransference are viewed as arising within an interpersonal field within which a new and mutually constructed psychic experience takes place (Ogden, 2004). The concept of the analytic third is often defined as the "psychological (triangular) space between self and other, subject and object, fantasy and reality", and may be viewed as "a third dimension that emerges from two persons fully engaged in the exploration of unconscious meanings, reasons, motives and actions" (Diamond, 2007, p. 1).

"Erotic feelings exist in all love and close relationships as a natural part of intimacy" (Mor, 2005, p. 52). Mann (2002) defines the erotic aspects of countertransference as including all mental and physical experiences and feelings of love that include both sexual attraction and sensual pleasure. Mann, however, states that "sexual attraction refers in a more restricted sense to genital drive impulses, excitement, pleasure, stimulation and phantasies" (Mann, 2002, p. 128). Mann argues that the erotic should not be limited solely to genital arousal as it may include "fascination, anxiety, disgust and incestuous desire" (Mann, 1997, p.6).

Mann (2002), states that the term 'erotic' (when referring to countertransference) is preferable as it includes aspects of both loving and sexual feelings that analysts may have for patients. He thus prefers to make use of the term 'erotic' as opposed to terms such as 'sexualised' or 'love' countertransference which may imply that sexual and loving feelings exist exclusively from one another in the countertransference experience of the analyst. The matter of defining erotic countertransference becomes a more complicated matter, as analysts are not in agreement as to whether erotic countertransference experiences are limited to purely sexual feelings, or whether such a countertransference constitutes the equivalent of actual love. Freud (1915b) seems to have been in agreement with the latter argument when he stated that the difference between real love and countertransference love "was a matter of degree rather than kind" (cited in Lemma, 2003, p. 246).

Coen (1994) comments that analysts experience uneasiness with their loving and caring feelings towards their patients and this is why "technical terms such as erotic and libidinal" (p. 678) are made use of (cited in Rabin, 2003). Coen states that these terms function as

defences against analysts' acknowledgement that they experience loving feelings for their patients. "Experience-near terms" such as "loving feelings" and "falling in love" are seldom referred to, as they generate anxiety due to their more experience-near quality (Rabin, 2003, p.678).

Young-Eisendrath (2007) feels that one needs to make a distinction between what she refers to as analytic love and erotic countertransference. Analytic love is defined as "the healthy affectionate bond" (p. 313) that arises between the analyst and the patient during the course of psychoanalysis. She stipulates that analytic love is distinguishable from transference or countertransference of an erotic nature as it comes to accept the "ethical" and "analytic boundaries" of the therapeutic setting (Young-Eisendrath, 2007 p. 313).

Young-Eisendrath states that analytic love usually follows a developmental pattern, beginning with feelings of need and desire which may intensify due to the idealisation of the analyst by the patient and vice versa - due to the "imagined resources that the other will bring" (Young- Eisendrath, 2007, p. 313). This desire and idealisation is inevitably challenged by the reality that neither party will receive what is desired and the recognition of this fact may result in feelings of frustration and hostility, including unconscious and conscious hateful attacks on the therapeutic relationship through the development of negative transference and/or countertransference reactions (Young-Eisendrath, 2007).

Young-Eisendrath's argument implies that erotic countertransference and countertransference love are distinguishable from one another, and that the emergence of the latter is based on the analyst's abstinence, which serves to transform both the analyst and patient's idealistic desires (erotic transference/countertransference) for one another after a period of disappointment and dissatisfaction (Young- Eisendrath, 2007). This implies that the erotic desires of both patients and analysts can be transcended through strict adherence to the boundaries of the analytic setting.

Furthermore, Young-Eisendrath adds that psychoanalytic therapy embodies the very same qualities of 'real' love in that the two individuals in the analytic dyad have to take personal responsibility for their own "subjective experiences" rather than holding the other accountable for them (p.310). Fantasies and wishes to control the other need to be overcome by one's "respect for the other's autonomy" (p. 310), and the analyst needs to be alert to

conflicts of “dominance-submission, abandonment-engulfment, attachment-separation, and dependence-independence that forms a part of every loving relationship” (Young-Eisendrath, p. 310). To this Cole (2007) adds that in some instances the intensity of the love that analysts and patients feel for each another may only surface in final sessions after a long treatment experience together, where both parties realise what they have come to mean to one another and that they will miss each other. However, it needs to be remembered that these transferences and countertransferences occur in the context of a “business transaction” (p. 351) and it is the awareness of this reality that places the analytic dyad in quite an unusual position when it comes to countertransference love (Cole, 2007).

Segal (1962) takes a Kleinian point of view when it comes to explaining the occurrence of analysts’ love for their patients. Segal states that analysts who claim to have fallen in love with their patients may be said to be functioning from Klein’s *paranoid-schizoid position.* In this sense, the analyst’s perception of the patient is characterised by splitting and idealisation. Only goodness and love are attributed to the patient who is perceived as a part-object rather than a whole (Segal, 1988). In this position patients become so concretely identified as projected parts of the analyst, that they are related to as being a part of the analyst’s self (Gabbard & Lester, 1995). For Klein, however, the primitive is not transcended as it is in Freud’s developmental scheme. There will, therefore, always be a continuous alternation between the paranoid-schizoid position (dominated by part-object relating) and the depressive position, characterised by more integrated and mature thinking in relation to whole objects (Segal, 1988).

In light of all that has been mentioned, whether or not ‘real’ love (that has erotic aspects) can exist within the therapeutic setting is something debatable and uncertain. Cole (2007) states that there will naturally be patients who strike analysts as “more lovable at times”, and there will also be “patients who, under other circumstances, appear as if they would be attractive romantic partners” (p. 353). For the purpose of this study erotic countertransference will be defined and limited to analyst’s consciously experienced sexual and loving feelings for patients. The question remains, however, what is it about these specific patients that makes them ‘naturally’ more lovable and possible attractive romantic partners? This will be discussed further in the section of this paper on the origins of erotic countertransference.

With such emphasis on the importance of love existing in the analytic dyad not much attention has been paid to its counterpart, hate. Mann (2002) states that underlying the sexualisation in eroticised countertransference one will find both hate and love together. This links to Gabbard's statement that the analyst's sexual feelings are often an unconscious defense against acknowledging a hostile countertransference towards the patient (Ivey, 2008).

Mann states that erotic feelings are necessary, as without them there would be nothing to modify aggressive or hateful feelings in the context of relationships with others (Mann, 1997). Freud (1950) distinguished between two classes of instinct, one of which is the sexual instincts of eros, which is far more evident and accessible to study, and the lesser accessible death instinct, which is an instinct of destruction. The opposition between the two classes of instincts is evident in the "polarity of love and hate" (Freud, 1950 p.59). "Clinical observation shows not only that love is with unexpected regularity accompanied by hate, but that in a number of circumstances love changes into hate and hate changes into love" (Freud, 1962 pp. 32-33). Mann, however, argues that sexual desire is not manifested in hostility unless it is frustrated (Mann, 1997).

The primitive defence mechanism of idealisation is employed to guard against its opposite which is devaluation, just as idealisation as a Kleinian manic defence, is used to ward off the anxieties associated with the depressive position –anxieties that arise with the realisation that one experiences feelings of both love and hatred for the same object (Klein 1935; Segal, 1988; Mc Williams, 1994). In light of this it is not hard to imagine that both love and hate can be found together in the erotic countertransference experience.

2.2 The Analyst's Internal Reactions to Erotic Countertransference

Elise (1991) states that erotic countertransference has become a taboo realm, where analysts have no problem acknowledging the sexual and romantic feelings that their patients express towards them but are unlikely to openly admit to having these feelings themselves. The analyst's sexuality is without a doubt "among the most unspoken psychoanalytic topics and is subject to enormous professional resistance" (Mann, 2002, p. 128).

One's subjective reaction to a seductive patient may include "enjoyment, fear, irritation, sexual excitement, or narcissistic inflation" (Mc Williams, 1999, p. 145). There is also a frequent anxiety amongst analysts that the erotic transference and countertransference may "wildly envelop either party and become uncontrollable" - as it does with analysts who engage in sexual relations with their patients (Mann, 1997, p. 23). As a means of managing these disturbing erotic feelings analysts may view patients as being "seductive" as in this way the problem can be attributed to the patient and not the analyst (Gabbard, 2004, p. 145).

Mc Williams (1999) mentions that analysts are afraid of noticing sexual arousal towards their patients due to the emphasis training programs have placed on possible sexual enactments. Mor (2005, p. 45) states that erotic tension or thinking during therapy sessions may produce "embarrassing silences" (p. 45). Analysts may experience difficulties in understanding what is happening, as well as feeling caught up in the interactive demand to respond to the erotic atmosphere. Although Mor does not state why this is the case, an explanation may lie in the phenomenon of projective identification. A discussion of projective identification is included in the next chapter.

Lemma (2003) builds on this imagery of fear and dread when she contends that when erotic feelings emerge in the analytic setting it becomes a difficult issue for both parties in the analytic dyad. Whether or not analysts always experience erotic feelings accompanied by such anxiety is, however, questionable if one takes into account the number of analysts who tend to act on their sexual feelings, or if one considers the lack of empathy of the narcissistic analyst, topics which will be further discussed. Most surveys conducted to determine the extent of analyst-patient sexual involvement, have found that fewer than 10% of professional psychotherapists have had sexual intercourse with their patients. Kardenere *et al.* (1976) indicate a figure of 6-7%, and Pope *et al.* (1979) 7%; and Pope et al. (1986) 6.5%. Pope et al.

(1987) found significantly lower rates of 1.9%. Holroyd & Brodsky (1980) found that 3.2 % of respondents to their survey had had sexual intercourse with a patient, and another 4.6% engaged in other types of sexual behavior (cited in Clarkson & Pokorny, 1994).

Gabbard (1998, p. 6) points out that far from reports of fear and phobic dread, he has found in his research that analysts derived a "voyeuristic enjoyment of the erotic tension in the analytic treatment", often suffused with a "sadistic" type of pleasure. In some cases, however, the erotic countertransference may remain unconscious but the analyst may begin to notice "minor enactments suggestive of special interest" in a patient (Gabbard, 2004, p.145). For example, analysts may realise that they pay attention to what they are wearing or check their appearance in the mirror before a certain patient arrives. Analysts may also find themselves feeling "unusually sympathetic" towards specific patients and avoiding the discussion of "negative issues" for fear of upsetting the patient (Gabbard, 2004, p.145).

2.3 Summary

This section of the review highlights the problem of defining erotic countertransference and also indicates the wide array of internal reactions analysts may experience in relation to their own erotic feelings for patients. It is evident in the literature that various analysts have put forward different perspectives on what constitutes erotic countertransference, and have further suggested, that there is a difference between erotic countertransference and countertransference love. There does, however, seem to be some fundamental similarities between the two concepts as both contain sexual feelings and a tendency to idealise patients. The researcher has also argued that feelings of hate may be inextricably interwoven with erotic feelings, underlying the idealisation of the patient, emerging when sexual desire is frustrated. This suggests that negative countertransference reactions may come to the fore during the course of the treatment process when the analyst experiences an erotic countertransference. It is also evident that analysts have a wide variety of internal reactions to their own erotic countertransference and possible explanations for this phenomenon will become more evident in the following section, which explores a number of viewpoints on the origin of erotic countertransference.

3. CHAPTER THREE

3.1 Theories on the of origins erotic countertransference

There are various psychoanalytic explanations put forward in the psychoanalytic literature to account for the origins of the erotic countertransference. After extensively reviewing the literature, six categories could be identified which all provide distinct explanations regarding the source of analysts' sexual feelings for patients. The more classically psychoanalytic viewpoints account for the origins of the erotic countertransference in the unresolved oedipal scenario, the narcissistic tendencies of analysts, and the phenomenon of projective identification. In the psychoanalytic literature reviewed, no specific theory seems to have been put forward by the intersubjective psychoanalytic approaches on the origins of erotic countertransference.

Other theories which fall outside the strictly psychoanalytic realm, and which will be referred to as 'non-psychoanalytic' viewpoints include erotic countertransference occurring due to sexual chemistry between analyst and patient, the erotic countertransference being a patient-specific or analyst-specific phenomena, and the genders of the analyst and patient playing a causal role. The author has chosen to refer to the latter as 'non-psychoanalytic' because although they emanate from the psychoanalytic literature, they contradict one of the most basic assumptions of psychoanalytic psychotherapy, that "complex unconscious mental processes are assumed to be responsible for both the content of conscious thinking and behaviour" (Fonagy & Target, 2003, p. 3). Freud (1962) himself said that "the division of the psychical into what is conscious and what is unconscious is the essential premise of psychoanalysis" (p.3). Freud (1922) stated that the unconscious can be defined as something of which the subject is unaware. Erotic countertransference is likely to be the product of unconscious motives and desires, whatever the analyst's conscious thoughts and intentions may be. Another psychoanalytic principle that the 'non-psychoanalytic' categories fail to include in their understanding of erotic countertransference is the impact of childhood experiences that are said to "shape the adult person" (Gabbard, 2004, p.7).

While the non-psychoanalytic explanations of the origins of erotic countertransference seem like feasible explanations on the surface, they pose a dilemma concerning the aspect of handling erotic countertransference in psychoanalytically oriented psychotherapy, as they

cannot be psychoanalytically conceptualised and understood, nor therapeutically applied from within this specific approach. In order to solve this problem current non-analytic conceptualisations will be debated and re-conceptualised in psychoanalytic terms.

3.2 The Origins of Erotic Countertransference in the Oedipal Scenario

Hook & Watts (2002) state that all individuals direct their first sexual feelings towards their parent of the opposite sex. Freud (1931) however states that for both sexes the first love object is the mother. Freud argued that a woman's attachment to her father is "preceded by a phase of exclusive attachment to her mother" which is equally as "intense and passionate" (Freud, 1931, p.21).

Klein (1937) also stated that the mother is the primary love object of both sexes, and our relationships with our mothers play a lasting role in our minds, possessing the power to affect our relationships with all other people at later stages of development. Klein (1937) states that in the beginning of the infant's life the primary object of infantile phantasy is the mother's breast. The mother allows the infant a temporary experience of security when she gratifies her child's needs through feeding. This sense of security is said to generalise from infancy to become an important component of one's satisfaction, whenever love is received in both childhood and adulthood (Klein, 1937).

The infant's experience of the mother is loss, particularly and intensely experienced during the *depressive position*, when the child is weaned from the breast. The breast has come to signify all that is good, loving and secure, and all of this goodness is perceived to be lost (Klein, 1935). Since the breast is first associated with the mother, feelings of having lost the breast extend to feelings of having lost the good mother (both internal and external mother) entirely. The child may, however, be assisted to preserve a belief in possessing a good object within if the external relationship with the mother is a positive and loving one. The mother-infant relationship is thus highly valuable as it enables the loss of this good external object to be experienced as less painful, and also serves to diminish the child's fear of being punished for having possibly destroyed the good object. This experience is important as it enables one to establish and maintain pleasurable relationships with others, even when individuals are sometimes fallible (Klein, 1936).

Klein (1936) states that it is important for the child to deal satisfactorily with the conflicting feelings of love, hate and guilt experienced during the depressive position. Children who find these conflicts unbearable may never establish a happy relationship with their mother and this opens the way for many subsequent developmental failures (Klein, 1936). Klein (1937) states

that feelings of guilt may become so deeply rooted in the child that this results in certain personality characteristics appearing in later life. These characteristics include a strong need for praise and approval, as evidence that they are loveable. This feeling that one is unworthy of love arises from the unconscious fear of being unable to love others truly and sufficiently, as well as being unable to master one's own aggressive impulses towards others and thus experiencing the dread of posing a danger to loved ones (Klein, 1937).

The infant's fear of the death of the mother needs to be dealt with adequately or it will have far-reaching effects on the individual's future mental well-being, including his or her capacity to love (Klein, 1936). The external, visible mother, therefore, provides the child with continuous proof of what the internal mother is like. All positive experiences that the child has with the mother serve as proof for the child that both the internal and external loved object have not been injured and the child's confidence in both his own and others' goodness is also strengthened (Klein, 1935).

The depressive position, however, is never completely transcended. The anxieties associated with feelings of ambivalence and guilt, as well as situations of loss revive depressive experiences, and are always said to reside within us (Segal, 1988). Good external objects that one encounters later in adult life will always be representative of and include aspects of the primary (internal and external) good object, implying that "any loss in later life will re-awaken the anxiety of losing the good internal object, as originally experienced in the depressive position" (Segal, 1988, p.80).

The essence of the depressive position is thus to be able to bear the ambivalence felt towards one and the same object and to work through accompanying guilt feelings by making attempts at reparation. This prepares the individual for future interactions as throughout life it is required that we continuously negotiate our ambivalent feelings of both love and hate felt towards others (Hook & Watts, 2002).

There seems to be a consensus among most analysts that our most "intense physical and emotional contact" originated in our experience with our mother's breast and that "adult sexuality" will, therefore "always include elements of this early physical and emotional experience" (Jørstad, 2002, p. 118). In psychoanalysis one's first relationships and how they

are experienced are viewed as being the foundation of “future psychic and sexual life” (Harding, 2001, p. 137).

To this Lemma (2003) adds that love in the outside world shares many of the “unrealistic aspects” of love in analysis (p. 246). Both types of love have “infantile prototypes” at their core and this is why both take on a “repetitive” and “idealising character” (p. 246). The psychosexual conflict that Freud termed the Oedipus complex occurs at a deeply unconscious level. Freud (1924) stated that the Oedipus complex is the central phenomenon of the sexual period of early childhood and “its dissolution takes place when it succumbs to repression” (p.315). However, it is likely that oedipal remnants will persist into adulthood.

This theory states that the erotic countertransference stems from the neurotic aspects of the analyst’s own unresolved Oedipus complex. According to this explanation, male heterosexual analysts react to female patients in the same manner as to the oedipal mother. Female heterosexual analysts relate in the same manner to male patients, as though these patients embody the oedipal father. In these instances, both positive and negative oedipal complexes can be activated, regardless of the analyst’s sexual orientation (Gorkin, 1985).

Mc Williams (1999) states that erotic transferences that arise in analysis are likely to include forbidden incestuous feelings as psychoanalysis provides a space for patients to work through these issues. Gabbard (1994, p.1) therefore aptly refers to erotic enactments between analysts and their patients as “professional incest”.

Mann (1997) describes this oedipal space in the analytic relationship by referring to a metaphor originating in the British Object Relations School. The metaphor firstly describes the “analytic couple in terms of a mother and infant dyad” (p.7) and, secondly, states that the psychological process between this pair is the equivalent of a “procreative relationship” resulting in an “analytic child” (p.7). “In this way the analytic couple (analyst and patient) have an analytic baby (the psychological growth of the patient, and often the analyst too), yet it is the mother and infant who have produced a baby together” (p.7). The metaphor is therefore one of incest and demonstrates how the “incestuous encounter” is at the centre of the analytic experience (Mann, 1997, p.7).

Racker (1988) highlights how the oedipal scenario can appear in certain guises and result in certain unconscious desires and wishes regarding the patient. When these are not fulfilled, intensely negative countertransference reactions may follow. Racker states that the male analyst who unconsciously relates to the female patient as being the oedipal mother may have the unconscious desire that the patient should fall in love with the analyst accompanied by the desire that the patient should, in addition to this, experience a positive transference towards the analyst. The patient who has a sexual relationship outside the analytic setting may, furthermore, be experienced by the analyst (at an unconscious level) as being reminiscent of his own oedipal mother, where he is once again the child whose parents have satisfying sexual interactions which exclude him. This then leads to an oedipal "desire to bind the mother erotically" (Racker, 1988, p.108) which may be expressed in the desire that the patient should refrain from establishing erotic relations outside of the therapeutic setting. This desire to bind the patient is the same as the "desire of parents not to let go of their children", and the analyst may therefore not want the patient to improve or to terminate therapy (Racker, 1988, p. 108).

Racker (1988) states that the countertransference situation which arises has important implications for treatment, as whenever the desire for the patient to fall in love with the analyst (or for the development of a positive transference to occur) is frustrated, "rejection and hatred" (p. 108) of the patient are likely to follow. The disappointed analyst may feel inwardly negative towards the patient who has now become the "bad mother" to him, and other countertransference reactions may include feelings of "hating her for not loving him and feelings of love when she suffers" - as a type of revenge for the oedipal betrayal (p. 109). The analyst may feel satisfaction when the transference is positive, as well as "castration-anxiety and guilt feelings" towards the patient's lover (Racker, 1988, p. 110).

If one takes the Kleinian perspective of the Oedipus Complex into account, one needs to consider that Klein's Oedipus complex takes place in the paranoid-schizoid position when the infant's world is extensively split and relations are mainly to part objects. This would further explain how any object which endangered the exclusive possession of the idealised breast/mother would be experienced as persecutory and would have projected into it all of the child's hostility (Segal, 1988).

Gabbard (1997) states that in the transference-countertransference dimensions of the analytic process, both members of the analytic dyad represent forbidden objects so that sexual relations between analyst and patient are incestuous transgressions. It is for this reason that patients who come for analysis with a history of incest or sexual abuse are considered high-risk in terms of sexual enactments. When female patients who have been involved in incestuous relations with their fathers enter therapy, particularly borderline patients, it is notable that they have lost a certain capacity for fantasy, as the forbidden oedipal desire was fulfilled resulting in an ego deficit (Gabbard, 1997).

Gabbard (1997) states that in this way the analyst may then be experienced literally as the father, rather than symbolically viewing him as if he were the father. Blum (1973) states that the eroticised transference of these patients may be characterised by a "tenacious, ego-syntonic demand for sexual gratification" which puts pressure on the analyst and which may be exploited by the latter (cited in Gabbard, 1997, p. 2). The analyst is not perceived "as if" he or she is a possible lover; he or she is believed to be the only individual able to fulfill the patient's sexual desires (Gabbard, 1997, p. 1). The boundaryless situation of the patient's childhood may be re-enacted in the analytic setting as these patients have a history of associating caring with sexuality (Gabbard & Lester, 1995).

Racker (1988) states that erotic countertransferences at the oedipal level may intensify, while awareness remains unconscious and beyond analysts' control. This situation may present certain difficulties to analysts in understanding patients, their behavior towards patients and interpretation of material presented during sessions.

In light of the above psychoanalytic theories regarding the origins and manifestations of the oedipal scenario in analytic psychotherapy, can one then be certain that the patient is always standing unconsciously for the oedipal parent in the analyst's countertransference?

Davies (1998) opposes this point of view, from a relational psychoanalytic perspective, and argues that analysts feel fearful when they experience an erotic countertransference due to a failure to acknowledge that erotic countertransference is the result of the normal experience of adult sexuality that manifests within clinical practice. She states that too much emphasis has been placed by psychoanalysis on the importance of purely infantile sexuality in

psychoanalytic developmental theory. As a consequence of this analysts automatically believe that any sexual feelings towards their patients are centered around their own unresolved infantile desires and pathological derivatives.

Davies argues that through a successful analysis of these infantile conflicts, analysts are allegedly able to free themselves from this erotic interpersonal dimension of psychoanalytic therapy (Davies, 1998). Ivey (2008), however, states that analysts' own analysis and training does not inoculate them against the influence of their own unconscious conflicts, which are "bound to be repetitively mobilised by emotionally charged interactions with patients" (p. 5).

Davies, however, concludes that we cannot assume that the analyst or patient always stands in the role of the oedipal parent. We also cannot assume that the erotic countertransference is in fact an adult expression of infantile sexuality (Davies, 1998). Davies argues that through her own clinical experience as patient, analyst and supervisor, that it is the sustained intimacy of the psychoanalytic process that may result in the analyst experiencing an erotic countertransference, which may have either oedipal or post-oedipal origins (Davies, 1998). She states that it is important for the analyst to recognise that sexual development continues beyond the Oedipus complex, and is especially prominent during the developmental phase of adolescence. She therefore argues that "Oedipus is not a complex capable of resolution", but the beginning of a "lifelong, post-oedipal process" (Davies, 1998, p. 752). The analyst may thus stand in the position of a post-oedipal parent, who is "in a constant state of experiencing, processing and recognising the child's emerging sexuality" (p. 752). As is the case with parent and child, both analyst and patient need to find a way to contain and manage the intensity of these sexual feelings and fantasies (Davies, 1998).

Mor (2005, p. 45) adds to this, stating that erotic countertransference constitutes part of the "emotional and intimate relationship in the 'here and now' therapeutic process which takes place between two adults". Gabbard (1998) disagrees and states that erotic transference and countertransference may include sexual desires that belong to many different developmental stages, and the exact source cannot be identified due its unconscious nature (cited in Mor, 2005). Harding (2001) states that analysts may also develop an erotic countertransference driven by infantile longings for the pre-oedipal mother as a protecting, nurturing and platonic object of love, which is markedly different from the sexual longings associated with the Oedipal mother (Harding, 2001).

Mann (1997) also argues against the erotic countertransference arising exclusively from the Oedipus complex. He states that unconscious erotic desires and fantasies of an incestuous nature are not merely transferred to non-family members whenever sexual attraction occurs. Evidence of this is said to be found in the *repetition compulsion* where individuals will repeatedly engage in relationships (even destructive ones), driven by unconscious past experiences, in the hope of rectifying these in the future (Mann, 1997).

Under the influence of the unconscious, individuals may be at one and the same time "compelled to repress disturbing material from past experiences while being driven to re-enact the repressed conflict" in the present life situation (Holmes, 2005 p.5). Repetitions from the past may be acted out in relation to others or "symbolised in dreams" (p.5). Freud's notion of the repetition compulsion offers evidence for an explanation of the origins of erotic countertransference as it implies that the analyst's past unconscious experiences may be reproduced in the analytic relationship with certain patients (Holmes, 2005). This explanation, however, doesn't entirely refute the impact of the Oedipus complex as a possible theory for the analyst's erotic countertransference, it merely provides an additional explanation.

3.3 Summary

The above discussion has highlighted the importance of the mother and negotiation of loving and hateful feelings that may exist in the analytic dyad. The theory of the Oedipus complex accounts for how the infantile prototypes of sexuality result in a repetitive and idealising countertransference and provides an explanation as to why unconscious desires and erotic wishes of the analyst may result in feelings of hatred in the countertransfrence when they remain frustrated. It was also highlighted that sexually abused patients are at particularly high risk concerning sexual exploitation as analysts are pressurised to comply with these patients' sexual wishes. Davies argues that the origins of erotic countertransference should not be exclusively attributed to the analyst's unresolved Oedipus complex, although she does not entirely refute this argument either. Instead, Davies holds that the sexual feelings of the analyst may also stem from post-oedipal sources. In addition to this it was argued that erotic feelings may also be coloured by pre-oedipal desires. There seems to be an obstacle in

identifying the developmental period from which the sexual feelings originate, due to the unconscious nature of this information. The researcher therefore concludes that erotic countertransference may be influenced by the analyst's own infantile maternal relationship, unresolved Oedipus Complex, as well as pre-oedipal and post-oedipal origins. In all cases, however, the source of the erotic countertransference resides in the realm of the unconscious and is therefore not completely knowable at the time it is experienced.

The arguments that follow next state that erotic countertransference is either a patient or analyst-specific phenomenon, and that it may be reduced to the 'sexual chemistry' that can exist between any two individuals. These will be debated in terms of their validity as psychoanalytic theories and will re-conceptualised by the author in terms of object relations theory.

3.4 The Origins of the Erotic Countertransference in the "Sexual Chemistry" between Analyst and Patient

Ceccoli (2004) takes a completely different stance by arguing that the erotic countertransference is nothing more than the 'chemistry' we are likely to experience with certain individuals we naturally find ourselves attracted to. The chemistry that Ceccoli speaks of allegedly surpasses theory and technique and is likened to the sexual attraction we may experience with any human being, whether within or outside the therapeutic context. This explanation is used to account for the fact that certain patients and not others become objects of intense desire for analysts (Ceccoli, 2004).

Pope, Tabachnick & Keith-Spiege (1986) researched patient characteristics that analysts found attractive and which aroused sexual interest by assessing responses to an open ended question: "How would you describe the patients to whom you have been attracted? Are there any particular salient qualities similar among them?" (p. 16). Respondents who reported that they had been sexually attracted to their patients indicated that their patients possessed the same characteristics they found sexually attractive in people who were not their patients. These findings on the surface, appear to support the theory of 'sexual chemistry', yet the authors have not posed the question as to why analysts find these particular qualities attractive, and therefore fail to recognise the potentially unconscious reasons for their erotic attraction.

The characteristics analysts found attractive were certainly diverse. Responses by male and female analysts were fairly balanced proportionately for all categories except two: 'physical attractiveness' was mentioned far more often by male analysts and 'successful' was mentioned far more often by female analysts (Pope et al., 1986). The categories that made analysts feel sexually attracted to their patients are presented in order of frequency and included: physical attractiveness of patient; positive mental/cognitive traits or abilities possessed by patient; patients whose behaviour is overtly sexual; vulnerable patients; positive overall character/personality of patient; kind patients; patients who were felt to fill analysts' needs; successful patients; 'good' patients; patients who were also attracted to the analyst; independence as a trait in patients; other specific personality characteristics valued by the analyst; resemblance of the patient to someone in the analyst's life; availability (patient

unattached); pathological characteristics in patients; patients who had been in analysis over a long period of time; sociability and extraversion of patients; miscellaneous category; patients who possessed the same interests, philosophy and background to the analyst (Pope et. al, 1986).

The findings of this research suggests that the analyst's erotic countertransference originates from specific characteristics, irrespective of the context in which the two individuals interact, yet the categories provided fail to take into account the individual subjective views of what these qualities comprise. For example, what one analyst considers a 'good' patient may vary from that of another analyst. Secondly the research does not question what the underlying reasons are for analysts being attracted to independent or extraverted personalities, or why a patient who reminds some analysts of a family member is found attractive, but isn't for others. Why did certain characteristics spark 'sexual chemistry' but others failed to?

Mc Williams (1994, 1999) provides us with one possible answer by stating that all human motives can be sexualised, for example some individuals will sexualise their dependency needs while others may sexualise their aggression. In all cases a relational theme exits in the sexual domain that accounts for why patterns tend to be re-enacted.

Closely related to the theory of erotic countertransference originating from the sexual chemistry between analyst and patient, are the viewpoints that erotic countertransference emerges only with a specific type of analyst or patient. As these two arguments are so closely interlinked they will be discussed and debated simultaneously in the following section.

3.5 The Origins of the Erotic Countertransference as A Patient-Specific or Analyst-Specific Phenomenon

Brems (2001) states that romantic feelings in analysts are only aroused in response to certain types of patients. Analysts are said to experience an erotic countertransference when a certain personality trait in the patient stimulates feelings and reactions irrelevant to the patient's presenting problems. This argument endeavors to explain why analysts are attracted to some, but not all of their patients.

Holomqvist (2001), however, argues that certain analysts are more likely to experience an erotic countertransference under any circumstances. Holmqvist undertook research to look at the patterns of consistency and variation in analysts' countertransference feelings towards their patients and his findings indicate that the analyst's own personal "feeling style" (p. 1) (which is not clearly or adequately defined), but explained as a type of "standard way of emotional relating to others", is more important than the patient's specific impact on the analyst's feelings (Holomqvist, 2001, p. 4). This argument implies that it is the analyst's typical way of feeling and experiencing other individuals that somehow results in erotic countertransference being experienced more often with a variety of patients.

Holomqvist found that analysts were very consistent in their ways of emotional relating and some were always more likely to develop loving and sexual feelings towards many different patients over time (Holmqvist, 2001). This implies that it is the contributions of analysts in therapeutic interactions that have a weightier influence on erotic countertransference than the patients' contributions.

Holomqvist, furthermore, found that analysts seem to have a "habitual reaction pattern" (p. 10) to their patients that may be useful in aiding them in understanding the processes that unfold during the course of an analysis (Holomqvist, 2001). This point of view suggests that one needs to consider the possibility that the analyst's erotic countertransference reactions belong "primarily to his or her own emotional universe" (p. 2), yet this point of view fails to take into account what the unconscious motivations and meanings are which underlie such an analyst predominantly relating to so many patients in an eroticised way. This argument is also

not in line with the current definition of countertransference where both analyst and patient are viewed as mutually influencing one another's interactions. Both of the above arguments raise the question as to whether we should view erotic countertransference as a patient-specific or analyst-specific phenomenon. A look at the object relations theory of Melanie Klein is put forward to answer these questions.

Klein (1935) states that sexual development is unquestionably influenced by an individual's object relations which can be traced back to the original emotions and attitudes felt towards one's parents who have shaped our individual attitudes towards others. One's object relations refer to one's relation to externally experienced individuals in the world, as well as to their representatives which reside in our inner world, in the form of introjected figures. This in turn impacts the way in which one is likely to relate to others in interpersonal relationships via projection (Steiner, 2008). Analysts' own introjected objects will therefore also impact on their experience of others, and this may account for the occurrence of erotic countertransference with certain patients. Steiner (2008) argues that the analyst is always led by the patient to take on the role of an internalised object. It is by observing this role that the analyst may be able to have insight into the patient's "habitual style" of object relating (p. 44).

The above discussion regarding object relations theory has been included to demonstrate how from a psychoanalytic viewpoint, one's object relations may more inclusively account for analysts experiencing of erotic feelings with only certain patients, or why certain analysts are more likely to habitually experience erotic countertransference feelings.

The researcher wishes to argue that object relations theory is relevant to the analyst's erotic countertransference experience. If sexual attraction is influenced by a number of unconscious object relations, then unconscious motives and desire are at the core of the erotic countertransference experience. This is argued to be the case as an internal object exists outside the realm of conscious awareness, as unconscious representations in phantasy. Although unconscious, these internal objects have the power to influence patients' ways of

perceiving, thinking and behaving - and by implication, the analyst's experience of erotic countertransference (Sandler & Sandler, 2003).

Gabbard & Westen (2002) take the theory of object relations even further stating that transference is based on "internal object relationships laid down in neuronal networks in early life" (cited in Gabbard, 2004, p. 71). This provides a basis for the existence internal objects according to cognitive neuroscience implying that they have been hard-wired into the brain at a biological level (Gabbard & Westen, 2002).

Although Westen and Gabbard are referring exclusively to the origins of patients' transfererence, the analyst by implication would also have such internal object relationships. If one were to hypothesise that this is true then the "real characteristics" of the patient would "trigger one neuronal network of representation rather than another" (p. 71). Features of the patient such as the "gender, age, physical appearance, dress, manner speaking, dress, hair colour" etc. would serve as both conscious and unconscious triggers for associations in the analyst's neuronal network (cited in Gabbard, 2004, p. 71).

3.6 Summary

The researcher has argued in this section that if one takes object relations theory seriously, one cannot dismiss the unconscious origins of erotic countertransference by merely reducing such an occurrence to the conscious level proposed by arguments such as 'sexual chemistry' and the erotic countertransference being a patient or analyst–specific phenomenon. This counter-theory has been put forward as a more psychoanalytically acceptable alternative to understanding the erotic countertransference. The researcher argues that it was necessary to re-conceptualise terms such as 'sexual chemistry' by making reference to object relations theory as the latter facilitates a deeper understanding of the patient and analyst's unconscious dynamics. An object relations theoretical understanding of erotic countertransference suggests erotic countertransference exists in terms of analysts' own internal and external object relations, whereas terms such as 'sexual chemistry' and 'attraction' are limited to consciously perceived characteristics of patients. It is hard to imagine how such non-psychoanalytic explanations are able to translate into psychoanalytic practice.

The following section, argues that the origins of erotic countertransference can be found in the narcissistic tendencies of the analyst. This implies that in certain instances, erotic countertransference may stem from a sort of pathological quality which resides exclusively in the analyst and seems to exclude the patient's contribution to the experience.

3.7 The Origins of the Erotic Countertransference as a Product of the Narcissistic Tendencies of the Analyst

Gabbard & Lester (1995) state that analysts' narcissism plays a central role in the erotic countertransference and occurs on a continuum ranging from narcissistic tendencies which are psychopathic to those analysts who are narcissistically vulnerable and needy of love. Research has also found that analysts who engage in sexual relations with patients fit a pattern of "narcissistic disturbance" (p.431), which originates from their unfulfilled longings as children to be mirrored and their need to merge with others. The patient then functions as a self-object who fulfills the analyst's need to be mirrored (Clarkson & Pokorny, 1994).

Narcissism comprises a key part of an individual's emotional life and consists of one's own personal criteria for self-approval and disapproval (Mc Williams, 1999). Freud (1922) originally defined narcissism as libidinal withdrawal from objects, and the instatement of the ego in their place. Freudians therefore defined narcissism as self-love or self-admiration that impedes relationships with others. Freud (1921) believed that the structure of love was fundamentally narcissistic in nature. Freud argued that when we fall in love, we "place the person whom we love in the place of our ideal ego, from whose position we long to be seen as lovable and desirable" (p.112). He stated that we love an object on account of the "perfections" (p.113) which we have tried to attain for our own ego, and which we should now like to gain in this roundabout way as a means of gratifying our own narcissism.

Kernberg (1975) viewed narcissism as being "essentially pathological" with an individual possessing a "grandiose self" (cited in St. Claire, 2000, p.156). Object relations theorists essentially contend that narcissism is not an "objectless state" as Freud contended, but "reflects intense relations to objects, particularly of an internal nature" (Greenberg & Mitchell, 1983, p.137).

Narcissistic needs that analysts bring into the therapeutic relationship include the need to be admired, loved and respected (Brems, 2001). Jørstad points out how narcissistic problems in the analyst can contribute to the occurrence of an erotic countertransference. Infatuations with other individuals, in and of themselves, "activate narcissistic tendencies in both parties" (Jørstad, 2002, p. 119). Mor (2005) states that an erotic transference may arouse analysts' narcissistic needs to receive a mirroring of their attractiveness and importance as individuals, and this situation often arises at the point of termination. Analysts who have a strong narcissistic investment tend to fall in love with patients who are perceived to be a product of analyst's own analytic creation (Brems, 2001). Narcissistic needs may also result in analysts feeling dissatisfied and negatively towards patients if they are unable to sustain admiring responses (Brems, 2001).

Analysts who possess extreme narcissistic tendencies i.e. personalities that meet the criteria for pathological narcissism (usually accompanied by prominent antisocial features), increase the likelihood of boundary transgressions and erotic countertransference enactments (Gabbard & Lester, 1995).

In order to define pathological narcissism from a psychoanalytic perspective, the term will be viewed from the points of view of both Kohut and Kernberg respectively. Kohut (1971) speaks of the narcissistic person who treats others purely to meet their own needs rather than as individuals in their own right. Interpersonal threats to self-esteem may result in rage-reactions and the need for revenge in order to deal with the narcissistic injury. These individuals have difficulties in establishing and maintaining relationships as they lack empathy, may pathologically lie, and have a limited capacity for humour (Kohut, 1971).

Kernberg (1985) describes a narcissistic personality structure in individuals who thrive on acclaim, have grandiose fantasies and are intensely ambitious, exceptionally self-absorbed, possessing a general inability to love others. He describes their behavior as lacking empathy, with a tendency to exploit others. They experience feelings of emptiness and boredom and only derive pleasure from admiration, although feelings of inferiority coexist alongside experiences of grandiosity.

Gabbard and Lester state that pathologically narcissistic analysts are more often males with "severely compromised superegos" (p.94), who already displayed signs of unethical behavior during their training programs (Gabbard & Lester, 1995). The most profoundly narcissistic

analysts may be males who have risen to the top of their profession and may be renown for their professional talents and contributions. The praise which this analyst receives consistently feeds his grandiosity and is something that he finds enthralling to the extent that he begins to view himself as “different from and superior to others” (p.94). This analyst believes that his transgressions of intimate boundaries with patients are acceptable by virtue of who he is. He furthermore lacks remorse and believes he can engage in unethical behavior due to his status in the field. This is an analyst who feels his patients should feel special and honoured to have received sexual favours from him (Gabbard & Lester, 2003).

At the other end of the narcissistic continuum we find narcissistically vulnerable analysts. If these analysts find themselves in situations that are personally distressing, including life events such as divorce, the death of a loved one, or even an adult developmental crisis related to ageing, they may give way to the fantasy that a patient may be able to ease their own emotional pain (Solomon, 1997). Gabbard and Lester (1995) state that the erotic countertransference and possible transgression of professional boundaries in these instances demonstrate how analysts’ own needs have not been kept aside from that of their patients’ needs.

Thus it seems that narcissistic excesses and deficits as personally experienced by analysts are likely to result in a progression from simply feeling, acknowledging and experiencing an erotic countertransference, to acting on those feelings with patients.

The analyst thus transforms a personal loss into an erotic countertransference to compensate for the loss (Solomon, 1997). Erotic countertransferences that occur within these types of contexts are usually motivated by both internal and external factors. Analysts' own emotional and sexual needs are not being met within their environments, so they begin to look to patients to gratify these needs (Gabbard & Lester, 1995). Furthermore, such analysts are intrinsically very narcissistically vulnerable, although this is not always apparent as they may appear to be functioning relatively well in everyday life and often have social supports.

When a crisis occurs, however, this narcissistic vulnerability may underlie and trigger the development of an erotic countertransference as the analyst desperately needs validation, longs to be loved and idealised, and may then use a patient in order to regulate his or her fragile self-esteem (Gabbard & Lester, 1995). In order to guard against this happening, it is

suggested that analysts should strive to nurture their own personal relationships, and give these priority, rather than putting relationships with patients first (Solomon, 1997).

This argument however does not take into account those analysts who develop an erotic countertransference but are not going through a personal crisis. It also does not account for why interpersonal relationships are difficult for the analyst in the first place and whether this area of the analyst's life can merely be reduced to the fact that they tend to prioritise patients over others. Gabbard and Lester argue that the issue is not one of love but of narcissistic imbalance. "The analyst obscures the patient's real qualities by seeing an idealised image of himself embodied in the patient", just as Narcissus fell in love with his own reflection (Gabbard & Lester 1995, p.98).

The majority of analysts who develop erotic countertransferences are 'love sick'. When the "love sick" (Gabbard & Lester, 1995, p. 96). When the 'love sick' analyst is a male, the typical situation involves a middle-aged analyst falling in love with a female patient who is a great deal younger than him. This infatuation usually occurs in the context of the life stressors already mentioned. These analysts are also more likely to be professionally isolated in private practice, where the only interpersonal contact on a daily basis involves their patients (Gabbard & Lester, 1995).

Gabbard and Lester state that sometimes the personal needs of analysts have deeper unconscious origins that transcend factors such as current personal distress, and that the very choice of analysis as career is sometimes based on the unconscious belief that that they were not adequately loved as children. These analysts hold the unconscious hope that through loving their patients that they will receive love in return. In this way they may believe their patients' needs are being met when in reality they more concerned with meeting their own (Gabbard & Lester, 1995).

This point is elaborated by Cole (2002) who believes that some individuals are drawn to doing analytic therapy because of a strong desire for intimate relationships under "controlled conditions" (p. 350). This includes the desire for relationships that go on with a number of different people at the same time, over an extensive period of time – which is permissible under these circumstances. Aron (1991, p.43) adds that individuals who are drawn to psychoanalysis as a profession "have particularly strong conflicts regarding their desire to be known by another and difficulties concerning intimacy" (cited in Cole, 2007, p. 350). The

abovementioned arguments suggest that analysts may be prone to develop an erotic countertransference based on their own difficulties with intimate relationships in the outside world.

Parsons (2005) adds to the viewpoint that " deep personal motivations often bring an individual into psychoanalytic training" (p. 1183) and the reasons for this may perhaps only be answered if analysts engage in further personal analytic work. This viewpoint implies that analysts should, therefore, allow themselves to be aware of and recognise their experiences of erotic countertransference and use this as a tool for further self-analysis, in order to better understand the possible influence of erotic countertransference on the analysis (Parsons, 2005). In this way the analyst searches for unconscious meanings of his or her experience in the analytic relationship so that these are less likely to be enacted in the therapeutic relationship.

3.8 Summary

The above discussion highlights the fact that narcissistic vulnerabilities and pathological narcissism may both contribute to the development of erotic countertransference reactions. While pathologically narcissistic analysts may intentionally exploit their patients, narcissistically vulnerable analysts have fragile self-esteems and may attempt to meet their own needs through their patients, including their wishes to be loved. If the origins of erotic countertransference lie exclusively in the narcissistic tendencies of analysts, then the patient's participation is eliminated from the picture and erotic countertransference may be viewed as arising exclusively within the analyst. This, however, is questionable, if one considers the psychoanalytic theory of projective identification that follows next.

3.9 The Origins of the Erotic Countertransference in Projective Identification

Projective identification describes “the unconscious phantasy whereby some aspect of the self (either a self or object representation) is split off for either communicative or defensive purposes, and projected into another person, who then becomes identified in the projector’s mind with the disowned aspect of him or herself” (Ivey, 2004, p.2). This definition “captures the dual status of projective identification as both an intrapsychic phenomenon and interpersonal process- as both an unconscious phantasy and the enactment of the phantasy in interpersonal behavior” (Ivey, 2004, p. 3).

“Ogden (1985) has stressed that the pressure to enact that is inherent in projective identification interferes with one's capacity to maintain an analytic space and reflect on what is happening between analyst and patient” (cited in Gabbard, 1997, p. 2). This is especially evident in patients who have been sexually exploited in their past, who often “feel that the analyst must take some form of action to address their pain” (Ogden, cited in Gabbard, 1997, p. 2).

This demand to act is apparent in the “introjective and projective processes between analyst and patient” (Gabbard, 1997, p. 2). Using projective identification, the patient coerces the analyst into assuming one of the various desired roles of self or object representations such as “omnipotent rescuer, victim, and abuser and the patient then assumes the complementary role” (Gabbard, 1997, p. 2). This process may provide a further explanation concerning the manifestation of an erotic countertransference, as the patient’s “transference phantasies cannot be viewed simply as intrapsychic events as they are inevitably enacted” (Ivey, 2004, p. 10). Thus “the patients’ projections will affect their behaviour towards analysts, which in turn influences analysts’ countertranference reactions”. These “countertransference reactions” will then be “registered by the patient and interpreted by him in the context of the projective phantasy” (Ivey, 2004, p. 10).

The analyst can supposedly become aware of the projective quality of a patient's communication. Projections are experienced as egodystonic and possessing a sense of 'otherness' that is distinctly different from the analyst's own inner experience (Hyde, 2006). However, contrary to this position, Sandler & Sandler (2003) view this experience of 'otherness' in terms of a compromise between the projected role assigned by the patient and the analyst's own personal tendencies.

Purcell (2006) states that the link between projective identification and erotic countertransference is specifically noticeable in the analysis of sexually perverse patients due to the "splitting and projective identification of the sexual excitement" (p. 107) in the patient's perverse transference. The sexually perverse patient "consciously enjoys sexual aims and objects that other people do not", and therefore "needs to rid him or herself (through projective identification) of the sadistic nature of the excitement" (Purcell, 2006, p. 107).

According to Purcell the function of projective identification is "offensively aimed at destroying the calm and strength of the analyst" (Purcell, 2006, p. 107). Projective identification of sexual excitement serves as a means of sadistically attacking and controlling the analyst and evoking a complementary masochistic response (Purcell, 2006). The perverse patient sets up an enactment of a sadomasochistic relationship based on projective identification that distorts the patient's perception of the analyst and at the same time "facilitates the analyst behaving in a manner appropriate to the unconscious projection i.e. enacting the projected sexual sadism" (Purcell, 2006, p. 107). The analyst is likely to respond with denial, suppression or avoidance, or feelings of powerlessness, annoyance and an inability to think meaningfully, which all interfere with the analyst's ability to function analytically with these patients (Purcell, 2006).

Perverse patients also induce analysts to "act out their provocation in interpretations or pseudointerpretations" (Purcell, 2006, p. 107). The analyst's excited responses are conceptualised as part of his countertransference, and it is an integral part of the analyst's working through to sort out those elements of his excitement that are personal countertransference reactions from those that are reactions to the patient's projections (Purcell, 2006).

Perverse erotic countertransference excitement may be “problematic because it carries with it connotations of immorality, illegitimacy, and pathology” (p. 111), so it is likely that the analysts perverse erotic countertransference “will tend to keep sexual excitement, especially that which occurs in response to manifestly non-sexual material-unconscious or unreported when conscious” (Purcell, 2006, p. 111).

Ivey (2008, p. 22) states that the patient, under the sway of his or her transference, mobilises countertransference responses, and these may be construed as an “interpersonal behavioral expression of the patient's internal world”.

> “While the analyst's unconscious emotional responsiveness is crucial to the enactment, this is activated and driven by the patient's transference. This definition is closely allied to current conceptualisations of projective identification, where the analyst is pressured to feel and behave in a manner consistent with what the patient has in fantasy projected into him or her” (Feldman, 1997; Joseph, 1989; Spillius, 1992 cited in Ivey, 2008, p. 22).

Gabbard (2004) states that analysts’ unconscious conflicts, defences, and internal object relations will determine whether or not patients’ projections affect them. Gabbard mentions that even analysts’ experiences of countertransference being an “alien force sweeping over them”, is actually an “affect-laden repressed self or object representation” that has been “activated by the interpersonal pressure of the patient” (p.134). Hence an analyst’s “usual sense of a familiar, continuous self has been disrupted by the emergence of these repressed aspects of the self” (Gabbard, 2004 p.134). The concept of projective identification may further explain why not all analysts experience the same countertransference responses to a patient. “The notion of a hook” in the analyst and a “good fit” between patient and analyst implies that the analyst’s “internal world will determine to some extent the nature of the response to the patient’s transference” (Gabbard, 1994, p.137).

Spillius (2007) states that in spite of the fact that there is the general consensus that splitting and projective identification affect both patient and analyst and give rise to both transference and countertransference reactions, analysts disagree when it comes to examining the value of countertransference in revealing the content of patients’ projections (cited in Steiner, 1998). Klein herself was skeptical, suggesting that countertransference provided more information concerning the analyst than the patient (cited in Steiner, 2008). Furthermore, the effect which

countertransference has on analysts is dependent on multiple factors such as the “analyst's state of mind and receptiveness to the patient” (Steiner, 2008, p. 47). “A further important factor derives from the fact that much of countertransference is unconscious” (p. 47). This implies that much of the erotic countertransference is unconsciously expressed and not available for introspection (Steiner, 2008).

3.10 Summary

If projective identification provides an explanation for the analyst’s experiences of erotic countertransference then it follows that it is the patient’s projections that influence analysts’ experience of sexual feelings, although it was pointed out by Gabbard that the analyst’s own internal world plays a role in the analyst’s experience and response to the transference. This theory, in addition to the previous discussion on internal objects, may account for why certain patients may elicit a erotic countertransference response and not others. Spillius also argued that examining countertransference in order to gain information about what has been projected by the patient may tell us more about the analyst. To this Steiner added that much of an analyst’s countertransference occurs unconsciously, so this content is not accessible for introspection. It therefore seems that although projective identification may account for why analysts have an erotic countertransference, the fact that countertransference occurs unconsciously and is influenced by their activated conflicts suggests that analysts may never have full insight into their countertansference experience. According to the psychoanalytic literature, it appears that much of what is happening between analyst and patient resides outside of each individual’s awareness, largely due to the unconscious conflicts stimulated by the interaction.

The last section dealing with the origins of erotic countertransference argues that it is the gender of the analyst and patient in the analytic dyad that is central to the occurrence of the analyst’s erotic countertransference.

3.11 Erotic Countertransference and the Gender of the Analyst

A great majority of analysts report that they experience sexual feelings for patients. Pope et al. (1986) found in their research that 95% of male analysts and 76% of female analysts reported feeling attracted to their patients on at least one occasion (Epstein, 1994). There is also a significantly higher number of male analysts who have reportedly had sexual intercourse with patients in comparison to female analysts. The percentage of male analysts who have sexual intercourse with patients is around 10%, while it is stated that female analysts form a tiny minority of around 3% (Clarkson & Pokorny, 1994).

It has been found that certain attitudes and practices with regards to analysts touching their patients is also a gender-specific phenomena (Perry, 1976 cited in Epstein, 1994). Survey findings suggested that female analysts were more likely to believe that non-erotic touching of patients could be therapeutically useful, yet were less likely to encourage or engage in erotic behavior. Engaging in erotic behavior was found to be more common in male analysts (Epstein, 1994).

Holroyd and Brodsky (1977) found that 27% of psychoanalysts engaged in non-erotic touch such as hugging, kissing or affectionately touching patients of the opposite sex, and significantly more female analysts engaged in such contact with other female patients than with male patients. Regardless, however, of whether the physical contact was with a patient of the same or opposite sex, physical touch has been found to generally be more frequently used by psychologists with a humanistic orientation than by those following a psychodynamic orientation (Pope et al., 1986).

In a subsequent analysis of their survey data Holroyd and Brodsky discovered that analysts who admitted having sexual intercourse with their patients had initially engaged in non-erotic touching of patients of the opposite sex more frequently than those that did not engage in non-erotic touching. The study thus concluded that gender-based (heterosexual) touching is more likely to lead to sexual intercourse between analyst and patient (Pope et al., 1986).

Gabbard (1998) believes that the gender dimension is one of the most important variables in the origin of the erotic countertransference. He states that a female analyst with a male patient is a far safer dyad, while it is significantly more dangerous for a male analyst to be treating a female patient. Gabbard's belief rests on the assumption that "if a man says to a woman that he has sexual feelings for her, an action is implied by that communication in all strata of society" (p.2). This does not appear to be the case for a woman communicating similar feelings to a man, possibly due to the fact that it is still culturally less acceptable for a woman to openly express her sexual feelings (Maguire, 1995).

Mc Williams (1999) states that the potential for the occurrence of erotic countertransference is lessened when the patient is a heterosexual male in treatment with a female analyst. This is because the combination of a female (who is in a higher position of authority by virtue of being the analyst) with a male (who is in a lower position of authority by virtue of being the patient) does not create the same erotic atmosphere due to the ideology of the western cultural system. Analysts are placed in more powerful positions than patients and thus reverse traditional roles when the analyst is a female with a male patient (Gray & Gannon, 2005; Maguire 1995).

"Gender stereotypes thus get activated" in analysis due to the fact that "they exist in the culture at large" (Gabbard, 2004, p. 71). It has also been suggested that with female analysts, erotic countertransference is more of a maternal eroticism characterised by nurturing and protecting opposed to the sexual feelings that possess an oedipal, genital sexuality (Gabbard & Lester, 1995; Harding, 2001).

Maguire (1995) disagrees and states that the reason for male analysts being more likely to develop an erotic countertransference for female patients concerns anxieties centered around possible homosexuality and feminine identifications they may have. The erotic countertransference is thus an unconscious attempt to assert their masculinity and heterosexuality (Maguire, 1995).

Gray and Gannon (2005) put forward an opposing viewpoint and state that the typical process of therapy demands showing vulnerability, expressing feelings, and confronting pain, while the traditional male role requires such behaviors as showing strength, being stoic, and denying pain. A common defense of traditional men against the shame and anxiety generated by the psychoanalytic relationship is the development of a erotic transference with a female

analyst (Gray & Gannon, 2005). Myers (1996) states that it is likely that erotic transferences and countertransferences may appear during the course of any long-term analysis. However, when male patients work with female analysts, erotic feelings may arise earlier in the treatment. This occurs as men are less accustomed to self-disclosure and tend to transform feelings of vulnerability into sexual desire to defend against intimacy. It is also argued that this may occur in the very beginning phases of analysis when male patients are likely to feel most awkward about self-disclosure. Female analysts may then experience an erotic countertransference as they enjoy the sexualised transference, "resulting attention, flattery, and compliments" (Gray & Gannon, 2005, p. 356).

Gray & Gannon (2005) state that another countertransference issue which may affect female analysts in their interactions with male patients is the female analyst's "own longing for intimacy with men" (p. 356). "There may be a tendency for female analysts to unconsciously try and resolve relationships with a distant husband or an emotionally absent father while working with male patients" (p. 356).

Gorkin (1985, p. 429) states that the "good hysteric female patient" is always more likely to "readily develop a warm, idealising, romantic transference" towards the analyst, which then results in a "more or less predictable" type of erotic countertransference response by the male analyst (p. 429). Gorkin therefore implies that although the analyst experiences an erotic countertransference, this is purely in response to the transference of the female hysteric. Gorkin states that, "unlike more regressed patients, the hysteric makes a concerted effort to avoid the emergence of sexual feelings towards the analyst" as she is "frightened by the dangers of her sexuality" (p.429). She thus represses her sexual feelings, yet by "suggestion, tone and gesture", creates a romantic atmosphere in the analytic setting (Gorkin, 1985, p.429).

Laine (2007) agrees that the genders of the analyst and the patient will always influence the analytical relationship. Cooper (1998) and Benjamin (1994) both agree that the genders of the analytic dyad influence how likely analysts are to experience an erotic countertransference and how this will manifest (cited in Rabin, 2003). Rabin (2003), however, argues that when making generalisations pertaining to gender we need to bear in mind the uniqueness of each analytic dyad, whatever the gender of analyst and patient happens to be (Rabin, 2003). In this sense, one may argue that it is the individuals that comprise the gendered dyad, rather than gender per se, that is most important.

This makes sense if one considers Gabbard's argument that gender may not account exclusively for the occurrence of an erotic countertransference due to the fact that as "dynamic psychotherapy deepens, gender and even sexual orientation becomes quite fluid" in the analytic dyad" (Gabbard, 2004, p.71). A heterosexual male patient may have sexual feelings for a male analyst and female analysts who consider themselves heterosexual may find themselves attracted to a female patient (Gabbard, 2004). Stern (2003) states that we have assigned individuals a very limited number of alternatives when it comes to sexual orientation, one is either: homosexual, heterosexual, bi-sexual, or at the very limit, asexual. However, individuals may experience idiosyncratic and conflicting desires and one's sexuality may at times be unstable. Maguire (1995) states that there is very little known or discussed in the psychoanalytic literature about the homoerotic countertransference reactions between same-sex analytic dyads, which indicates a further taboo area surrounding erotic countertransference.

3.12 Summary

The exact role which gender plays in the development of erotic countertransference seems to be unclear. Research seems to provide evidence that male analysts are more likely than female analysts to be attracted to their opposite sex patients (as well as engage in sexual behavior with them) due to cultural norms, yet the fact that gender and sexual orientation may be viewed as fluid (both within the analytic setting and outside of it) suggests that the impact of one's gender on the development of sexual feelings of analysts for patients is variable. There appears to be very little research reporting analysts who usually consider themselves to be heterosexual, developing an erotic countertransference to same-sex patients. Perhaps this is because it is assumed that it is not common or that it is yet another area of taboo that has not been looked at much in the literature and research. Another area of the literature that is almost non-existent is the occurrence of homoerotic countertransference in the analytic dyad. More research is needed in this area in order for us to clearly establish what the impact of the genders and sexual orientation of patient and analyst are in the occurrence of erotic countertransference.

4. CHAPTER FOUR: HANDLING EROTIC COUNTERTRANFERENCE

4.1 Handling Erotic Countertransference within the Therapeutic Setting

"Winnicott (1960) maintains that the greatest threat to psychoanalytic therapy is not sexual desire itself, but the analyst's inability to acknowledge his or her own part in it" (cited in Jørstad, 2002 p.120). Mann (1997) states that Freud too struggled with his erotic countertransference and so developed a number of rules to minimise its occurrence. Such procedures include refraining from making any physical contact with the patient and remaining neutral. The ability of analysts to remain neutral has been debated since then, as both analyst and patient's unconscious conflicts, impulses and history influence both individuals' behaviours and conscious attitudes (Kahn, 1991). Analysts are constantly being influenced by their patients while equally influencing them and by virtue of their own personal analysis are not free of the influence of their own unconscious (Lemma, 2003).

These matters have especially important significance when we move onto the aspect of psychoanalytic therapy where we need to discuss the impact of the erotic countertransference on the therapeutic relationship, and the technical question of how to manage this. A number of radically different sets of advice emerge within the literature, yet all of these varied positions seem to present their own set of dilemmas for the therapeutic alliance. This section of the research report addresses the second research question concerning how best to address erotic countertransference in the psychotherapy context.

The arguments that were put forward regarding the origins of erotic countertransference have aimed to highlight the unconscious aspect of these origins. Due to the fact that we may not be fully aware of the meanings and origins of erotic countertransference at the time of experiencing it, it will be argued that the most therapeutically sound approach would to be to adopt a position of psychoanalytic abstinence. Abstinence includes being cautious to avoid excessive gratification of the patient's transference wishes and comprises "an attitude of restraint" (Gabbard, 2004, p.61). Analysts on the other hand abstain from gratifying any of

their own needs and the focus remains on the patient (Barrows, 1999). If we are always acting on the basis of unconscious personal motivations, some of which we cannot have insight into, then it is problematic to make effective use of the technique of self-disclosure (recommended by relational psychoanalysts) in an ethical manner (Jørstad, 2002). A number of alternative means of dealing with erotic countertransference will be put forward, in addition to analytic abstinence, that do not involve self-disclosure of sexual feelings towards patients.

4.2 Defining Self-Disclosure

The process of intentional self-disclosure, as distinct from unintentional self-disclosure involves analysts deliberately sharing experiences and ideas with their patients" (Ivey & Ivey, 2003, p. 319), related to their own personal lives (Roberts, 2005). Another definition states that self-disclosure includes:

> "The analyst's conveyance of information to the patient about any aspect of the analyst's life experience, in or out of the treatment relationship. Both self-expression and self-disclosure involve either intentional or inadvertent communications by analysts" (Goldberg, 2001, p.11).

It will be argued that self-disclosure, particularly of erotic countertransference is problematic in a psychoanalytic context. In the literature that follows, an investigation is undertaken into the respective viewpoints that are advocated.

4.3 Relational Psychoanalysis: A Postmodern View that Advocates Self-disclosure

Knight (2007) argues that the recent literature on the concepts of countertransference and self-disclosure in the analytic relationship have contributed to the re-vision of the traditional idea of the neutral, detached, and abstinent analyst. “Relational psychoanalysis is a contemporary perspective” that places a strong emphasis on the “interpersonal dimension” of the therapeutic dyad (p. 277). Relational psychoanalysis states that “the analytic relationship is mutual and co-created, involving the dynamic interplay of multiple subjectivities and multiple self-representations” (p. 277). This is a fundamentally different perspective to that held by more classical psychoanalysts (Lemma, 2003). The analytic relationship as a being a “socially constructed phenomenon rooted in the idea of intersubjectivity within the analytic relationship” has in turn given rise to the understanding that the analyst contributes toward what emerges as the patient's analytic material (Knight, 2007, p. 277). Intersubjectivity refers to the “mutual influence” of the analyst and the patient on each other and the “consequences of this” (Lemma, 2003, p. 46).

Knight goes on to state that:

> “The notion of mutuality in the analytic relationship relies on the philosophical and ideological assumption that the analyst and the patient are both implicated in the patient's process. Therefore, transference, for example, is never simply the patient's experience of the analyst but always includes the analyst's own psychology and participation in the patient's patterns of relating and reenactments” (Knight, 2007, p. 277).

The emergence of these new perspectives correspond closely with the principles of postmodernism. Knight states that:

> “Essentially, postmodernism has challenged and deconstructed the positivistic assumption of an objective, scientific authority that adheres to the production of single truth or reality. Instead, postmodernism presents the idea of multiple

> realities and plural interpretations and meaning is viewed as being socially constructed in the matrix of interpersonal relations" (Knight, 2007, p. 278).

In this regard, postmodernism challenges traditional psychoanalysis claiming that the analyst is unable to be a detached, "all knowing" individual able to provide "truth in the form of interpretations" (Knight, 2007, p. 278). The more psychoanalytic theory progresses toward viewing analysis "as involving a two-person system, the more sanction will be found for permitting analyst self-disclosures" (Hyde, 2006, p. 73).

At the heart of Classical psychoanalysis we find the "Cartesian doctrine of the isolated mind considered to be an objective entity alongside other objects" (p.45), possessing the ability to accurately perceive the nature of an object. "This stance maintains a belief in the possibility of the analyst's neutrality and objectivity, as it suggests that mental life can exist independently of the clinical situation" (Lemma, 2003, p.45).

Kohut (1959) defined empathy in terms of vicarious introspection, shifting the analyst's classically objective position as an observer towards a participatory position in the analytic dyad. Self psychology advocates that analysts make use of their inner and affective experiences with the aim of better understanding their patients' affective states. A self-disclosure should thus remain closely tied to analysts' empathic understanding of patients' needs and affects in the present moment (cited in Goldberg, 2001).

Gabbard (1995) states that contemporary analysts view countertransference as "a joint analytic creation", while Hirsch (1998) adds that "the widespread tendency to recognise the prevalence and potential usefulness of countertransference enactments heralds a theoretical convergence toward a more intersubjective position" (cited in Ivey, 2008, p. 21).

4.4 Self-Disclosure : Helpful or Harmful to the Patient?

Knight, (2007) argues in favour of self-disclosure from a relational psychoanalytic viewpoint. Relational psychoanalysis advocates that self-disclosure is therapeutic, and should be viewed as a respected technique. Self-disclosure is said to "enhance the therapeutic or working alliance", as it is a type of "empathic attunement or responsiveness" that may "encourage the patient to become more fully involved in the analysis" (p. 283). The patient may additionally perceive the analyst as being more "authentic" in the analytic relationship (Knight, 2008, p. 6).

Young-Eisendrath (2007), however, argues against this viewpoint and states that analysts cannot and should not be so clearly known, due to their "relatively more protected role" (p. 313). This may result in the analyst remaining somewhat idealised even at the termination point of treatment as the analyst takes the position of remaining "anonymous, less retaliatory, and more forgiving than in other relationships" the patient may have in the outside world (Young-Eisendrath, 2007, p. 313). It is the patient who needs to be known, loved, and accepted, but the analyst is somewhat unknown and should remain this way even after the treatment has ended (Young-Eisendrath, 2007). To this Kahn (1991) adds that psychoanalysis should remain focused on the patient and not the analyst.

Knight (2008) states that self-disclosure can either be of an intentional or inadvertent nature. Analysts are always interacting with their patients and may disclose aspects of themselves with conscious intention, or inadvertently and unintentionally reveal something about themselves. In either instance, Knight states the analyst is "willing to be known by the patient" (2008, p. 4). Gabbard (2004) adds that unintentional self-disclosures may involve mutual eye contact with patients, tone of voice, body postures etc. Information is also revealed in the way consulting rooms are decorated, changes in facial expressions in response to various comments, and even the choice of when to speak within a session. These unintentional self-disclosures are part of the unconscious communication that takes place within the analytic situation (Mor, 2005).

D'Abreu (2006) agrees that analysts may often unintentionally reveal unconscious feelings to a patient, as even personal analysis is impeded by "a wide and unrestricted access to unconscious influence" (p. 956), but this doesn't necessarily translate to the analyst being willing to be known by the patient, as analysts are often not aware of their unintentional disclosures.

This is because analysts are always at the mercy of unconscious feelings, even as they make their interpretations. This is due to the fact that:

> "The analysts' own ambitions (e.g. to cure, to be successful in their profession), their theoretical frameworks, an article they may have read recently, a psychoanalytic talk heard the night before, their experiences during the day with their families or with other patients who elicited some emotion or worry, are all part of the endless influences that could be unconsciously present" (D' Abreu, 2006, p. 956).

The presence of unconscious content in the process should therefore not be forgotten. The analyst's awareness of these emotions and appropriate use of countertransference is a significant instrument for understanding what is happening in the analytic relationship (D'Abreu, 2006). Ivey (2008, p. 2) states that "patients unconsciously draw" analysts into "feeling and acting towards them in ways that indirectly reflect transference-countertransference constellations implicated in their psychological difficulties", and countertransference is thus an important psychoanalytic tool at the analyst's disposal that can be used to understand what is happening with the patient.

Greenberg (1995, p.1), however, argues that we need to guard against rejecting something merely because it is "not real analysis", without first investigating what the impact on the patient may be. Ivey (2008), however, states that "it is the unconscious meaning and impact that an intervention has that distinguishes whether it is truly therapeutic or whether it merely gratifies a transference fantasy", so without "a methodology for evaluating the unconscious impact" of self-disclosure, this choice of intervention is questionable from a psychoanalytic point of view (Ivey, 2008, p.3). Thus, while a patient may consciously welcome an analyst's erotic self-disclosures, at an unconscious level this may be experienced as dangerous and deeply threatening to the analytic process.

However, a relational viewpoint argues that analysts' self-disclosures that stem from their countertransference reactions serve to facilitate and deepen the analytic process (Gediman, 2006). Knight (2007) states that the emotional expression of analysts is beneficial to patients and analysts who are afraid to disclose aspects of who they are, feel reluctant to do so as they fear appearing vulnerable in their presence of their patients. This is because self-disclosure involves revealing parts of themselves that have been hidden from both their patients and possibly themselves.

Jørstad (2002) states that there is a difference between transgressing a boundary in order to further analysis in a useful way, and violating a boundary that may significantly harm one's patient. This statement implies that in some instances self-disclosure is permissible and in other situations a self-disclosure can constitute a boundary violation. Hyde (2006) argues that the question remains as to how much self-disclosure constitutes too much? and are all kinds of self-disclosure appropriate? Hyde points out that this is a discussion, where disagreement exists even among relational theorists (Hyde, 2006).

Ivey (2008) argues that it may not ever be appropriate to intentionally reveal one's sexual feelings to patients as there is something about the specific nature of erotic countertransference that puts it in a different category to other feelings experienced towards patients. Self-disclosure of sexual feelings may be different from disclosure of other feelings the analyst may have. Gabbard (1996 cited in Ivey, 2008) explains this by using a hypothetical father's disclosure that he has sexual feelings for his young daughter. While the daughter may have sexual feelings for her father, and even wish that these may be realised, the father's expression of such feelings would be experienced as particularly threatening due to the "incest taboo". While this self-disclosure would inflame her "oedipal wishes" (p.4), these would be accompanied by anxiety and guilt. A similar response may be anticipated in the transference of patients receiving a disclosure of sexual feelings (Ivey, 2008 p. 4). Mann (1997) states that analysts should not expect their patients to be able to handle disclosures of their sexual feelings as this is the equivalent of expecting a child to handle knowledge of a parent's incestuous feelings.

Mor (2005), however, adds that even if the analyst does not intentionally self-disclose sexual feelings, "erotic communication is often pre-symbolic and takes place in the fantasy-inducing visual field of nonverbal communication", where either party may communicate his or her desire to the other quite unwittingly (p. 45).

Davies (1998) advocates intentional self-disclosure of sexual feelings, thoughts and fantasies analysts have toward their patients. Davies recounts how after disclosing that she was flirting with one of her male patients, she assured him that the place in which they could be a man and a woman together was like the analytic relationship itself, "a place of thought, not action" (p.755). She emphasises that this place could never exist in "real time and space". It is, therefore, "an imaginary place unbridgeable with the real world" (p.755). Davies condones self-disclosure by placing an emphasis on boundaries and fantasies. Davies says we all have sexual desires on which we do not act as such actions would be inappropriate and wrong. She suggests that this is the "true legacy" of the Oedipus complex- the capacity to sustain those desires for the things we can never have (Davies, 1998, p. 756).

Ivey (2008) poses a counter-argument by stating that analysts' avoidance of self-disclosing sexual feelings relates to an important aspect of transference resolution involving "mourning what one can never have in relation to the analyst" (p.5). Analysts who confess sexual feelings make it more difficult for patients to let go of "the fantasy that these mutual desires may one day be realised and a true union with the 'ideal' transference object be attained" (p.5). A self-disclosure of this nature may heighten sexual feelings in the analytic dyad that increases the risk of a sexual enactment (Ivey, 2008).

It is widely accepted from a relational psychoanalytic perspective that requests for information by the patient are significant sources of knowledge (Knight, 2008). Psychoanalysis, however, assumes that patients' communications within psychoanalytic treatment possess meanings beyond those intended by the patient, thus communications cannot be merely understood at a conscious or surface level (Fonagy & Target, 2003).

Ivey (2008) points out that listening to patients' questions regarding analysts' sexual feelings at a manifest level, rather than listening for the latent unconscious significance of what is being communicated, is what "distinguishes psychoanalysis from other therapeutic modalities" (p.5). When analysts treat patients' questions as a "manifest communication" and respond to this with a personal self-disclosure "it disregards the question's potential unconscious meaning" and also "restricts the patient's scope of fantasy about the analyst's private existence" (p.5). Self-disclosure therefore restricts psychoanalytic inquiry (Ivey, 2008).

Gabbard (2004) is in agreement with this as he states that if there is uncertainty about the value of answering a patient's question, the analyst can explore why this information is of importance to the patient. Analysts should rather investigate the reasons for the questions as opposed to merely self-disclosing. Gabbard emphasises that it is completely acceptable to tell a patient " I don't mean to be impolite but I prefer to keep my private life out of therapy" or "this process is for you and the focus must be on you" (Gabbard, 2004 p. 47).

Gabbard (1998) also highlights alternative approaches to self-disclosure that have a positive effect on the therapeutic alliance. He once had a female patient who demanded to know whether he shared the strong attraction she felt for him. Gabbard responded to this question by pointing out the dilemma in which she placed him. He told her that he felt it was a question he was unable to answer. If he said he didn't have sexual feelings for her, he felt that she may have found his response hurtful and devastating. If he disclosed that he did have sexual feelings for her, then she may have felt that the analytic situation was less safe than she had previously believed it to be. The patient accepted this response and later thanked him for not complying with her demand (Gabbard, 1998).

Pfannschmidt (1998) takes an extreme approach to handling erotic countertransference. He states that "erotic and sexual feelings, phantasies and impulses" in the therapeutic relationship may be utilised in analysis to foster "developmental growth" (p.128). Pfannschmidt proposes an "erotic sexual program" with direct reference to Winnicott's transitional space. He speaks of patient and analyst possessing "a psychic realm of creative imagination" and an "interactive play room" comprising the therapeutic couple and their experience of erotic and sexual feelings (cited in Mann, 2002, p.128).

Pfannschmidt proposes that patient and analyst should "speak openly of their erotic and sexual feelings and phantasies, enjoy them and when possible, work through them analytically" (cited in Mann, 2002, p.128). When erotic desire and fantasies produce extreme anxiety, even horror, these too should be expressed and worked through. Pfanschmidt argues that abstinence is being maintained as long as the analyst is not pursuing his own gratification, but is rather analysing the "relational interaction in the transference and countertransference" (Mann, 2002, p. 128). Gabbard (1998), however, believes that excessive and exclusive dealing with erotic transference and countertransference issues may constitute a defense against dealing with other problematic issues, and content brought by patients to analysis. He indicates that an overemphasis on the erotic by analysts may stem from their

own unsatisfied needs and emotional issues, and that these needs may interfere with the therapeutic process. Ehrenberg (2005) also alerts analysts to the possibility that any effort to attend exclusively to one's erotic countertransference may be a form of resistance with respect to other problematic issues.

Many authors have implied that self-disclosure of an analyst's erotic countertransference is the equivalent of enacting at a verbal level and constitutes a boundary violation (Gabbard & Lester, 1995; Greenberg; 1995; Steiner, 2006). Ivey (2008) defines the term enactment as patients' transference fantasies that are lived out in verbal and non-verbal behavior towards the analysts. Ivey (2008) states:

> "The analyst is frequently drawn into realising the patient's transference fantasies which (Sandler, 1976) led to the understanding that these events are transference-countertransference interactions to which both parties unconsciously contribute. In other words, an enactment is said to occur when the patient unconsciously recruits the analyst's subjective predisposition to feel and respond in certain ways by behaving in a manner intended to elicit an emotional reaction from the analyst that confirms a transference fantasy" (p. 22).

Hyde (2006), who follows the relational approach to psychoanalysis, recounts his experimentation of using his countertransference responses in analysis by commenting directly about them with a statement like, "I just became aware that I am feeling X and I wonder what that may have to do with what's happening between us?" (p. 71). However, Hyde states that he became shocked and embarrassed when during one of his sessions with an adolescent girl he suddenly became aware that he had a full erection. Hyde was very concerned that his patient could see this and felt ashamed that he had physically responded in this way. Hyde states that no matter how he tried, he could not imagine any reasonable way of bringing the reality of his physiological response into the therapy in a way that would be tolerable to his patient.

Hyde adds that he had a sudden fantasy of being in court, on a witness stand, with the prosecutor asking him if it was true that he had an erection with his underage patient and if it was also true that he talked with her about his erection and how he would be asked to explain "the clinical rationale for such outrageous behavior" (p. 71). Hyde believes if he had disclosed it would have been a crossing of boundaries taken too far.

Hyde states that the therapeutic use of erotic countertransference, unconscious communication, and projective identification may entail some form of disclosure by the analyst, yet this raises two essential questions that are very controversial (Hyde, 2006). Firstly, “how much should therapists tell patients about their inner experience?” and secondly, “how can therapists decide whether particular disclosures are likely to be helpful to the patient, or whether they constitute an acting-out in the service of some unconscious need on the analyst’s part?” (Hyde, 2006, p. 72).

Gabbard (1998) states that self-disclosure can often lead to enactment. Gabbard has had extensive experience in evaluating, consulting on, and treating analysts who have had sexual relationships with their patients. He positions himself against self disclosure, by pointing out that the vast majority of these relationships ended up in being tragic and damaging, and many began with the analyst’s disclosure of his or her erotic countertransference (Gabbard, 1998).

According to Gabbard (2004, p.52) most boundary violations such as “sexual relations with patients begin with subtle countertransference enactments” that may initially seem benign. They often get out of control as analysts “convince themselves that what they are doing is simply accommodating to the patient’s needs and furthering the process” of analysis (p.52). Often the first step is the self-disclosure of an analyst’s own personal problem, which leads to “a role reversal” within the analytic dyad (p.52). The patient becomes a “sympathetic listener” and the initial reaction to the self-disclosure may be so encouraging that the analyst assumes that a self-disclosure is actually a helpful technique (p.52). This may then lead to the patient comforting the analyst, for example, providing a hug at the end of the session as a way of “bolstering the analyst in a time of need” (Gabbard, 2004, p.52).

Knight (2007; 2008) also states that analysts’ emotional surrenders (disclosing of emotions and feelings towards patients) should not constitute an uncontrollable expression of emotion, which may potentially lead to enactment relative to their own psychological histories. Although both analyst and patient may feel overwhelmed at times by powerful emotions, and both may feel a sense of being emotionally out of control, it is the analyst's behavior and expression of emotion that remains within control (Knight, 2007).

Gorkin (1987) argues that in his own clinical experience he has never found disclosure of erotic countertransference to be helpful, on the contrary, he has found them to be harmful to the patient. Gorkin states that patients to whom he has disclosed found the information

overwhelming, in the same manner as an analyst's disclosure of the wish to hurt the patient might be experienced. Analysts should exercise restraint with regard to intentional self-disclosure of sexual feelings to patients, even if they are central in the countertransference experience (Ehrenberg, 2005).

Gabbard (1998) cautions that one can never truly be certain of what the impact of a self-disclosure on the patient will be in advance. What may be intended as a harmless, helpful comment on the part of the analyst may be experienced by the patient as a blatant seduction that compromises the safety of the analytic frame. Unger (2005) points out how even courtesies that are considered to be everyday behavior may take on deeper meanings in the psychoanalytic setting. The balance of power is not equal in the analytic dyad and this is why appropriate limits need to be adhered to and limitations placed on what analysts may express (Gabbard, 2004; Gabbard & Lester, 2005).

4.5 Summary

The arguments supporting a relational perspective have endeavored to show that self-disclosure is a useful therapeutic technique, yet in the context of psychoanalytic therapy this seems to be a highly problematic intervention. Relational psychoanalysts argue that self-disclosure deepens the analytic process, yet there seems to be much evidence that self-disclosure of erotic countertransference constitutes enactment at a verbal level, may be experienced by patients as a boundary violation, as well as possibly lead to further sexual enactments between analyst and patient. The point was made that analysts are always unintentionally disclosing aspects of themselves to patients and relational psychoanalysis seems to highlight the impossibility of analysts remaining neutral and unaffected by patients. Intentional self-disclosure of sexual feelings is problematic because latent content of patients' communications are being overlooked and there is no certainty that the disclosure will merely impact the patient in a benign way.

Certain relational psychoanalysts have overtly stated that disclosure of analysts' sexual feelings to patients is quite acceptable, however, it does not seem to make sense that analysts make use of a therapeutic technique that has clearly been shown to be anti-therapeutic. It furthermore does not make sense to use a non-psychoanalytic technique that is so fraught

with potentially problematic outcomes, when there are a number of other interventions available to the analyst as suggested by Gabbard which do not place the patient in a position of vulnerability, and the analysis in jeopardy.

4.6 Self-disclosure and its Impact on the Therapeutic Alliance

The potential for psychological change in psychotherapy is based a great deal on "the function and strength of the therapeutic alliance" (Horvath & Greenberg, 1994, p.13). The therapeutic alliance includes the establishment of a collaborative relationship between analyst and patient that enables the two parties to work together in order to accomplish therapeutic tasks and goals (Horvath & Greenberg, 1994; Mc Williams, 1994).

Depending on the strength of the therapeutic alliance, it is said that the analyst may use his or her discretion to establish whether or not it is permissible to participate in certain experiences with the patient, including but not limited to intentional self-disclosure (Taerk, 2000). Rabin (2003) supports this permissive stance, stating that self-disclosure is not the issue. Rather, it is "the moral character of the analyst" and the "unique patient-analyst dyad" that are crucial aspects (p.683). There seems to be no question that the analyst's moral character may be important if one considers that pathologically narcissistic analysts intentionally exploit their patients. However, it may be argued that whatever the moral character of the analyst happens to be, it is self-disclosure as a therapeutic technique itself which seems to be problematic when it comes to analysts' sexual feelings, regardless of the analyst's intentions or the individuals that comprise the analytic dyad.

Horvath and Greenberg (1994) add that patients vary in terms of the length of time required to establish a good working alliance with analysts. Patients presenting with neurotic difficulties are likely to establish an alliance in less time than individuals with more serious borderline or psychotic pathologies (Horvath & Greenberg, 1994). Lotter (1999) argues that boundaries exist to protect analyst, patient and the therapeutic alliance. Regardless of the strength of the therapeutic alliance, it is safer not to self-disclose personal information to patients as it enables them to maintain more power, when analysts maintain the analytic attitude and therapeutic frame. Lotter (1999) states that there is as an unequal power differential between analysts and their patients which makes it imperative, that patients feel that the therapeutic space is safe (Lotter, 1999).

Knight (2008) advocates the use of self-disclosure yet also points out the main reasons argued for by other analysts against self-disclosure. Firstly, self- disclosure takes the attention off the patient's concerns and is likely to burden the patient, causing a breakdown in the therapeutic alliance, and it is "unethical" as it may be damaging to the patient (p. 286). Analysts cannot

be sure if they are able to disclose in a sensitive or skilled enough manner. This means that, there is a greater chance that they will damage, rather than strengthen the alliance with their patients.

Jørstad (2002) states that the principle of "awareness instead of action" (p.5) can be viewed as preferable. Analysts should try to effect more positive treatment outcomes by consulting with a colleague before enactment occurs (Rabin, 2003). Furthermore,

> "It is not possible for analysts to make a decision about self-disclosure from an objective position, as we are always acting on the basis of unconscious personal motivations, some of which we cannot be aware. Analysts are, therefore, too inevitably subjective to be able to make use of this technique ethically" (Jørstad, 2002, p.5).

It is evident from the discussion above that the potential negative impact of erotic countertransference self-disclosure on the therapeutic alliance outweighs any benefit that such an intervention may have on the alliance. In the following section, it will be claimed that self-disclosure is not a psychoanalytic technique and that it should not be used in psychoanalytic therapy. This concludes the argument against self-disclosure of analysts' erotic countertransference.

4.7 Self-Disclosure Is Not Psychoanalytic and Should Therefore Not Be Used

Freud (1919) was clear when he stated that analysts must abstain from responding to patients' sexual wishes. Analysts should also refrain from any type of over-gratifying attitude towards their patients (Lemma, 2003). The boundary between thought and action was pertinent to Freud when he distinguished between the pleasure and reality principles. Freud (1950) stated that there exists in the mind a strong tendency towards attaining pleasure, but that tendency is opposed by certain other realistic circumstances. Under the control of the ego's need for self-preservation, the pleasure principle is replaced by the reality principle. The reality principle also seeks pleasure, although it is a delayed and diminished pleasure that needs to be attained by taking realistic factors into account.

Furthermore Freud (1922) pointed out that the transference is overcome by showing patients that their feelings and perceptions do not originate in the present situation, do not concern the analyst as a person, and that something is being reproduced that transpired in the patient's past.

It, therefore, makes sense in adhering to psychoanalytic principles that one should refrain from using the technique of self-disclosure and, when encountering an erotic countertransference, analysts should adhere to the principle of abstinence. Abstinence implies that analysts avoid behaving in a way that may inappropriately influence or compromise patients' transference wishes (Gabbard, 2004). "This then strengthens patients' resistances by gratifying unconscious fantasies instead of exploring their origin, nature and latent significance" (Ivey, 1999, p.9). The analyst's abstinence is a special kind of behavior that allows patients to regress as well as access unconscious thoughts and feelings (Ursano, Sonneberg & Lazor, 2004). "In order to resolve unconscious conflicts with internalised childhood figures, patients need to re-discover these figures and re-enact them through the 'creative illusion' that we embody qualities of these internal figures" (Milner, cited in Ivey, 1999, p.10).

Abstinence is, therefore, crucial to the effectiveness of psychoanalytic technique, as it ensures that our patients do not obtain any type of "substitute satisfaction" from the analyst - which is likely to inhibit therapeutic progress (p. 118). Patients need a "degree of pain or conflict" so that they have some impetus to want to change (Lemma, 2006, p. 118).

The analytic attitude involves analysts inhibiting, to a degree, their everyday personalities so as to receive patients' projections, allowing space for the development of transference. Analysts therefore adopt a very specific attitude when responding to patients' communications that is different to that of other individuals in the patient's life. Analysts refrain from offering advice, practical assistance and reassurance. Instead, they listen to and interpret unconscious meanings of patients' communications (Lemma, 2006). Analysts avoid specific activities that deviate from the frame and interventions that obstruct patients' free associations. Actions that restrict the analytic process involve "being moralistic, judgmental, directive, flattering, praising or reprimanding, asking and answering questions unnecessarily and attempting to win approval" (Ivey, 1999, p. 9).

Clinical experience has repeatedly shown that useful transference reactions emerge in patients when frustration of their wishes is experienced. Abstinence therefore creates a situation of relative deprivation that is crucial to psychoanalytic treatment, in that the transference nature of the patient's sexual feelings can be explored and addressed (Lemma, 2006).

Segal (1962) regards the analyst's attitude as an essential part of the analytic setting, and argues that analysts should refrain from actions that may interfere with the development of the transference. Analysts' functions include sympathetically understanding and communicating knowledge acquired during the analysis when patients are most ready to receive and understand it.

Self-disclosure has the tendency to "rupture the transitional space" because "it makes concrete that which should remain symbolic", i.e. the analyst's love (Gabbard, 1997, p.4). If a patient suspects that his or her analyst has sexual feelings towards him or her, this is a fantasy on the part of the patient that resides in a "symbolic realm" (p. 4). If the analyst discloses that he or she does have sexual feelings for the patient, this confession makes the fantasy a concrete reality, which may have the effect of closing down the analytic space. What this means is that the patient previously possessed the freedom to create what he or she needed to create in the analytic space, and this is now no longer possible (Gabbard, 1997; Gabbard; 1998).

Gabbard (1997) elaborates this point by highlighting that "the psychoanalytic situation depends on the capacity for both participants to establish a reality that is unlike any other" (p.

2). In the analytic space “ideas and feelings can be ‘played with’ in an illusionary realm” where experiences may be viewed as being both simultaneously “real and unreal” (p. 2). It is a realm in which “the analyst may be experienced ‘as if’ he or she is someone else”. This “illusionary joint creation” has been referred to as “analytic space by Ogden (1989) or potential space by Winnicott (1979), and is generally regarded as crucial for symbolic thinking to take place” (cited in Gabbard, 1997, p. 2). Epstein (1994) supports the notion that analysts should apply the principle of abstinence when it comes to dealing with feelings of sexual arousal and excitement by patients. Analysts who adhere to this principle act as healthy role models for their patients (Epstein, 1994).

D’Abreu (2006) states that it is important to remember that no matter how rational interventions may appear on the surface, and even if their purpose is to facilitate a patient’s awareness, what is said will always contain aspects of an analyst's “feelings, emotions, and personality” (p. 953). The presence of unconscious content in the process should therefore not be forgotten.

Jørstad (2002) states that as analysts’ reactions may contain an unconscious aspect, this should remind them of their limitations, and indicate to them that they are always in danger of acting out rather than containing what has been projected into them.

Analysts “need to gain insight into what is being re-enacted with them” (Casment, 1985, p. 133). Casement (1985) states that “analytic holding is always based upon a capacity to tolerate being genuinely in touch with what the other person is feeling, even to the extent of feeling those feelings oneself”. Bion (1962 cited in Steiner, 2008) stated that “the analytic attitude can be considered as one where the analyst allows himself to receive projections and, as far as possible, refrains from action” (p. 48). According to Bion the phenomenon of projective identification is a primitive form of communication and the “forerunner of thinking” (Bion cited in Britton, 1992, p 107.) This implies that analysts should “attempt to replace action with thought, and when analysts are able to understand what is being communicated by patients, they are able to verbalise thought as an interpretation” (Bion cited in Steinberg, 2008, p. 48). Interpretations thus serve as interventions to contain the patients’ projections (Casement, 1985; O’ Shaunessy, 1981).

Gabbard (2004) states that containment is “the process by which projective identifications are ‘metabolised’(p. 136) enabling analysts to differentiate their own thoughts from those

belonging to their patients. Analysts "don't simply endure patients' unconscious attacks on their thinking, but carefully sort out their own contributions from their patients, and contemplate how they are recreating the patient's internal object relations". The analyst's own self-analysis may enable them to reflect on the way in which their own conflicts become re-activated by particular patients (Gabbard, 2004 p. 136). Ivey (2008) also argues that self-disclosure often indicates a "failure of containment" (p.3). Ivey states that:

> "Containment is typically considered to mean the activity of tolerating and emotionally processing the patient's intense feelings or projective identifications, but it applies equally to those mental processes devoted to apprehending, understanding and processing the analyst's own feelings and unconscious contributions to the therapeutic interaction" (Ivey, 2008, p.3).

If the analyst is the recipient of projections which are too difficult to think about, and containment fails, then enactment is likely to be the end result (Steiner, 2008). The analyst's ability to contain patients' longing for love and attachment are, therefore, critically important to psychoanalytic psychotherapy. Analysts can, therefore, never banish their erotic countertransferences at will but they can contain their sexual feelings, become aware of them and refrain from enacting them (Mann, 1997).

4.8 Summary

The above argument has endeavored to highlight how analytic abstinence and containment as psychoanalytic techniques are sufficient to deal with erotic countertransference reactions of analysts, and the rationale for both strategies has been discussed. Both abstinence and containment are more classic psychoanalytic ideas, yet due to the sensitive content and potential hazards of erotic countertransference disclosures, they have been put forward as the most ethically and psychoanalytically sound alternatives within the psychoanalytic literature.

In the section which follows, some alternative suggestions are included pertaining to the management of erotic countertransference over and above maintaining analytic abstinence and containment of sexual feelings. These are included in the research report in order to show

that alternative means of handling the erotic countertransference should be considered. These compliment abstinence and containment and do not make use of self-disclosure to patients.

5. CHAPTER FIVE: ALTERNATIVE SOLUTIONS FOR DEALING WITH EROTIC COUNTERTRANSFERENCE

5.1 Highlighting the boundaries of the therapeutic relationship before treatment commences

Epstein (1994) proposes that a number of basic verbal statements should be provided to patients upfront before commencing psychoanalysis in order to make the nature and boundaries of the therapeutic relationship clear. This includes mentioning to patients that their minds and bodies belong to them and that nobody including the analyst is allowed to "take liberties in this regard" (p. 206). Analysts should mention that the sole purpose of analysis is to foster patients' "health" and this does not involve satisfying analysts' needs (Epstein, 1994, p. 206). Analysts may also point out to patients that there is a difference between feelings and actions and that it is possible to have "strong desires" (p. 206) and not act on them. This may demonstrate to patients that erotic feelings which may arise can be handled without either party being "swept away by them" (Epstein, 1994, p. 206).

Lastly, analysts should make it clear to patients that the type of relationship being established is solely for their treatment purposes, and regardless of any emotions that may arise in members of the dyad, this will never lead to a "direct life involvement like that which may transpire between friends, relatives or romantic partners" (Epstein, 1994, p. 206). Epstein maintains that patients benefit from being informed about these issues upfront, especially if they have been previously exploited or abused in prior therapy.

The rationale for providing patients with this information at the beginning of therapy is that patients may feel reassured by this attitude. Patients are provided with a clear message that the analyst has thought about these issues beforehand and wishes to remain professional during the course of the relationship (Epstein, 1994). Gabbard (2002) also agrees that some patients benefit from explanations regarding how the relationship in the analytic setting differs from other relationships with individuals outside of treatment.

5.2 Educating trainee analysts about erotic countertransference in supervision

Bridges (1998) states that as the psychodynamic process is characterised by intimacy, trainees need to be educated on how to "deal competently with sexual and loving feelings" that may be felt for their patients (p. 1). There has been to date, little consideration for including education of erotic countertransference and how to handle it in most clinical training programs for psychoanalysts. Bridges believes that this should become part of the training provided by the psychotherapy supervisor, who should educate trainees about the occurrence of erotic transference and countertransference (Bridges, 1998).

However, supervisors themselves often lack formal training in this area, which leaves them inadequately prepared to deal with students' sexual feelings in supervision. The source of the problem may lie in the "shame, phobic dread, and self-consciousness" associated with these feelings in clinical practice, felt by both trainees and supervisors (Bridges, 1998, p. 6). Trainees may react to and respond to sexual feelings, fantasies and erotic dreams about their patients as if the feelings were "unethical" or a "manifestation of misconduct" (p. 6). Supervisors may well react with the same sense of danger and respond as if these feelings pose a threat and are very inappropriate (Bridges, 1998).

Supervisors need to support trainees and reassure them of the distinction between feelings and behaviours, giving trainees permission to experience and explore these feeling states (Bridges, 1998). Many supervisors have made a clear and conscious effort to restrict discussions during supervision to the patient's material as a way to prevent any "boundary confusion" between what transpires in supervision as opposed to one's own "personal therapy" –and trainees may choose, appropriately, to take erotic feelings for patients to their own personal therapy (Bridges, 1998, p. 6).

A matter-of-fact introduction to erotic countertransference may serve to diminish the embarrassment and shame that trainees may experience around discussing such feelings and serve as a means to normalise erotic countertransference. Some trainees may also find it more comfortable to raise these issues with a supervisor of one gender, and "overwhelmingly difficult with someone of another gender" (Bridges, 1998, p. 13).

Containment and symbolic understanding of these feelings is crucial in order to suggest how best to use this information therapeutically. Supervision could thus increase trainees' comfort

with their experience of erotic countertransference by shifting from concrete concerns to more “abstract symbolic understandings” of the situation (Bridges, 1998, p. 34).

Gabbard and Lester (2003 cited in Bridges, 1998) state there are certain “red flags” (p. 43) that should alert supervisors regarding a trainee’s performance. Trainees who demonstrate “a marked, repetitive pattern of boundary crossings with the absence of a self-observing capacity about the treatment relationship and the therapeutic process warrant careful attention” (p. 43). These trainees may become analysts who engage in a pattern of boundary violations without self- reflection which may harm their patients.

5.3 Group supervision to manage erotic countertransference

Robins (2008) states that supervisory groups, which make use of an approach referred to as countertransference supervision, differs from traditional supervision and has also been found to be useful in the management of difficult countertransfernce experiences, including erotic countertransference.

Whereas traditional supervision emphasises theory and technique with a minimum of self-disclosure, group supervision encourages personal emotional disclosure, accompanied by non-judgmental reactions (Robins, 2008). Countertransference supervision groups comprise a group of analysts who get together and share their erotic countertransference experiences, as well as other difficult emotions with one another. This has been found to be effective in assisting analysts in managing erotic feelings for patients (Robins, 2008).

The group is there to "offer support and mirroring that promotes holding, acceptance, and healing" (p. 4). The group also has a leader who is "skilled in both countertransference processing and group dynamics" (Robins, 2008, p. 19). Personal therapy is beneficial to enable analysts to work through their own conflicts and developmental issues, however, this does not ensure the resolution of analysts' countertransference phenomena (Robins, 2008). The belief that personal analysis removes analysts' "personal resistances and conflicts" (p. 17) is countered by the evidence that old past issues seem to be consistently revisited (Robins, 2008).

The process of Countertransference Supervision involves an analyst presenting his or her case and being provided with reflection and an open space to allow further processing of countertransference issues (Robins, 2008). The rationale for these meetings is that within the analyst's profession, countertransference is "an ongoing experience which requires reflection and affective knowledge, as well as sharing, in order to avoid professional burnout" (Robins, 2008, p. 28).

These long-term groups afford a space that counteracts the practicing psychoanalyst's felt sense of "isolation and aloneness" (p. 20). The emotional demands that are "inherent in the role of a psychoanalytic therapist open up an enormous vulnerability to wounds, conflicts, and re-traumatisation" (Robins, 2008, p. 32). The recognition that "emotional woundedness exists in analysts", and the sharing and mirroring that may take place in a nonjudgmental and

accepting atmosphere, provides an ongoing support system that highlights the reality that analysts also require healing, and that a community of peers can offer a professional space for this (Robins, 2008, p. 32).

6. CHAPTER SIX: SUMMARY AND CONCLUSION

This research report was concerned with addressing both the origins and handling of erotic countertransference experiences of psychoanalysts. The study firstly aimed at identifying the sources of analysts' erotic feelings for their patients so that it could be determined how best these feelings could be managed in order to protect the therapeutic alliance and prevent possible sexual enactments from occurring.

An investigation into the origins of erotic countertransference shed some light on the sources of analysts' sexual feelings. Firstly, it appears that the analyst's unresolved Oedipus complex may be one source. However, it was also made clear that sexual feelings could emanate from other developmental stages including pre-oedipal and post-oedipal stages of development. The one resounding point of agreement seemed to be that the developmental stage from which the erotic countertransference originated could not clearly be determined due to the unconscious source of such sexual feelings.

It was also argued that object relations theory provided a more psychoanalytically consistent explanation of the occurrence of 'sexual chemistry' between analyst and patient, and erotic countertransference as an 'analyst or patient-specific' phenomenon. Internal object relations of analysts, however, also reside beyond conscious awareness and may impact upon the occurrence of erotic countertransference. It was also mentioned how analysts themselves may enter psychoanalysis as a profession due to unconscious conflicts emanating from their childhoods, and that in spite of personal analysis, the analyst may not be freed of all these influences.

The phenomenon of projective identification was also put forward as a source of analysts' erotic countertransference and again it was established that although this may also be a possible source of the analyst's sexual feelings, much of the analyst's countertransference is unconscious and thus not knowable. The very definition of projective identification highlights the unconscious aspects of this process as it is the patient's unconscious phantasy, and unconscious projection that is enacted in interpersonal behavior. Complicating this is the fact that unconscious emotional responsiveness may result in enactment.

Projective identification as well as analysts' re-enacting unconscious internal objects may both account for why analysts are attracted to certain patients and not others, and why the analyst and patient's gender may have a part to play in the development of an erotic countertransference. If the erotic countertransference stems from analysts' own unresolved oedipal issues then it makes sense that opposite sex dyads of analyst and patient may result in patients being unconsciously related to as either the oedipal mother or father. However, as sexual orientation is characterised by fluidity in the analytic setting, and homoerotic countertransference is a particularly neglected area in the psychoanalytic literature, the extent to which gender plays a role in the development of erotic countertransference seems uncertain, even though there is much statistical research that implies that male analysts are more likely to develop sexual feelings for female patients. Thus, although gender may play a role, it is uncertain exactly what the impact of certain gendered dyads will have on the development of erotic countertransference.

A further important aspect that the study seemed to elucidate was that due to the oedipal origins of some erotic countertransferences and the narcissism of some analysts, that the denial of erotic fulfillment by patients may result in negative and hateful feelings becoming a part of the countertransference experience.

Unintentional self-disclosures of erotic countertransferences may occur unconsciously within the therapeutic setting, however, intentional self-disclosure was argued to be a technique that should not be used in psychoanalytic therapy for a number of reasons. The two main arguments which emerged include, firstly, that it may have a harmful effect on the patient and treatment process, and, secondly, that it is unethical due to the unconscious motives of the analyst when self-disclosing. Instead it was suggested that speaking to patients regarding requests about self-disclosure, and explaining to them that such self-disclosures may compromise the safety of the analytic setting, highlighting that the treatment is about them and not the analyst, seem like more feasible alternatives. In addition to this the maintenance of analytic abstinence and the containment of the sexual feelings which may arise in the analytic setting have been argued to be more psychoanalytically appropriate and ethical interventions.

Other alternatives have also been put forward with regards to managing erotic countertransference. These alternatives seem to promote psychoanalytic techniques of analytic abstinence and containment as they allow analysts the opportunity to discuss and

gain insight into their erotic feelings and manage them in contexts outside of the therapeutic setting in which the erotic feelings occur. These alternatives, which include addressing issues of erotic countertransference more explicitly in training programs and in group countertransference supervision, offer opportunities to move past the secrecy of analysts' erotic feelings for patients. It is hypothesised that the more the issue of the analyst's sexuality is brought out into the open the more at ease analysts will feel in discussing and seeking assistance regarding the management of erotic feelings for patients. In order to maintain the safety of the therapy and the therapeutic alliance between analyst and patient, this research report concludes that due to the unconscious dynamics involved in the occurrence of erotic countertransference within the psychoanalytic setting, analysts should refrain from self-disclosure of sexual feelings and instead maintain an attitude of analytic abstinence.

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