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The Guilty Pleasure of Erotic Countertransference: Searching for Radial True

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Although the use of the analyst's countertransference remains a point of controversy, it is a rare analyst who would not consider countertransference feelings useful fodder at least for the analyst's private reverie. *But when the affective valence leans erotic*, *countertransference becomes once again taboo*. This article explores the erotic meanderings of an analyst in relation to several patients with the aim of illustrating how erotic countertransference can be used to further the clinical process in each example. Cases include patients of both genders. Material is considered from within contemporary relational formulations, including the assumptions of multiplicity, the dialectic between relationality and autonomy, and judicious clinical technique that respects the complexity of clinical process.

We think we want to talk about sex. We think we're comfortable with it. When my son, Ethan, was 8, he said, ''Mom, I could never do what you do when I grow up. I'd have to read all those books with bad words in them.'' But *we* have no problem with that! And we know the famous caricature about psychoanalysis: ''It's all about sex.'' So who, if not us (and porn stars) should be comfortable talking about sex?

This reminds me of an episode that occurred during my own analysis. I'd had an erotic dream about my analyst and when I awoke, I thought to myself, ''Cool!'' As far as I knew, I wanted this to happen and I looked forward to telling my analyst all about it. So I got in my car and began the drive to his office, as had become automatic, having driven there four times a week and this was the 3rd year of that habit. So, it's fair to say, I knew the way. On this particular morning, the 563rd time (I did the math, including Bunker Hill Day and Flag Day, which my analyst considered ''scam holidays''—but I digress), I inexplicably and for the first time in 3 years missed the exit to Brookline off Storrow Drive. Further, I did not notice that I was on my way to downtown Boston until I arrived at none other than Government Center... Superego City.

By the time I retraced my steps, chuckling all the while yet also realizing I was more uncomfortable than I could admit, I finally arrived at my analyst's office with just enough time remaining to explain what had happened. No time to tell the dream on that day. Apparently, in its efforts to derail, my unconscious can keep track of time too. When I left his office, my analyst said, ''See you tomorrow... maybe.''

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So we think we are comfortable talking about sex. Our bodily desires. Embodiment. Libido. Erotic Countertransference. Big words about an everyday thing. What we want on a physical (I mean sexual) level. And this was me, *as a patient*, when we're supposed to talk about sex. What about when we're the analyst? Not only are we not supposed to talk about it, we're not supposed to have those feelings at all. This is an impossible standard and I doubt anyone really believes it. But there was a time when all countertransference feelings were thought to be a sign of something unanalyzed, forbidden, or taboo.

As we all know, countertransference has become a legitimate lens through which analysts monitor, explore, and analyze their patients' dynamics. Whether viewed as the container of disavowed wishes or as part of a cocreated unconscious dance, analysts of all ilk now consider countertransference a crucial part of the clinical process. Although the use of the analyst's countertransference remains a point of controversy, it is a rare analyst who would not consider such feelings useful fodder at least for the analyst's private reverie. *But when the affective valence leans erotic, countertransference once again becomes taboo* (for notable exceptions, see Davies, 1994; Gabbard, 1994; Wrye and Welles, 1994; Phillips, 2002, 2003; Celenza, 2006; Wolfe, forthcoming).

It is very difficult for analysts to admit having erotic feelings for a patient, even in the protected environment of a supervisory dyad. In my work with sexual boundary transgressors (Celenza, 2007), many have reported, ''I tried to tell my supervisor, but he or she just said, 'You should bring this to your analysis . . . oh, so sorry, time's up.''' And it usually was, because the supervisee (now transgressor) brought it up at the end of the hour.

We want our patients to talk about their sexuality in a meaningful way that will evoke meaningful, analytic responses in us. What makes an experience meaningful? What is meant by the phrase, ''I know what you mean''? Psychoanalysis, an essentially hermeneutic discipline, specializes in the art of association—a ''this is like that'' kind of endeavor based on analogic thinking. In contrast to the linear, cause-and-effect sequential logic of the left hemisphere, nondominant or right hemisphere cognition is the type relied upon for our work: synthetic, gestalt oriented, and integrative (see Watt, 1990; Celenza, 1993, for a more elaborated discussion of the neurophysiology of cognition along these lines). Our main tool, empathic listening, is based on the evocation of such associational links through affectively resonant self-other identifications contextualized within our own histories. Always relationally based, we call upon one or many self-other identifications in constructing an analytic response. Further, these self-other identifications are part of an overarching self-organization that contributes to a core feeling of self.[1]

To make analytic use of such associational links, we must have the capacity to examine the full range of countertransference responses, including erotic, within ourselves. For the purposes of this article, I make use of the metaphor of a bicycle wheel with multiple spokes requiring periodic rebalancing or ''truing'' to reset the delicate, counterbalanced tension among these spokes. But we have a moving core at the center capable of transformative evolution along with some spokes that are only tenuously connected. It is these loosely connected spokes that, when evoked through associational links with our patients, may potentiate an intense, perhaps eroticized, countertransference response in us.

[1]The question of whether the self is stable or has a core at all is a point of current controversy revolving around biological-essentialist versus postmodern, antifoundationalist epistemologies (see, e.g., Mitchell, 1996, for a discussion of how these controversies relate to the construction of gender polarities).

CONTACTING ME: THE LITTLE GIRL INSIDE

In 2007, I wrote that the question ''Why can't we be lovers?'' is calibrated and danced around in every relationship regardless of age, gender, role, or context. After all, *our unconscious is never married* and there are no boundaries or limits in our imagination. This question sometimes comes up heatedly, sometimes subtly, but most often it is not admitted, either verbally or consciously. In my writing, I went further still and suggested that this question should be a moment in every treatment—that the analyst should wonder where she stands in relation to each patient on this question, meaning what she erotically feels toward her patient. It is a meaningful question, especially for those patients in whom the capacity to erotically arouse seems dormant or dead.

Like the bicycle wheel with multiple spokes, the erotic dimension of our connection is one that adds to the balance, each spoke representing a crucial dimension in a pattern of relating that may repeat itself over and over. When these spokes are in balanced tension, we can call it radial true. Calling upon the multiplicity of roles we have for our patients, each spoke has its tension counterbalanced with the others.

Having put this question out there, Why can't we be lovers?, I forgot to anticipate what might happen if one of my patients read it. Rachel enjoys showing her body, mostly to herself, but notices she walks around the locker room in her gym a little too long. She can feel the gaze of other women on her skin. ''It's like they're touching me,'' she says. Similarly, the heat of the sauna on her genitals arouses her and she masturbates in the stall. She talks about this to me, knowing (and fearing) that she is on the verge of taking her clothes off during a session. Is this erotic? Yes, definitely. Is it an erotic move toward me? On one level, yes. I tell her she wants to be seen and touched, that her 27 year-old body is like a throbbing fire engine—both enflamed and calling out to be doused. The fact that she has not had sexual relations with her lover for several years is implicated but is not the whole story. On another level, her disrobing is a flowering—she wants her erotic body to be seen in its pubescent glory; she wants her mother's admiration. She is also stoking her sexuality in order to distract herself from mourning her father's death—coming, as it did, a few weeks before she began menstruating. He never got to see his little girl flowering into a woman and she never felt his gaze on her nubile body.

Who am I to Rachel? At least a mother, father, lover, and her own pubescent self. Embedded within this formulation is the theoretical assumption of multiplicity (Modell, 1990; Mitchell, 1993; Bromberg, 1998; Davies, 1998; Dimen, 2003; Harris, 2005) based on the development of identity as deriving from multiple same-gendered and opposite-gendered identifications. These identifications arise through different processes and may be global or partial, metabolized, undigested, or alien (Harris, 2005). Conscious or unconscious, these identifications comprise a mosaic that continually evolves and kaleidoscopically transforms as we explore ''gender's wide arc and the corresponding wide arc of relationship structures and object ties'' (p. 852) as Corbett, (2008) and others (Elise, 1998; Dimen and Goldner, 2002; Goldner, 2002, 2003; Roughton, 2002; Phillips, 2003) have described.

Being multiple selves is the human condition and being multiple others to our patients is the analytic condition. When multiple (emergent) selves are presumed in relation to the question ''Why can't we be lovers?'' we see that this is ultimately an unanswerable question. After all, to whom is the analyst speaking? And from where within herself? A response through one lens contradicts another. Thus, a helpful response to this question conveys the message, ''I am many things to you and I don't want to invalidate any one of them.''

Judicious clinical technique respects the complexity of clinical process. So, when I feel an erotic counterresponse to Rachel, I must also ask myself, in which dyad am I responding erotically and what might it mean? As a parent, my erotic countertransference response might signal the repetition of an oedipal conquest or traumatic memory; as a lover, my countertransference may signal her emerging health but also a way station. Given the imbalanced, asymmetric structure in analysis (Aron, 1996; Hoffer, 1996) her erotic move toward me may signal a budding readiness for gratification in her real life;[2] as a child, my erotic countertransference may be her projected and unmourned longing for her father. And finally, there is a level at which my erotic countertransference is mine—arising from within me and reflecting my own needs and desires. Then, I must ask, Who is Rachel to me? The answer will have many spokes.

We more easily recognize lost, disclaimed selves in others. For most persons, the opposite-gendered self is more easily seen as ''not me'' and can become a disavowed self with whom we long to reconnect. Think of how poignantly, painfully even, we love our opposite-gendered children—he who looks like me yet is not me—in his sweet innocence and vulnerability, that good little boy so devoted to pleasing. The same-gendered child resides in the self as well, though we are likely to have done more analysis with her. She's not as likely to be so dramatically disavowed or neglected. But this is not true for everyone; gender is a difference marker (Goldner, 2002) some more readily embrace (see Celenza, 2000, for a discussion of a case of same-gendered disavowal).

Our readiness to embrace the same-gendered child, however, does not mean the connection is uncomplicated. In my work with female sexual boundary transgressors, it is striking how often the erotic countertransference involves an overidentification with a female patient. One transgressor reported to me, ''She was the child I was. I couldn't stand the pain she was in.'' Two thirds of female transgressors engage in sexual relations with a female patient; many of these transgressors are not previously self-identified as gay. As Sinsheimer (2010) notes, unconscious homophobia is a risk factor for sexual boundary transgressions. Homoerotic identifications that drive us to suddenly act in unfamiliar or uncharacteristic ways (compared with the more patterned modes) can be conceived as disconnected spokes that have been recaptured and connected anew. We feel gleeful at the return of a prodigal child, a lost shoe that finds its mate in the closet (pun intended).

THE DEVELOPMENT OF EROTIC COUNTERTRANSFERENCE

What if there is no sexual desire in relation to the patient? Whether or not a patient arouses sexual desire in the analyst is an important indicator of the patient's vitality and strength. The absence of erotic energy (mutual and bidirectional) should prompt the analyst to explore inhibitions or other conflicts.

I've written extensively about Michael, whose erotic imaginings toward me became the central focus early on in his treatment (Celenza, 2006). I discerned a merger fantasy underlying his erotic longings. The merger fantasy had a sadomasochistic structure and represented a defensive move whereby he subjugated himself to sidestep the exploration and expression of

[2]In the clinical setting, it is wise to remember that a demand for love is an absence of a capacity for loving (Frayn and Silberfeld, 1986). Thus, Rachel's erotic move toward me may represent a step in the development of her erotic life outside treatment but is not to be taken at face value from within the treatment (Freud, 1915).

his own subjective desire. It was largely through my countertransference that I understood this formulation, especially from the way in which I experienced his attempts to penetrate me. I was not excited by Michael's aggressive or more phallic moves. Rather, it was as if his penetrations were too soft or weak. He seemed to lack substance or hardness; it was not possible for me to feel *him*. He attempted to ''get inside me'' with an obsessive interest in my life but rather than being excited, I felt closed in, suffocated. His examination of me felt *too* in me, appropriating, as if he wanted to take me over or *become* me.

In the middle phase of Michael's analysis, I noticed a crucial development in my countertransference. He had become more appealing. *His more differentiated presence* allowed me greater room to breathe and to see him from a crucial distance which, paradoxically, *made intimacy possible*. At the same time, his hostility seemed to intensify and I was aware of an increasing discomfort in me. These developments finally culminated in his sharing a fantasy to murder me, the crux of which revolved around stabbing me repeatedly until I cried out, in a lurching, bloody, and passionate plea. Orgasmic in nature, this did not turn me on, but it did grip me so that I could not think of anyone or anything else but Michael for a period of time.

Michael stirred me up so much, I needed others to calm me down. I got consultation from various ''thirds''—all phallic figures to fortify my intimidated self. It can be said that not only did the dyad need a third, not only did Michael need a father, but also I needed a man. What was this move and how does it connect with the erotic dimension of the treatment?

I had wanted to engage the man in Michael and facilitate his emergence. In so doing, Michael's aggression came through in full force; perhaps the man in Michael then needed to make contact with the man in me. Counterbalancing the feminine with the so-called masculine aspects of our roles, we both needed more phallus—Michael had not wanted to experience me as an empowered, phallic woman and I too resisted access to the male in me. It took a third to say, ''Yes, we want to kill the person who humiliates us and rejects us. More than that, you want to make me spill my guts the way you feel you have done with me.'' A third man and the man in me.

As his analysis continued, Michael transformed in his ability to erotically excite me. Not that this was at the forefront all the time, but I did find myself imagining living with him, being his lover, and identifying with the women in his life. Normal and nonpressured erotic musings occurred along with the full range of everyday concordant and complementary affective experience. Michael had become whole—a bicycle wheel with all the spokes.

THE OPPOSITE-GENDERED SELF: CONTACTING "NOT ME"

It is in the psychoanalytic context (with the attendant assumptions of multiplicity, condensation of affects, multideterminism, and ever-deepening layers of unconscious meaning) that the question of gender and homophobia becomes strained. As Michael made contact with the man in me, Thomas made contact with the boy. But not just the boy . . . the *little* boy. Opposite-gendered selves are often different ages—selves further away in time and gender make apt repositories for disavowed vulnerabilities and wishes. The rescue of a lost self in whom we have placed denied or disavowed experience can be a strange and potent attractor.

The psyche continually strives toward integration and we are in love with our little boy and little girl selves. Sometimes love is primarily an identification with these lost selves and manifests as a mutual rescue fantasy, begging the question, Exactly whom are we saving? Leonard

and Michelle (from *Two Lovers* [Gray, 2009], played by Joaquin Phoenix and Gwyneth Paltrow) are such lost lovers—inexplicably drawn to each other because, in Leonard's words, ''I'm fucked up too—I want to help you.'' Love is, in part, salvation.

Thomas grew up an only child with a rageful, alcoholic mother. She either anxiously clung to him or violently batted him away. He never knew which mood would overtake her body when he arrived home from school. Sports, camp, and his cousin's home were sites of refuge. He wanted his cousin's home to be his real home, though the family was wealthier and he wasn't always comfortable there. Carl, his same aged cousin, was a good friend but also a competitor for his aunt's attention. For his thirtieth high school reunion, Thomas returned to his hometown, a successful attorney with a family of his own. He stayed with his cousin because his mother had passed away. They got dressed for the occasion and then poignantly, while straightening Thomas's tie, Carl said, ''Now they'll see who you are.'' Thomas was touched and proud, as was I for him.

Many months later, I referred to that moment when Carl straightened his tie, especially the way his cousin had overcome rivalrous, competitive feelings with a comment that recognized what Thomas had survived. My eyes welled with tears and my throat constricted as I repeated what his cousin had said. Thomas asked, ''Are you crying?'' to which I admitted I was. He was deeply moved and blew me a kiss when he left the office that day.

This did not worry me, I thought. I felt a special connection with Thomas and it was all good. We have virtual love affairs with our patients. Isn't this as it should be? Another spoke in the wheel.

I've written about the perils of erotic countertransference, the ways in which sexual feelings for our patients can move us to violate boundaries. Most of these cautionary tales involve defensive efforts to manage our self-neglect (Celenza, 2010; Harris, 2008; Sinsheimer, 2008) or to eroticize negative countertransference (Celenza, 2007). The so-called slippery slope is actually a dance with parts of ourselves we are unwilling to acknowledge or admit. Our patients often need to bring their sexuality into the foreground and not just dance with us but tango as well; we need to be pushed and pulled; held in open embrace with a seemingly dissociated body; to be led (and sometimes to lead); to pivot, staccatolike, and then be taken on a long glide, sometimes drastically, sometimes close to the edge. The question is, Are we always up to it? What if we don't like it? What if we do?

Thomas and I continued on, meaning we proceeded with analysis in the foreground. In the background, however, there was no doubt in either of our minds that we had a ''special connection.'' He felt I uniquely understood him; more—that I *felt* him. He told me how important I was to him. I was not surprised and felt the same toward him. I remember thinking, ''We are simpatico. I love his sense of humor, his sensitivities.'' He wittily described scenes from his life; I laughed with ease and from deep inside. He said if we were both single and had met in a different way, ''I'd be all over you.'' I smiled and felt a mutual resonant feeling. I also thought, ''It's a good thing we both have vital and satisfying marriages.'' I did my due diligence—I consulted with my peer group, especially in relation to the question, ''Was this treatment deep enough? Was it negative enough?'' All of this was in the background.

One day, Thomas began a session by saying, ''I'm disappointed in you. I've been angry at you for a few weeks but I haven't told you. I thought things might change, so I waited, but they haven't. I need to tell you.'' The only words that came to me, and I don't remember if I uttered them out loud, were, ''Uh-oh.'' He said, ''You've stopped meeting me at the door when I leave. You don't get up anymore, at least not before I do, and I think you're avoiding me.'' I had no awareness at all that I had changed my usual habit. As with all of my patients, at the end of the

hour, I would acknowledge our time was up, walk to the door, and open it. There I would say good-bye, looking each patient in the eye as they walked toward me and out the door.

I told Thomas I was unaware of a change in me and asked him to tell me what he had noticed and how he felt. He said he felt hurt that I seemed not to trust him. He didn't want anything to change between us, but he thought I had become uncomfortable with the way we had been interacting. He did not want to be the cause of anything destructive between us, but he also wanted to feel he could speak his mind and tell me everything he felt. I promised him I would think about this more and it will not surprise you to know that at the end of that session, I made sure I was the first one at the door.

We think we're comfortable. But what exactly was my discomfort? It wasn't the syncopation, the facile way in which we discussed his life. It wasn't even the revelation of emotion on the day I had wept, nor was it the exposure of the vulnerable little boy in me who so poignantly identified with little Thomas. We had a special way of playing—''deep play'' (Herzog, 2001) that had sexual overtones—but I don't think I was uncomfortable with that either. The discomfort was more in the way of a nagging guilt—was I enjoying him too much? Did our play cross over to flirtation in a way that seductively offered something I could not and would not deliver? Though he did not seem to mind, I did not know if this would always be true and more to the point, was I behaving with his best interests in mind?

Our work is sometimes a guilty pleasure and we must always ask, Pleasure for whom? What if we enjoy it? Surely, this can be part of our work, but are we in balance, with the work of analysis in the foreground? Does each spoke contribute to the truing of the wheel?

DISCUSSION

What do our patients want? They say they want our love, or more pointedly, to have sex—but do they really want that? We are many things to our patients, simultaneously and equally important: analyst, woman, person, mother, father, sibling, and child—all spokes in the wheel. At any one time, a plea for love or sex is a plea from within only one of these dimensions. To respond, that is, to gratify the wish is a gratification from within one mode of relating. The man may want a kiss but the child does not. In the context of psychoanalysis, this multiplicity is irreducible; each spoke needs to be in balanced tension with the others.

I have come to believe that our patients do not really want us to gratify their erotic wishes despite their vociferous protests to the contrary. But they do not want us to simply maintain our professional role either. This was the mistake of the abstinent classical analyst who refused to allow his patients to know him personally. What our patients want is not an engagement from within one single dimension (i.e., the role, the person, the professional, or the woman) but to have the multiple roles coalesce into one, as it were. Our patients will say, ''I want you to touch me in a personal way, not from your professional self.'' But in this phrase they are expressing a void, a problem to analyze. Both a desire and dread; a need and incapacity. What they need is to expose it; what they want is for us to remain in role but in a personal, authentic way. It is structurally like an oedipal moment but not only that. As Davies (2003) wisely put it, in healthy families, the oedipal conflict is both won and lost. Just how is this done? I would venture to say that the parent conveys, ''I would if I could.'' Or, ''In another time or place.'' This is what we need to convey to our patients.

Our patients complain of the tease and seduction in the therapeutic context. It is tempting to think that we shouldn't go there at all. Herein lies the guilt. Are we in fact seducing and then rejecting them? But the fact that they can be so stimulated, can feel their desires intensely and strongly, means they are expanding and deepening their experience. The effectiveness of therapeutic action is in the stirring of desire. For this we should not apologize. The goal, to live fully and feel intensely, has always been among the many goals of psychoanalysis.

In closing, I am reminded of an interaction with my analyst that prompted a very useful exploration—it began with a flirtation. One day, I walked into his office and was about to lie down when I discovered, to my horror, a barrette on the couch. I picked it up and held it between us. I said, ''You see other women?'' He deftly replied, ''It's a transvestite.'' In that one phrase, he conveyed to me his very deep understanding of my dynamics and distress. The message was ''I know you want to be my 'one and only' and I'll play along but at the same time let you know that this is a game you need. We'll talk about it.'' On a personal level, I loved that he could play with me that way—funny, astute, and penetrating. Sexy, professional, and deft, all in one package. Like a well-balanced bicycle wheel, he spoke to me in radial true.

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