Countertransference Love and Theoretical Model

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The analyst's countertransference feelings of love, particularly sexual love, have been subject to minimal examination in the literature. In this era of expanding psychoanalytical models, it appears that some theories of therapeutic action lend themselves more to addressing such themes than do others. There is always considerable overlap among psychoanalytic models, although there are nonetheless some clear differences in the way countertransference affect is experienced, filtered, and utilized.

As noted in earlier articles (Hirsch, 1986, 1988; Hirsch and Kessel, 1988), there is a relatively sparse psychoanalytic literature focused upon analysts' sexual, romantic, and otherwise loving feelings toward patients. Harold Searles' (1965, 1979) pioneering work is a noteworthy exception, though his focus on schizophrenic patients somewhat allows his work to be viewed as out of the mainstream and therefore not entirely relevant to more everyday analytic experience. Heinrich Racker (1968), in his classic writing on the transference-countertransference matrix, also frequently refers to analysts' reciprocal feelings of love in response to patients' loving engagement in the transference. He does not address sexual and romantic love specifically yet implies it quite clearly by underscoring that the analyst, as well as the patient, is always in the sway of one feeling or another over the course of the entire analytic enterprise. His now widely quoted point that the analytic relationship is not one between an ill patient and a well analyst emphasizes the whole spectrum of affective engagement (see Ehrenberg, 1992). This spirit of mutuality of affective participation, of

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- 171 -

course, was introduced to the field of psychoanalysis by Ferenczi (1933), the intellectual forerunner of both the interpersonal and object relations schools of thought. His awkward, yet pioneering, efforts to address both parental and romantic love in the countertransference were met with sufficient vilification to help in the suppression of this theme for many years hence.

Romantic and sexual countertransference feelings in particular are indeed a delicate theme, although such feelings in the transference have obviously been absolutely central since the first moments of psychoanalysis. Many analysts informally acknowledge such feelings to their friends and sometimes to their supervisors, yet formal discussion in the literature or at public meetings understandably creates considerable anxiety because of the incest taboo. The line between brave and ethical treatment and destructive acting out can be thin, and except for violence perhaps, there is no greater violation of ethics than sex between patient and therapist.

There is a contemporary twist to this anxiety since the thrust of some of the most recent countertransference literature emphasizes not only countertransference feelings but countertransference enactments (see, e.g., Jacobs, 1986; Chused, 1991; Levenson, 1991; Hirsch, 1993; Hoffman, 1992). The term “enactments” sounds much closer to acting out than does the by now almost quite respectable acknowledgment of private countertransference feelings. Enactments, as I use the term, refers to a living out of affective experience, usually by both parties in the analytic dyad, within the strict boundaries of the psychoanalytic frame (see Levenson, 1992).

Acting out, on the other hand, is a violation of the frame. Enactments place the concept of countertransference much closer to the concept of transference (McLaughlin, 1981, 1991). Both transference and countertransference enactments reflect an unconscious affective immersion in the interaction, much as Bird (1972) has described in his classic paper on transference and transference neurosis. Enactments imply a mutual transference, if you will, with the role of the analyst differing primarily in two ways. For one, the analyst retains the role of observer (participant-observer or observing participant) more so than does the patient. Second, the relationship is normally asymmetrical since while patients speak fully about their immediate feelings, outside life, history, dreams, and so on, analysts generally do not. The analyst is an observer who unwittingly becomes a participant and therefore, an enactor (Sandler, 1976; Feiner, 1977;
Singer, 1977; Hoffman, 1983; Levenson, 1983; Gill, 1983; Hirsch, 1985; Mitchell, 1988; Stern, 1989; Aron, 1990; Greenberg, 1991; Ehrenberg, 1992). My primary assertion in this essay is that mutual two-person enactments are ubiquitous in psychoanalytic work (see, e.g., Wilner, 1975) and that the spectrum of feelings of love are common among these. My thesis is that because different psychoanalytic theories of therapeutic action conceptualize the patient-analyst interaction in sometimes radically different ways, this has a profound effect on whether or not enactments are addressed and examined. In particular, I am interested in how analysts' romantic, sexual, and nonsexual, loving countertransference feelings are examined, viewed, and productively used in the analysis, based upon the analysis' preferred model of therapeutic action. Following Tansey's (1992) schema of discussing varying viewpoints of psychoanalytic knowledge or expertise, I refer to Mitchell's (1988) delineation of three theories of therapy: the drive-conflict model; the developmental-arrest model; and the relational-conflict model. As a proponent of the latter model, I argue that adult romantic and sexual feelings in the transference-countertransference matrix are most readily addressed in that model, and I use clinical illustrations to clarify. Certainly any distinct dichotomy based on theoretical groupings is artificial, since, as Tansey (1992) notes, analysts work in a complex combination of ways, and analysts from different perspectives may sometimes have more in common than those from within the same theoretical orientation (see also Gill, 1983; Hoffman, 1983). I wish to make clear that my thesis here is not that the relational-conflict model is a more productive one in general but that it more readily lends itself to the fullest examination of sexual and romantic countertransference participation.

**Drive Conflict Model**

The position of, or hierarchy between, patient and analyst is most sharply dichotomized in the prototype of this model. The role of the analyst is purported to be the neutral and objective interpreter of the patient's unconscious. The patient is dominated by infantile sexual and aggressive drive derivatives, what Mitchell (1988) calls "the metaphor of the beast." The patients' direct or indirect transference observations about the analyst are thus viewed as drive-dominated, a function of unresolved infantile wishes based on drives. These beast-baby feelings are either expressed as wishes toward the analyst or attributed to the analyst. In the latter instance, these attributions are normally interpreted as inaccurate: that is, they are inevitably seen as projections or distortions and reflect only the inner world of the patient and nothing about the would-be neutral analyst. The deprivation of the analytic situation is regression promoting, and the patient is believed to become a recrudescence of his or her primitive affective baby-self. Sexual feelings are viewed as drive based. Infantile sexuality, not mature adult sexuality, usually reflects the interpretive schema of the analyst. That is, the patient's sexual feelings are not generally viewed as coming from the adult psyche of the patient, expressed toward a peer, adult analyst. The patient is a beast-baby, and the analyst is one or the other, innocent oedipal or pre-oedipal parent. Viewing the patient as having mature lustful or romantic transference feelings is less likely within this interpretive schema. This makes it far easier for analysts to distance themselves from the patient's expression of romantic sexuality. Essentially, the feelings may be seen as more impersonal since both sex and aggression are drive-based and emerge from this infantile part of the adult.

As Racker (1968) has noted, the classical psychoanalytic position always views the child as initiator of oedipal sexuality. Both he and Searles (1979) have asserted that it is more likely that the child's sexual feelings toward the parent have been initiated by the parent's sexual feelings toward the child. This perspective returns to the sequence of Freud's original seduction theory and dramatically reverses the direction of parent-child and analyst-patient sexuality in psychoanalysis, subsequent to Freud's rejection in the seduction theory. The role of the analyst in the drive-conflict model, however, is to maintain an opaqueness so that participation is minimized and the patient is always viewed as the initiator of sexual desire. In this one-person psychology, the analyst does not unwittingly flirt, and countertransference feelings in general are purportedly self-monitored and thus controlled. If the patient sees the analyst's affective initiation or participation, the analyst has erred. Countertransference awareness is used to stay on a neutral course and not interfere with the explication of the patient's infantile, eroticized intrapsychic world. There is little room for acknowledgment of unwitting participation on the analyst's part for this would redirect the focus from the patient only to the social or interactional field. The analyst's sexual or romantic feelings, initiating or responsive, are thus allegedly controlled.

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This may be less difficult than expected under normal social circumstances since the patient's sexual flirtations are not viewed as real adult material but as derivative infantile material. If the analyst were unwittingly to engage in flirtatious behavior or if sexual feelings were to show, this would reflect countertransference acting out—an analytic error to be corrected. In Racker's terms, the baby or ill patient carries all of the affect, and the adult and well analyst has it under control. Further, if the analyst's affective participation is visible to the patient and identified as such, this may be viewed as a function of the analyst's unresolved infantile unconscious. The possibility of seeing such feelings as real adult feelings toward the patient thus may be readily dissociated: "It isn't me; it's my unresolved neurotic infantile drives." Sexuality is viewed as less personal (drive-based) for both analyst and patient. Adult or mature sexual, romantic, or affectionate feelings or enactments are fundamentally not normally addressed in the transference, much less in the countertransference, until perhaps the end of analysis, when the patient may be viewed as mature. On the other hand, the patient's immature or infantile sexuality is usually the heart of the analysis of transference.

An excellent illustration of this strict, "by-the-book," drive-conflict model is offered by Dewald (1972). The entire volume is a case study, with transcript, of what appeared to be a highly successful analysis of a very attractive woman. Throughout the text, the male analyst is openly idealized personally and romantically. The material is dominated by sexual and aggressive transference wishes and fantasies, and these are interpreted as emerging exclusively from within the patient's psyche. That is, Dewald did not see himself as at all unwittingly participating in this transference to himself (Levenson, 1991). In my view, Dewald graphically presented himself as a strong, idealized man to a woman whose life history was devoted to compliantly pleasing men. From my perspective, she gave Dewald just the sort of analytic material he needed to publish a book validating his preferred analytic model. This countertransference enactment never came close to being analyzed since the analyst, based on his theoretical schema, could not have possibly seen this sadomasochistic, sexually charged interaction from a two-person psychology point of view. His patient's explicit and often highly erotic sexual material was interpreted as infantile sexuality, and there was no indication that he felt any sexual (infantile or mature) feelings in reciprocation or that his idealized position in her life pulled for such feeling in her. He viewed himself as an entirely neutral nonparticipant in her transference.

"Right now I want to put your penis in my mouth and nurse on you and have you make love to me" (Dewald, 1972, p. 426). One moment later:

"I think how fascinating your penis is and I want to touch it and feel it and taste it and know what it is because I don't have one. I want one of my own to experiment with" (Dewald, 1972, p. 426).

Dewald's volume is replete with this erotically charged material, sometimes coupled with genetic interpretations that fit perfectly with drive-conflict metapsychology. Both the patient's sexuality per se and her passive, orally sexual compliance are viewed as emerging from her infantile sexuality only. This in turn makes it easy for the analyst to dissociate from countertransference sexual response since he can view her erotic material as not real or not adult. The patient is a sexual beast-baby, and an analyst does not have reciprocal sexual feelings in that context. This "baby," however, was quite attractive and flirtatious and said many very erotic things to her analyst. It takes considerable denial never to feel sexually excited in this context and not to see how his position of power stimulates the patient's sexual excitement. One significant risk in the analyst's dissociation of sexual and romantic countertransference feelings and participation in this context, as well as in general, is that it disempowers the patient and leads to a greater likelihood of change by compliance—the dreaded transference cure. The idealizing patient may willingly submit to the view that his or her perceptions are distortions when they may, indeed, be quite attuned to the analyst's affective engagement. Though other analysts who subscribe to the drive-conflict model in fact work quite differently than Dewald (e.g., Sandler, 1976; McLaughlin, 1981, 1991; Lipton, 1983; Jacobs, 1986; Chused, 1991), he illustrates how the prototype of this model may lend itself to the disavowal of sexual and nonsexual loving countertransference feelings and enactments. This, in turn, may readily lend itself to unanalyzed repetition of earlier configurations. The patient's enactment is always analyzed but the two-person repetitious enactment is denied.

Developmental Arrest Model

The proponents of this model comprise, largely, some object relations theorists and some self psychologists. The patient is viewed as fundamentally a child in an adult body, though the child is far from a drive-conflict beast-baby. The child of the developmental arrest model suffers from a deficiency disease based on poorly attuned parenting. This depriving or
overly impinging experience has stunted development. Although the patient may function quite highly in a variety of respects, development is arrested in other significant ways. Growth cannot take place unless the deficiencies are corrected or repaired. This reparation, in the form of psychoanalysis, may compensate for the earlier deficiencies or restimulate the thwarted growth process or both. In what Mitchell (1988) refers to as the “developmental tilt,” the deficiencies are viewed as early ones and treatable only by addressing the regressed or baby-patient. That is, the damage done to the individual is perceived as early damage primarily and not necessarily consistent up the developmental ladder. For change to occur, treatment must focus upon the earliest points of difficulty; the reparative work is focused upon the child and not the adult self, as in Balint's (1968) “basic fault.” In this regard, the patient is viewed as in need of external supplies, quite the opposite to the drive-conflict patient who needs to renounce wishes. Patients are, indeed, often divided into two categories: those with sufficient early development where the focus is on the renunciation of infantile wishes as part of adult life and those with deficient early experience who cannot move forward until those early needs are met. That is, wishes are based upon conflict (you want it, but it is immature and you cannot have it) while needs are seen as preconflictual, like food to a malnourished person. There can be no therapeutic action unless these needs are met. Further, in this developmentally titled-toward-childhood perspective, the patient's needs are usually unrelated to words per se. From this perspective, the content of the analyst's words or interpretations is not important except as a reflection of the analyst's understanding or attunement. It is often unclear whether analysts who work from this model view all their patients in this way, or if, indeed, two entirely opposite forms of psychoanalysis are engaged, based upon diagnosis. Kohut (1984), in his final work, maintained that what he once believed was necessary for narcissistic patients only was actually the most meaningful therapeutic action for all patients. I believe Winnicott (1965), the most significant spokesperson of the developmental arrest model from the British school, maintained this two-treatment diagnostic category.

The primary position of the analyst from this point of view is the provision of need through the nonverbal action of psychoanalysis. Words are only actions and these actions may reflect the analyst's attunement, holding function, good-enough mothering, repairing, mirroring, containing,

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- 177 -

or the offering of oneself as an object for identification. The analyst does not exist so much as a real second person but as a supplier of missing structure or early experience. The analyst's sense of separateness is minimized; there is no separate psychic reality. The self of the analyst in this one-person psychology is subsumed to meet the patient's developmental needs, whatever they are. This may include the need to be alone in the presence of another. The patient is not viewed as the initiator or as the repeater of early problems. In addition, the patient is viewed not as using the analyst as an object to play out conflict, but instead, as guiding the analyst toward a repairing function. This requires an exquisite sensitivity to what the patient may subtly convey as a need and a studious avoidance of being the bad object, although breaks in empathy do inevitably exist. The analyst is thus very distinct from the outside world or the familial world of the patient, for these worlds are composed of both good and bad objects. In a conflict model, the patient's adhesion to the old and the bad leads to a pull for the analyst and patient to repeat, but in this model, as Mitchell (1988) notes, the patient's "true self" is released by the analyst, who has few of the “false self” requirements of the rest of the world.

Regarding the main theme of this essay, in this world of the good-enough mother/analyst, there is little sexuality in either the transference or countertransference. Unlike the beast-baby of the drive-conflict model, we have Mitchell's (1988) “sleeping beauty baby.” A deprived baby, in the hierarchy of needs, feels no sexuality. Symbolic touch or love is in the form of the gentle, parental kiss, the refusal to impinge, or even the parental discipline of hate (see Epstein, 1977). Sexual feelings in the transference are far overshadowed by longing for parental holding. Since countertransference is largely what Racker (1968) refers to as concordant, the analyst tends to identify with the patient's perceived internal needs. Complementary countertransference experience is too separate from this perspective. Projective identification is the primary form of countertransference, and the analyst is purportedly aware of the patient's needs by virtue of identification with them as well as by allowing himself or herself to be used in order to meet them. The analyst, in identifying with the patient's basic needs and fulfilling them, does not tend to feel sexual or romantic. The relational configuration is parent-child and the kind of love expressed from analyst to patient is the holding love of adult to young child. Whereas the transference love expressed in the drive-conflict model is intensely sexual but not really sexual (child sexual or drive-based sexual), transference love here is longing for maternal nurture. In both models, there is little room for personal acknowledgment of sexual or romantic countertransference love since the patient is not a sexual adult but a baby of one or another variety.

Winnicott as an analyst is vividly illustrated in both Margaret Little's (1990) book about her analysis with him and Harry Guntrip's
(1975) article on the same subject. Both of these outstanding psychoanalytic contributors felt enormous life saving benefit from their work with Winnicott, and each compares his work very favorably with prior analyses with other very prominent analysts (Ella Sharpe, Ronald Fairbairn). Both Little and Guntrip viewed themselves as having major psychic deficiencies despite having achieved exceptional heights in the field of psychoanalysis. Little (1990) describes in great detail her treatment with Winnicott as more environmental provision and healing than psychotherapy per se. Much of what transpired between patient and analyst was physical in nature and unaddressed in words. For example, early in therapy Little, in a fit of rage, broke a vase valued by her analyst. He left the room in obvious upset and anger, but the vase was soon replaced by another, and nothing was said about it again. At another period in analysis, Winnicott had been suffering from serious heart disease and depression related to it and to the breakup of his first marriage. This was all very obvious and known to his patient/colleague, but again, the matter was not put into words by either.

Much of what Little describes in her analysis focuses upon physical provision. After an initial period, sessions were doubled in time for the duration of treatment, and most of them were spent with her hands clasped between Winnicott’s, while lying beneath his blanket. He took full responsibility for supplying strength and was actively directive in practical affairs. Little describes him as taking over her life. He visited her at home for sessions when she was ill and made certain she was accompanied places while he was on vacations. He acted as her medical director, always carrying a thermometer and ministering to her medical treatment. At one point in the treatment he hospitalized her, at least in part because he himself had heart problems and felt he could not take care of her. He served coffee and biscuits at the end of each session. At one particular point, Little notes that he actively took sides against her mother by telling her that he really hated her mother. In speaking in overview about her treatment, Little notes that “sexuality has no meaning here” (p. 89).

Guntrip (1975) compares Winnicott favorably with Fairbairn, who focused upon Guntrip’s adhesion to early bad objects. Winnicott, aside from being a warmer individual to Guntrip than was Fairbairn, totally de-emphasized conflict. According to Guntrip, Winnicott focused on the very early good mother and was able to be that good mother in the transference for Guntrip. Guntrip writes of Winnicott as becoming the good breast to his infant self at the point where his actual mother lost her maternal interest and could not stand her young son. “Here at last I had a mother who could value her child” (p. 153). When Winnicott died, Guntrip states that he did not collapse as he had in response to other losses in his life, since Winnicott had taken his mother’s place and made it safe to remember the early, good mother. “Winnicott, a totally different person [from Fairbairn], understood and fulfilled the emptiness my mother left in the first three and one half years” (p. 159).

In profound contrast to Dewald’s description of his analytic work, there is no mention of sex or romance in the transference. Similar to Dewald, however, there is also no mention of sex or romance in the countertransference. Love plays an enormous part in the developmental arrest model, but as described here, it is maternal love to a baby-patient. Speaking in terms of the developmental tilt, the patient’s relational needs are those missing in the earliest moments of life, not right through the life cycle. As illustrated by Winnicott, more strikingly with Little than with Guntrip, the treatment consisted far more of caretaking than what many of us know as psychoanalysis. As Little notes, the patient as baby is filled with fundamental needs, and sex is not yet nearly a relevant theme. The analyst of the developmental arrest model, indeed, views the patient as a not yet sexual child. There may be considerable enactment of nurturance and provision but not of romantic or sexual love. Winnicott literally took almost total care of Little for the duration of the therapy, and one can say that mother-to-child love was acted out as the essence of the experience. With Guntrip, this seemed to be more attitudinal and perhaps symbolic, but with Little, there literally was no maintenance of anything close to the usual therapy frame. In these illustrations (which are perhaps extreme ones) of the model of developmental arrest, countertransference love of mother to child is at the absolute center of the relationship. Romantic and sexual countertransference love, in contrast, is nonexistent. Though I am aware of many far less extreme examples of the developmental arrest model (see, e.g., Stolorow and Atwood, 1992).

I do argue that the model in general discourages optimal awareness of romantic love in favor of maternal love.

Relational-Conflict Model

Mitchell’s (1988) preferred model of therapeutic action stems from his background in interpersonal psychoanalysis in combination with the clinical theory of Ronald Fairbairn. For most interpersonal analysts, beginning with Fromm (1956, 1964), Sullivan (1953), and Thompson (1950), interaction with others conveys the essence of personality or character; the observable engagement, in the transference and extratransference, is indicative of the internalized patterns or templates. Sullivan’s term, “personification,” refers to
internalized life experience with others that leads both to expectancies of the future and to unconscious self-fulfilling prophecies. In strong reaction against what was believed to be an overemphasis on the intrapsychic and the reification of internal structures, interpersonal analysts usually preferred not to speak in terms of inside versus outside. It was assumed that the outside reflected the inside, but emphasis on internal was viewed as overly abstract and theoretical. Interpersonal analysts were viewed by the majority of psychoanalysts as superficial, of having minimal conceptualization of unconscious process or the intrapsychic (Hirschl, 1985).

Fairbairn (1952), on the other hand, viewed human development very similarly to the way interpersonal analysts viewed it and, indeed, elaborated strong conceptions of the internal world. His focus was on the internalization of interpersonal relationships as the basic building blocks of human development. His concept of internalized object relationships is very similar to Sullivan's personification, though the latter concept was understated and used more by implication than specifically elaborated.

Fairbairn and the interpersonalists had very similar notions of psychotherapeutic action, and these are essentially summarized in Mitchell's (1988) integrative concept of relational conflict; a marriage of Fairbairn and interpersonal psychoanalysis. As elaborated by Fairbairn (1952), Fromm (1964), Schachtel (1959), Searles (1979), and Singer (1970), problems in living are a function of adhesion to the loved ones of the past, an inability to separate from the familiar and the familial. This embeddedness, to use Schachtel's term, reflects a loyalty to, and a love toward, those real and internalized significant others. It reflects an active striving to maintain old attachments, regardless of how limiting or inhibiting such a position may be. Indeed, the more depriving or harmful the internalized figures of the past, the stronger the adhesion. An impoverished or limiting environment leads to greater fearfulness of exploration and of seeking new experience. One rigidly holds on dearly to the little available, and separation from embeddedness is thus more difficult. This, in contrast with the model of developmental arrest, is a conflict model. The key conflict is between the striving to maintain early attachments to internalized loved ones and separation from this enmeshment. In this context, patients in analysis are viewed as both striving for new and richer experience while also looking to repeat internalized old patterns, which must define one's sense of self. The patient in relational conflict is a more active patient than one viewed as in developmental arrest. In the latter, one is looking for missing supplies in order to grow while in the former, the patient is looking two ways: to repeat the old and bad experience and to be exposed to new, separation-enhancing experience. In the interpersonal or relational conflict model psychopathology is defined not by what was missing in the past but by the perpetuation of that troubled past. The patient pulls the analyst in two directions, repetition and new experience. Ehrenberg (1992), Feiner (1977), Gill (1983), Hirschl (1993), Hoffman (1983), Levenson (1983), Sandler (1976), and Stern (1989) all note that the analyst cannot avoid repeating the old or bad attachments before winding out of them and reaching new relational configurations. The analyst is influenced or used by the pull of the patient's life and life history to engage in a complementary countertransference (Racker, 1968) with the patient, which, in effect, is a facsimile of familial configurations. This is always unwitting participation; it is never purposeful or technique-based. As Greenberg (1981) has noted, participant-observation is a description, not a prescription. Fiscali (1988), Gill (1982), Hirschl (1985), Levenson (1991), and Mitchell (1998) emphasize that change stems from new experience, from analyzing the repetitious mutual enactments from within the system and working one's way out to form a new relationship. It is a therapy model of enrichment in contrast with replacement and/or insight primarily, though verbal insight is, indeed, part of the process, more so than in the developmental arrest model.

The patient of the interpersonal, relational-conflict model is not a beast controlled by immature drives or a baby waiting for external supply. The patient is viewed as an adult, perhaps with immature qualities but a conflicted adult with will and willfulness. The analyst is not primarily an interpreter who resists enmeshment or a supplier of developmental needs but an unwitting participant in an interpersonal configuration. The analyst is conceptualized primarily as a second person in this two-person psychology, not predominately a blank screen, a container, or a selfobject. The analyst is a second psychic reality in the dyad and does not strive to remain outside the interaction (drive-conflict model) or exclusively to remain in empathic attunement (developmental arrest model). Both positions are considered impossible by definition. Because the unique individual analyst is seen as being pulled into the patient's internalized world, it is essential to use one's sense of separate self or psychic reality to identify the configurations and emerge from them. There is considerable uncertainty (see Hoffman; 1992; Stern, 1990) in a psychoanalytic situation dominated by unwitting participation and where prescribed technique (e.g., holding, interpreting, selfobject function) is minimal.

In the interpersonal, relational conflict model, the patient-analyst relationship more closely resembles other social relationships. The analytic frame is clearly set; the analyst is still the observer, and the relationship is usually asymmetrical. Nonetheless, in this
context, adult to adult, there are very considerable engagements (Ehrenberg, 1992) and mutual enactments (Hirsch, 1993). Since the patient is not generally viewed as either a beast-baby or a deprived one, the patient’s sexual feelings toward the analyst may very well be those of a reasonably mature, sexual adult. Reciprocally, this adult patient may be the object of considerable sexual attraction or romantic love. The less-defined nature of the relationship, combined with the conception of both parties as adults, leads to a greater likelihood of acknowledgment of normal sexual and romantic countertransference feelings. Such feelings may be initiated by the seduction, flirtation, or romantic love of the patient, but they may also be initiated by the analyst. As Racker (1968) and Searles (1979) have noted about Oedipal love, it may be more likely that the parents initiate it. Given Racker’s (1968) observation that the analyst and the patient are always feeling something toward one another, one can only expect the presence of the total range of affect. To the extent that love in various forms, as well as lust, is a part of everyone’s range of affect, it is difficult to conceive that such feelings are absent in the countertransference. The

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- 183 -

presumed barriers of patient as driven infant or deprived baby are not as relevant here, and adult loving and sexual feelings are more likely to be consciously experienced and acknowledged to oneself. Further, as noted in the beginning of this essay, countertransference feelings are normally lived out as countertransference enactments. From this perspective one cannot avoid enactments but strives to observe the inevitable field of mutual enactment. Indeed, the analytic engagement is a series of enactments, a reliving of the old, and an evolution to the new. The nature of romantic, or sexual, or parental love will be enacted as a repetition of the old and relived together in that context. Also, if the analysis is effective, new transference-countertransference configurations will develop and perhaps newer versions of sexual, romantic, and parental love will emerge in the transference-countertransference matrix.

In the following section I use clinical examples to attempt to illustrate themes of romantic and sexual countertransference love, working in this model of therapeutic action. Each patient discussed is a composite portrait of a number of patients I have seen over the years.

**Clinical Examples**

Shortly after completing analytic training, I began working with a woman A, who was the most attractive female patient I had yet encountered. In addition to exceptional physical beauty, she was very smart, sensitive and imaginative, quite worldly, and broad in her interests. She was in crisis, in the midst of another in a series of stormy breakups with men. The men tended to run in a pattern: charismatic, manic, wealthy, prominent, or both, unreliable, undependable, and inconsistent. Some of them had drinking or drug problems, and from her description, they seemed to have considerable external power and internal weakness. She very openly described how drawn she was to their power and how intense and exciting were her sexual relationships with them. She had recently begun therapy with a male therapist who counseled that her lover was too unstable for her and that she ought to terminate the relationship. In a moment of mourning, sorrow, and teachfulness, the therapist embraced her and held her and then began to caress her, first tenderly and then in a sexual manner. She allowed this but was hor rified and enraged afterward, never returning to him and beginning analysis with me.

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- 184 -

A was very successful in her profession and highly creative as well. She was her father’s clear favorite and was thoroughly shocked by his sudden death when she was a mid-adolescent. His fatal heart attack was precipitated by blatantly self-destructive health care. A apparently mourned effectively and carried on in life, achieving in school and work and always active socially and avocationally. Her mother had always been disappointed in the patient’s father for his only modest business achievements, and his death seemed related to a decline in his business and in his economic future. Mother, whom A described as rather bland and maternal, became more alive after her husband’s death.

My second thought upon initially seeing A, after noting her pulchritude, was that I did not want to die on her; to let her down as did her father. In the early part of analysis I felt effective, for she readily put this last relationship behind her and became even more successful in her work. She met men very easily. Most of those to whom she was attracted had similar characteristics to those of her former lover; some were publicly prominent figures. She was very open in speaking about the considerably erotic nature of these relationships. In the midst of this she dated a man (X) toward whom she experienced a quieter, more tender kind of sexuality and who, although doing well in his work, lacked the flare and panache of her other lovers. She did not consider him as special among the men in her life, but when I pointed out the different emotional tone she described to me, she began to become increasingly exclusively interested in him. I was concerned that she was responding to my preference for him and, indeed, when I inquired, she noted that he
reminded her of me more than the other men in her life. I believed that we discussed this sufficiently to control for most transference influence. Further, I was different from X as a person in so many ways that it appeared to both of us that it was he with whom she was falling in love and that this was separate from her affection for me.

In about one year or so, A married X and they very quickly had a son. Though X was totally devoted to her and the child, he turned out to have some significant character weaknesses. His professional life began to decline while hers continued to escalate. While pregnant with her second child, she became increasingly furious toward her husband and found herself interested in other men, similar in character to her previous lovers. She was also furious at me for her being in the same situation where she started and left therapy at a point where her marriage was very

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- 185 -

tenuous. She had had some years of previous therapy with a woman and felt thoroughly let down, that nothing ever really changes through this medium. I was left feeling that I totally disappointed her; I essentially died like her father and husband. My only sense of value in her life was related to how much having children had meant to her, and perhaps this may not have occurred without her therapy experience. I believed that her professional success would have continued to develop with or without me and that I fundamentally confirmed her consistent belief that men will not stay alive.

Whether or not A, like her mother, precipitated her husband's depressive decline or married a fairly weak man to begin with is impossible to unravel. Were I more present and able to analyze my way out of the transference-countertransference configuration, she either would not have married X in the first place or would have been more supportive of him while married, thus avoiding a very sad repetition. In retrospect, my countertransference love for A led to strong rivalry with the charismatic, highly sexualized men in her life. I felt like her warm and tender but weak father, steady before his death but unexciting. I was not fully attuned to my rivalry or how nonsexual I felt in her eyes. I believe that she found a man (X) with whom I more identified, and I unwittingly encouraged that relationship above others. I think that I unconsciously identified with A's father, viewing her as a special patient and wanting her to see my true strength and value in contrast with her exciting lovers. In not being sufficiently aware of my rivalry and defeat at the hands of her exciting lovers, I missed the opportunity to analyze her view of me as her weak father. My manifest desire was to be strong for A, to be a combination of the sexually exciting and the tender man in her life. Were I more aware and at ease with my weaker feelings in relation to her, her own conflicts between repetition of her familial pattern and her desire truly to find a stronger and more reliable man may have had a better chance at integration. Her previous male therapist caressed her sexually and died for her in that most inexusable way. I, despite my resolve to remain vital, died because I could not bear consciously feeling as weak and useless as did her father. Fortunately for A and for me, I was able to put this retrospective analysis to use. After an almost two-year hiatus, freshly divorced, she consulted me about a problem with her son. I was more able to directly address her disappointment in me and my similarity with her father, and analysis resumed. My increased ability to

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- 186 -

tolerate her lack of romantic interest in me compared with other men in life allowed A more space to integrate her tender and erotic sides.

B was in his late 20s when I began seeing him while in analytic training. He was on leave from law school, close to graduation, and one presenting problem was his paralysis in finishing. He also had no romantic life and stated that he was sexually interested in women but very inhibited and frightened of sexual impotence, something that had plagued him in what he reported to be a very spare sexual history. He was an attractive man, soft, gentle, and untouched-looking, yet reasonably masculine. He was very educated and cultured, and his sizable inheritance allowed him to live a life dominated by reading, art, music, charitable interests, and managing his money. He appeared very calm and tranquil though he was obviously very lonely. He had no close friends and his parents had both died a few years back. I had the intuitive feeling that he was gay, in great conflict about it and concealing it from me. He was insistent throughout the analysis that he was not and that his sexual history and current fantasies were exclusively heterosexual.

B's mother was vain, labile, and thoroughly materialistic and related to her son as if he were a cherished museum piece. She was proud and doting yet did not seem to view him as a separate person or even as a person. Father was powerful and competitive. He kept his son in his shadow, never facilitating identification with his strong aspects. It seemed as if B were there to adore and admire him and as if this ought to have been sufficiently sustaining.

In the early stage of this failed four-year analysis, B quickly returned to school and received his degree with honors. I saw no further external or internal progress. His analysis became a transference devotion to me and to my life. I was both his father and mother, and he was there for my narcissistic pleasure. He took a strong interest in my life, and I had the idea that he would walk
around my neighborhood, surreptitiously watching me instead of living his own life. I took two short leaves to be with my family, since both my children were born during his treatment. He seemed enormously interested in them in a very tender and caring way. I had fantasies of his being their uncle or baby-sitter or benefactor, and in these thoughts, he was very loving to them. I had desires to include him in the rest of my life as a friend, to share some mutual interests, and to absorb some of his cultivation and noblesse oblige.

All of these feelings were clear to me and used as the central focus of

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the analysis, yet my own countertransference feelings never changed. I always enjoyed seeing him and felt totally relaxed with him, despite my growing awareness that I was not at all helping him. Like his father and mother, I was getting everything, and he was getting nothing. My repeated focus upon this theme lead to acknowledgment of this, and he eventually terminated treatment, and I have not heard from him since. Despite my exhortations, he refused to begin with another analyst, though I hope he has by now.

Some time later, related to an experience with another patient, I recognized that B and I were involved in a mutually homosexual relationship that resembled the one between him and his father. The only missing ingredient was my explicit sexual fantasies, the absence of which, I believe, is related to my own inhibition and anxiety. In retrospect, he was telling me through his relationship with me that he was indeed gay and wished to come to terms with it. We spent ridiculous amounts of time speaking of his inhibitions with women. Were I more comfortable with the homosexual nature of my countertransference, it would have been clear to me in process, and he may have been helped to begin to live a life more devoted to satisfaction of his own desires. Like his father and mother, I never got past a willingness to accept his sacrificial devotion and he thus was never able to channel his many talents into finding both love and work that belonged more selfishly to himself. I was enmeshed in the old and bad patterns with him. Because I was too anxious about my own homosexual feelings, they were enacted without being analyzed and he was unable to separate from his patterned interpersonal configuration and emerge as a separate self.

My experience with B helped me work more effectively with C who was approximately my age and from a similar cultural background to me. He had never married. He had had two close male friends who were gay, but he had never consummated homosexual sex. He was ostensibly interested in women but was very shy and awkward. He was talented in his profession and this alone enabled him to just get by economically, for many years. He was nice looking in a shaggy dog kind of way but his manner of dress and the way he carried himself suggested depression and inadequacy. He sought therapy in relation to his involvement with a somewhat bizarre, manic-depressive woman who drove him crazy but with whom he could not separate. She energized him in a way, and he feared returning to his lonely and depressed life without her.

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In the initial two years of analysis, much happened. His sloppy and shaggy clothing and general appearance were upgraded. He began to do better professionally, to take more initiative and engage in a more lively way. He reactivated a long-dormant interest in sports and felt far better physically. He traveled more and became increasingly interested in art, music, theater, and film, all of which had been peripheral interests up until that time. We talked a great deal about how much these changes were based on his identification with me and what indeed represented his own private awakening. He began more actively to date women, but nothing developed in his love life. When women were interested in him, he believed they were exploiting him. They wanted to spend all of his money (he was very frugal), drain him sexually, or both. He was very bitter toward most women and, as movement in analysis ceased, toward the world in general. In particular, I was draining him of his limited financial resource, and this grinding resentment became the central focus of interaction for two years or so.

Despite this most sour relatedness I felt as comfortable and at ease with him as I always had. Like B, he was thoroughly uncompetitive and undemanding and easy for me to be with. I could be playful and sarcastic and spontaneous with him, challenging his anger, passivity, and depressive sense of victimization. In spite of the dysphoric and often deadening interaction, I looked forward to our sessions and to how relaxed I was with him. He almost always led me to feel that my own life was rich, thriving and abundant in comparison. He reminded me of an older cousin with whom I was very close but who never made anything of his life. I was the star of that segment of the family.

In C's family, I was his narcissistic father to his depressed and bitter mother. Father ignored his wife and son and was openly unfaithful with women. Mother and son were home alone, empty and depressed, while father spent all of his very modest family income on his own pleasures. In the fifth year of analysis, for no reason that I can point to, I recalled something that C had noted in passing, very early in the analysis, and that I had, remarkably, forgotten. Until between age 12 and 13, when C angrily put a stop to it, father would bathe him, and in so doing, would play with C's penis. This was the only source of affection or touch between them and
after C stopped it, there was no other physical or emotional contact. This, indeed, captured my relationship with C. I conveniently repressed this significant history because, like father, I enjoyed

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- 189 -

playing with his penis. C tried to address it through his bitterness at my exploitation, but, in part, he again feared that it was our only source of potential contact and did not fully wish to lose it. He had become my sexual playing, bitter and passive-aggressive but also compliant. He was there for me to exploit and use for my pleasure, and this configuration was familiar and familial. The addressing of this homosexual repetition became the center of our analytic work for some time.

Summary

My main thesis has been that optimal awareness of analysts' romantic and sexual unwitting participation is best facilitated by the interpersonal, relational-conflict model. I am not arguing that this model is the most useful overall but have restricted my comments to this one theme. Indeed, in the clinical examples used, both Dewald's patient and Winnicott's seemed to fare better than my own. In discussing the three models and in choosing particular examples (Dewald and Winnicott), I have emphasized differences among models. The principles described and the examples used are prototypes or maybe even stereotypes, utilized to make a point. As already noted, there are more contemporary examples of the drive-conflict and developmental-arrest models that are less extreme and more balanced. I believe that I am aware that most analysts of all persuasions work in ways that do not usually line up so clearly on prototypical scales. I am certain that in most instances, analysts use elements of all three models in their work. Also, analysts work quite differently in the privacy of their offices than in the public domain of written presentations (Sandler, 1983). This suggests that most of us work, in fact, in an even more out-of-model way. Nonetheless, there are real differences in theories of therapeutic action, and prototypes can be useful in highlighting the strong or weak points of each model. I have tried to convey that one of the strong points of the interpersonal, relational-conflict model is that it allows the analyst more readily to acknowledge and therefore productively use the broadest range of countertransference enactments, in particular, sexual and romantic countertransference love.

References


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- 190 -


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