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Boundaries and Risks:

Working with erotic transference

Erotic transference, has posed a problem for analysts from as early as Breuer's treatment of Anna O (1895). Breuer terminated the treatment and went on a "second honeymoon" with his wife, in a state of virtual panic (Gay, 1988; Tansey, 1994). The problem there, of course, was not the transference but the countertransference.

A common way of protecting against this kind of potentially problematic countertransference is to limit the development of erotic transference, with or without the analyst being aware of doing so. The danger of this is that curbing the erotic transference may be tantamount to rendering a treatment sterile. Certainly the issues at stake not only include those pertaining to erotic life and sexuality, they have bearing on the relation to desire in general, and on capacity for emotional aliveness in the broadest sense, as well as on the capacity for cognitive and imaginative freedom.

A case presented at a recent conference comes to mind. In that instance a male analyst's response to his female patient's florid erotic transference, was to tell her she must make peace



with the fact she could never have him in that way. He saw this as the condition for the continuation of “analytic” work. In structuring it as he did, however, he not only established that her fantasy or desire could never be played out physically, he closed off the exploration of the fantasy and feeling. He also foreclosed the opportunity to clarify whatever constraints she herself might have experienced internally, had she been free to explore her feelings analytically. Perhaps he was afraid of what opening that door might have led to in the countertransference. Alternatively, we could wonder if some form of interactive enactment was at play here, and that he himself did not quite grasp how he may have been colluding with her in some way to create a stalemate.

Unfortunately the kind of foreclosure that occurred in this example is all too common. The challenge, of course, is to be able to create a context of adequate safety for both patient and analyst to be able to open themselves to the kinds of complex and sometimes disturbing feelings that working with erotic fantasies and feelings might require. It is not a matter of constricting the analytic field by designating such feelings as out of bounds. Rather we must find ways to expand the analytic field so it can contain the erotic, or any other feelings, without encouraging our patients in some untoward way, and without causing undue risk to either patient or analyst.

What I have found facilitating in this regard has been to playfully ask what a patient imagines might happen if I were to say “yes” his or her advances. Though this may seem potentially risky, even seductive, this inevitably has opened an interesting exploration. In one instance what emerged was the patient’s acknowledgment that if I were to have responded to his



overture he would have been conflicted. Had I not invited him to play with the idea as I had we might never have gotten to this, as he would have continued trying to convince me to say “yes.”

At first I thought that the point here is that by inviting such an exploration of what the “real” relationship could be, were boundaries to be eliminated, we shift into the symbolic realm. Once we achieve this then the patient is free to go in any direction, and take the fantasy as far as imagination permits. My idea was that this establishes the realm of imagination as an explorable analytic space, both internally and in interaction with another. It also allows for confronting the limits of imaginative possibility and whatever conflicts there may be in this regard. A patient whom I have done this with, however, has helped me to understand that there was more to it than this formulation captured. He emphasized that it wasn't just moving into the symbolic realm that was the issue. It was my playfulness and the fact I was not repelled or shocked or turned off that mattered to him. (Perhaps a smile, a twinkle in my eye, something non-verbal.) He remembered one moment where he had said to me “you know I could actually kiss you now.” The fact that I did not seem to find that distasteful, and could actually convey this, without any need for actual words, seemed to be what mattered most to him. His experience was “You put the anxiety back in if the patient realizes you could have the fantasy too. (There is a delicate balance here between being too closed off and being too intrusive with our own feelings. Either is problematic. Being receptive in the way I was is very different than sharing a sexual fantasy of my own which can be threatening to the patient and may foreclose the analytic possibility.)



This way of engaging requires that both analyst and patient be willing and able to risk this kind of play. Where this may be problematic, this itself becomes grist for the mill. Conflicts and limitations regarding the capacity for playfulness, both internally and interactively can then be addressed. This also allows for the chance to explore within the analytic space itself, whether it is safe to play with this specific other, and how far one can go not just interactively, but also internally in the context of this interaction. For some it can be an opportunity to discover capacities and possibilities never risked before. The analyst's openness in effect becomes the key factor here.

The process this kind of playfulness structures can thus become healing in and of itself as discovering the analyst enjoys the play, and can find the fantasy appealing, even if it is not to be pursued, can be profoundly meaningful. It can challenge a patient's conception of his or her own desirability, and ability to have an impact on the other, in a way that can be affirming. This is particularly crucial if the patient's experience in the past has been of feeling no power to affect another internally and no sense of their own potential desirability. (See Searles, 1959; Ehrenberg, 1992; Davies, 1994.)

Where the analyst seems frightened to really engage erotic feelings, the patient may feel that such feelings are toxic, undesirable, even dangerous. If the analyst can embrace such feelings, however, and invite their exploration, even celebrate the freedom to explore them, the implicit message is quite different. The latter allows for moving through the feelings to see where they might lead. Often we discover that the wish to engage the analyst "romantically" or sexually, may be more a power issue than an erotic one. It may be hostile, competitive, a way of



turning the tables, a way of bringing the analyst and the analysis down, or more simply, a way of putting the analyst on the spot so the patient is off the hook. Or, a patient's wish may be to gain control of the relationship, or to equalize it, or even to destroy it, by sexualizing it. At the same time, it may also be a way of testing what the analyst feels, and of exploring one's own capacity for feeling, or to test his power to evoke the desire of the other. It may have to do with a wish to experience themselves as agents who can have impact on the internal experience of the analyst, not just be at the mercy of another who cannot be affected in any way. Just as some patients feel it is important to be able to feel they have the power to make us laugh, cry, sleepy, they may also need to feel they have power to be sexually attractive and desirable (especially if never felt able to have such impact on his mother.)¹

Expressions of erotic feelings can also be a way of testing if the analyst is strong enough to be able to help the patient, and to sustain the kind of analytic safety necessary for the patient to be able to take an analytic risk. Sometimes the eroticization is a defense against something more threatening. One patient felt it was easier to be "romantic" and talk about these

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What I am stressing here is that if not being able to have an impact on the parent was the problem in the first place, reliving the experience of not being able to have any impact with the analyst, becomes a retraumatization. Discovering one is able to affect the analyst and that the analyst is receptive emotionally, and not afraid of being affected by the patient, can be very healing



illusions, than to deal with his fears of competing in his work context. He felt he was "too proud to fail." Of course these were issues in the sexual arena as well. The analytic situation was liberating precisely because he could express and explore such fantasies knowing the boundaries were secure.

Sometimes what we learn from an exploration of erotic feelings and fears is that it may not be a fear of frustration or of gratification, and whatever anxieties about retribution, castration, annihilation, these may stir, that may be of concern. It can sometimes be a fear of vulnerability to desire. Patients, have expressed fears they might be carried away by passion to the point of losing control in dangerous ways and becoming rapists or murderers. Others have expressed fears of being perpetual victims.

Openness to the evolution of erotic feelings can allow for experiences of working through, and for growth and development,² so long as whatever occurs can be contained. The impact of this kind of experience was eloquently articulated by one patient. While in the throes of an intense erotic transference, this patient who had formerly been quite depressed, angry, bitter, described feeling that it was as though he didn't even recognize himself. He reported that he felt 'so different from the person whom he had come to know himself to be.' And, as he

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Rank, as early as 1929, noted "The so-called transference which for Freud represents nothing but a reproduction of the infantile, becomes a creative expression of the growth and development of the personality in the therapeutic experience (p.6)."



struggled with the awe of realizing that where he thought he was dead, and it was a “foregone conclusion,” he reported now finding himself feeling excited, expectant, alive. He noted:

“I was awakened here.... I have a feeling of a need that I didn't even know I had till I came here. I feel I have been living a claustrophobic life. . . . I was starving. . . . Believe it or not, I never was aware I was living in this state. . . . How was it that I felt so emotionally impoverished? . . . And though I still don't know the answer, before I didn't even know the question.”

Perhaps even more to the point, the impact of this (in his words) was that

“ it permitted me to have feelings I didn't know I was capable of.”

Questions that now could be addressed included why the internal boundary had been so constricted. What were the internal prohibitions, conflicts, constraints and why? What were his fears and fantasies?

A patient who became emboldened by my open delight in response to some of the wonderful fantasies he would construct, began to mischievously challenge why I wouldn't run away with him in reality as opposed to just in fantasy. Moments of closeness now aroused fantasies of being murdered or castrated, which could now be analytically engaged. The actual experience as we moved through our own interaction in this way, permitted him to understand for the first time how constricted his imaginative life had been, and to begin to have a glimpse of why.



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He was then able to make links to painful issues in his relation to his mother, and to mother and father, and to begin to engage a process of mourning for what had not occurred there.

The chance to experience and explore erotic feelings and fantasies, and to realize that they are valid and can be embraced and respected, whether or not they are "appropriate," can be a revelation and healing for some patients. The issue of how such feelings come to be ignored, denied, or foreclosed, can then be engaged. For some such an exploration may open on to ambivalence about claiming (or reclaiming) an inner life. Classic oedipal fears may be at issue here. Issues around the boundary between impulse and action, such as the fear that if one feels one's feelings one would be obliged to act on them, also can be focused. Issues around the relation to owning the freedom of one's own imagination, fantasies, desire, and about the boundaries between fantasy and reality can be explored. In essence what is at issue is the very nature of "interiority." It had to do with the dimensions of inner psychic space.

For some patients opening to yearnings of any kind is an issue. If such patients dare to ask for something, anything, be it to change a session, or a personal question, we must be able to understand the importance of the gesture. We must recognize the courage that has gone into taking such a risk, and find a way to embrace and even to celebrate the yearning, longing, wanting. It becomes a matter of "being" as opposed to hiding or denying. The same is true if the patient risks some kind of erotic fantasy or expression of desire, and wants to know if we could feel attracted to them. It also applies if patient argues for "consummation." We must



understand the vulnerability and risk in these gestures, and the potential pain, frustration and disappointment of risking such feelings in a context where there are real limits to the kind of satisfaction we can offer. This is particularly crucial with those patients for whom any experience of erotic feelings may be a major achievement, and for whom it may have taken years of analytic work for this to even become possible. (This is particularly an issue with patients who have been traumatized, humiliated, abused, early on)

The question is not whether we will run off into the sunset with our patients. If we do, we foreclose the analytic possibility. Rather, as William James noted in the quote I referred to earlier, it is the chance to discover “new flights and reaches while (the feeling) lasts” that matters. What is at issue is how to help forge new experiential possibilities. What is often most helpful at such moments is to slow things down to such an extent that we can really look in slow motion, frame by frame at how we got to the place where it became problematic. What are the fears, fantasies, imagined dangers? Studying the interactive subtleties in a moment by moment way makes it more manageable and less threatening for both patient and analyst than if suddenly it feels like it is moving so fast neither patient or analyst can even see what is happening. (See Ehrenberg, on Impasse, in press CP, 2000).

One patient had fantasies of my going with him on a flying saucer or a magic carpet to places he had been that he had loved. On the one hand this reflected an enormous act of courage and daring, yet there was still the question why such surreal fantasies. Why not something more realistic. Even as this was clearly a measure of new degrees of freedom, it thus also confronted him with the extent of his own remaining fears as he found himself frightened,



shocked, threatened by the thought of something more realistic. It was then possible to clarify the dangers he experienced as attached to letting his own thoughts go past the internal boundaries he had come to rely on, and to fear transgressing. As he struggled with these issues in the immediate experience between us, he began to experience new degrees of inner freedom, and moments of exhilaration. During this period he expressed a fantasy of wanting to make me pregnant, wanting to have a baby with me, wanting to have power over my body and my mind, wanting to possess me, wanting to be able to touch me from both inside and outside simultaneously. There were many associations to childhood and fantasies about his mother and her body.

As he was now able to explore parts of himself he had heretofore felt frightened of, he found himself able to be present in the analysis as well as in his sexual relationship with his wife in ways that had not been possible for him before.

Interestingly, though he often came up with disturbing images, such as images of cutting me up, or at other times of liquifying me in a blender and then drinking me, I was never afraid of him. Sometimes I felt shut out, or even annoyed, but generally I was more moved by the fragility of his positive feelings, and his fears of vulnerability, than by any danger from the negative ones. He in turn wondered if this reaction on my part was a compliment or an insult. At times I didn't know myself. But it was clear that however violent his fantasies were, I did not feel the kind of chilling fear I have occasionally felt with other patients, where the content may have been more seemingly benign. What was most moving to me here was that as this treatment progressed he began to report his own awe, as he felt a sense of **“the ceiling being**



lifted on his imagination.” The dimensions of his interior life seemed to open. In fact he then began to have all manner of fantasies and feelings, including sexual fantasies and feelings, and to be able to explore these in a way he never would have been able to dare to before. The point here is that as he dared to take his own feelings and fantasies to new limits, we were able to see what the problems were both internally and interactively when erotic feelings were active. I use this example to show how moving with the erotic feelings, something that is often considered dangerous, can actually be quite otherwise.

For some patients erotic feelings are threatening in that they lead to the patient becoming controlling, violent, dependent, desperate, whatever. Where there are real problems in dealing with such feelings, the only way they will be accessed and worked through is if they can be explored from inside the patient's experience. For this to be possible we have to create a space where it feels safe to risk the feelings in the first place. This requires establishing the boundaries between fantasy, and reality, and creating an area where it is safe to engage in imaginative kinds of play for the analyst as well as for the patient. If the patient's fantasy is disorganizing to the analyst this can evoke anxiety sufficient to deter the patient from going further with the fantasy. On the other hand, if the analyst is too responsive to the patient's fantasy it can be just as threatening as if the analyst were too afraid.

Whether we get a transference of vulnerability and desire, or a transference of defense, (and erotic transference can be either, or both at the same time), depends on the conditions of analytic safety and care we are able to structure. Analyzing the patient's fears is not sufficient here. The analyst's willingness to take an emotional risk is also key. Whether the patient will



take emotional risks and dare to move into areas of being that feel threatening or may even have been foreclosed, will also depend on the analyst's continuing sensitivity to the patient's vulnerability.

These considerations pertain in part to what has been called the "working alliance" but they go far beyond traditional conceptions of this. The intersubjective interplay here is not simply a facilitating context, it is the medium of therapeutic action.

Since erotic transference does not necessarily evoke erotic countertransference, and vice versa, the chance to explore what it does evoke, becomes analytically useful. Sometimes in the face of the patient's "erotic" transference we may feel anything but erotic. We may feel maternal, protective, repulsed, offended, frightened, whatever. Our own response often tells us much more about what the analytic issue might be than the actual content of what the patient verbalizes. What is crucial here is that we work from the truth of our feelings, whether or not we choose to disclose them. In the above examples, had I not genuinely felt delight, the patients would have known unconsciously, if not consciously, whether or not I explicitly said so. Bringing this level of the affective dialogue into the analytic discourse, however, opens the field so that what is not usually open to exploration can then be explicitly addressed.

The same applies for negative feelings. In those instances where I have felt afraid, turned off, or any other negative feeling, regarding this as vital data has always proved extremely useful analytically. It is not a matter of disclosing our feelings in some crude or insensitive way.



Rather we must find ways to use them to analytic advantage. In one instance telling a patient about my sense of danger led to the patient revealing that his wish was precisely to frighten me. (See Ehrenberg 1992). Had I pretended not to be affected the provocative behavior might have only escalated. The same applies with regard to any other feeling.³

In terms of dealing with "obnoxious" behavior, it is important not to lose sight of the fact that challenging the analyst can also be a way to test what the analyst feels, and to test one's own capacity for feeling as well. If we are not sensitive to the patient's vulnerability, and the anxieties at the basis of the "obnoxious" behavior, and only focus on the defensive aspects of their response, the work will never go forward. In such instances the patient may be blamed, but I believe it is the analyst's insensitivity, not the patient's limits, that is the issue. Much may be at stake here, as our response can be what will settle it one way or another for the rest of the analysis, sometimes for the rest of the patient's life.

The discovery that one can survive negative feelings and even get through these to very unexpected positive feelings can be powerful. It is not what occurs at any specific moment, that is the issue. Rather it is what both patient and analyst are able discover in an ongoing way, that becomes crucial.

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Winnicott notes that at the extreme an unresponsive analyst can provoke a patient to suicide.



What we must recognize in such situations is that there is a vast difference between an analytic exploration of erotic feelings and fantasies, and engaging in way that may be a form of sexual acting out, just like telephone sex might be, even if there is no physical touching. If the patient is dangerously seductive (or we feel dangerously vulnerable) our ability to analytically engage the full complexity of what is involved can be what the analysis will stand or fall on. Often, opening a dialogue about the sexual tension or innuendo that may be the undercurrent to whatever content is being considered, can lead to its evaporating. Sometimes this reflects a defensive flight from the material too "hot" to handle, but other times it helps clarify that the eroticization itself is the defense against other kinds of material or anxieties that are more threatening.

Working up to the very "edge" in all of these contexts, both requires and permits struggling with the boundaries between fantasy and reality, imagination and actualization, each step of the way. This allows for learning how patient and analyst open and close themselves in relation to each other and in general, and why, and where each may actually be at risk, and what the risks might be. Dealing with all of this becomes the growing point of the work for both patient and analyst.

Since there are hazards for both patient and analyst, the dilemma is how to sustain a context of analytic safety adequate to the kinds of feelings that must be engaged. How do we keep it open and alive without either participant feeling played with or trifled with and later hurt or disappointed. This requires our being able to walk the fine line between being unfairly seductive, or being at sexual or emotional risk ourselves at one extreme, and being so closed



off we may render the treatment sterile. There is always the risk of acting out and real boundary violations. Nevertheless there is much to be learned from not backing off when things get more threatening. Staying with whatever is in the room, however puzzling, disturbing, whatever, can lead to new understanding, for the analyst as well as for the patient. It allows for studying what happens at the very boundary of the interaction. If real danger points can be successfully negotiated this can be a profoundly liberating achievement for both patient and analyst.

The paradox here is that the amount of risk that becomes tolerable ultimately depends on the degree of safety we can establish. It is a matter of staying within the analytic boundary without closing off. The danger is that the latter (closing off) is often equated with the former (maintaining the boundary), at the price of foreclosing an analytic possibility. The issue is how to create an arena safe for creative exploration and play.

Though focusing on the “interaction,” in an interpretive way, may seem to be what I am talking about, it is not. The latter involves looking at it from a “meta” level perspective, and reflects assumptions of “objectivity” (even if one step removed) and of “authority.” My interest is in exploring the relationship from inside, and staying very close to experience, both the analyst’s and the patients, as it shifts from moment to moment. This permits a unique kind of emotional journey with the opportunity to discover what the consequences are every time a risk is taken or avoided on either side. This involves openness to the unexpected and unknown. The premise here is that insight is not what sets things in motion, rather it is the fruit of the process and of the experience that is achieved.



In terms of my title "Boundaries and Risks" what I have tried to convey is that though there are risks to working with erotic transference, the risk of not doing so, or of doing so in an overly controlled way, is that the deepest issues may never be engaged. It becomes a matter of playing it "safe" at the expense of avoiding rather than facilitating an analytic process.

I believe the continuous exploration and examination of what occurs at the "intimate edge" (Ehrenberg, 1974, 1992) of the relationship establishes the context of safety that permits the kind of risks necessary to work with the most intense, difficult, even obdurate, kinds of erotic transference. It allows for working with very potentially threatening issues in a way that becomes the medium of the work and the locus of analytic and therapeutic action.

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