Commentary on
Papers by Tansey, Hirsch, and Davies

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When Michael Tansey originally organized this series of papers for a panel at the April 1993 Division 39 meeting, he invited me to serve as a discussant. Because I was already overscheduled to speak elsewhere, I declined the invitation, although with considerable distress that I would miss a rather unique opportunity. I was particularly pleased, then, when given a second chance (the return of the distressed) to comment on these three groundbreaking contributions in the pages of Psychoanalytic Dialogues.

Two of the authors (Tansey and Davies) appropriately invoke the affect of dread in their titles. Erotic countertransference has been the last taboo in psychoanalytic circles. Tansey’s historical references amply testify to the sordid array of sexual transgressions in the early years of our field. He is, of course, only skimming the surface by mentioning well-known published cases from the past. Virtually every institute and society harbors “family secrets” involving analysts who have married former patients and others who have referred patients on to other colleagues after engaging in sexual relationships and ending the treatment. The closets of our institutional houses are full of skeletons.

In the same way that awareness of incest has surfaced in recent years, so has the problem of sexual enactments between therapists and patients—professional incest, if you will (Gabbard, 1989a). Because of the difficulties the mental health professions have encountered in attempting to address the problem, 12 states have already criminalized therapist-patient sex, while several others are seriously considering it.

The reasons for our reluctance to grapple with a serious professional
issue of this magnitude are not entirely clear. Many traditional drive theorists appear to be influenced by a somber pessimism (reflecting Freud's, 1930, attitude in “Civilization and Its Discontents”) about our ability to master sexual and aggressive drives that are overwhelming in their power and intensity. Others, when confronted with colleagues who have succumbed to temptation, comment on the ubiquity of human frailty and our need for tolerance.

Another factor at work in some instances is a form of paralysis that grips analytic institutes when one of the senior and highly respected members is charged with sexual misconduct. Ethics committees may be comprised of younger analysts who were analyzed and supervised by the accused analyst. We all know that transference is never fully resolved, and the residues of idealization may undermine any form of active effort to address the problem.

Moreover, our wish to stereotype analysts who have sex with patients as psychopaths who are substantially different from the rest of us assures that nothing will be done. As long as we projectively disavow our own vulnerability and temptation, we are neglecting the most important approach to prophylaxis—systematic examination and understanding of the inevitable countertransference enactments to which all analytic flesh is heir. In this regard these three papers represent a significant breakthrough in our beginning efforts to investigate what has thus far eluded our understanding.

The Lovesick Analyst

As Tansey notes in his discussion of the Spielrein fiasco, there has been a historical tendency to blame patients for the transgressions of the analyst. Some therapists, on the other hand, explain their behavior by saying that they are simply “in love” with the patient, and therefore ethical considerations are irrelevant. Frieda Fromm-Reichmann (1989), for example, described her situation as follows: “You see, I began to analyze Erich. And then we fell in love and so we stopped. That much sense we had!” (p. 480). Margaret Mahler, writing from the point of view of a patient who had a sexual relationship with her analyst (August Aichhorn), commented that the two of them were “in love with one another, making impossible the classical relationship between analyst and analysand” (Stepansky, 1988, p. 68).

The irony is that many lovesick analysts (Twemlow and Gabbard, 1989; Gabbard, 1994a) who succumb to the apparent charms of the patient no longer view the developments in the analytic dyad as involving transference or countertransference. They rationalize the transgression as involving “real love” that transcends mundane considerations of transference and countertransference. This confusion between “real love” and transference love was perhaps enhanced by Freud’s tendency to talk out of both sides of his mouth on the subject in his classic 1915 paper. On one hand, transference love had “the essential character of every state of being in love” (p. 168). On the other hand, “it displays its dependence on the infantile pattern more clearly and is less adaptable and capable of modification” (p. 168). While transference love was both “real” and “unreal” (i.e., displaced), Freud stressed that the analyst must treat it as a new edition of an old love (Schafer, 1993; Gabbard, 1994a, in press). In any case, most of us would be highly skeptical of any analyst who claimed to be able to distinguish real love from transference love and even more skeptical of an analyst who sanctioned acting on one while abstaining from acting on the other.

The same ambiguity applies to countertransference love. Analysts who have become lovesick have lost the “as if” nature of the countertransference. This erotized countertransference—analogous to Blum’s (1973) distinction between erotized and erotic transference—compels them to action rather than reflection (Gabbard, 1994a, b, in press). The task of the analyst, as always, is to maintain that precarious state of being both a participant in, and an observer of, the heat of the moment. In relational terms, the analyst must strive for the dual state of awareness that involves the optimal tension between being the old object and the new object, similar to Greenberg’s (1986a, b) concept of neutrality. Reports from that nether region in which the analyst is being sucked into the vortex while simultaneously climbing out of it are our best opportunity to demystify the erotics of the analytic enterprise.

Transference–Countertransference Enactments

In recent years, analysts from divergent schools of thought have converged on a consensus regarding the inevitability and usefulness of countertransference enactments (Sandler, 1976; Hoffman, 1983; Jacobs, 1986; Mitchell, 1988; Gabbard, 1989b, 1991, in press b; Aron, 1990;
Chused, 1991; Greenberg, 1991; McLaughlin, 1991; Coen, 1992; Hirsch, 1993). Analysts operating from different theoretical models differ in the extent to which they stress the relative contributions of patient and analyst to the enactment. While the Kleinians tend to view the patient as largely responsible for creating feelings in the analyst, those writing from the classical perspective focus much more on contributions from the analyst's past that are revived in the enactment. My own view is that countertransference enactments are a joint creation involving contributions from both patient and analyst (Gabard, 1993, in press; Gabard and Wilkinson, 1994). Even in projective identification, there must be a “goodness of fit” between what is projected onto the analyst and the residues of self and object representations within the analyst that are likely to respond to the coercion by the patient (Scharff, 1992). Tansey, Hirsch, and Davies appear to be in substantial agreement with me on the notion of enactments as joint creations, and all demonstrate considerable skill at identifying and analyzing these enactments. As Davies eloquently argues, these enactments must be drawn out and shepherded into a transitional arena where they can be subjected to the “play” of containment and interpretation.

The sobbing female patient encountered by Tansey evoked a powerful erotic response in her analyst. In his courageous self-disclosure, Tansey describes how he struggled with feeling like a rapist and with the highly disconcerting fantasy of sexually assaulting a helpless, terrified child. This blending of sexual attraction and sadism was understood by Tansey as a complementary identification with an internal abusing object in the patient. In my own experience as an analyst who has spent a good deal of his career treating and evaluating analysts and therapists who have had sexual relations with patients, I have come to recognize that male therapists frequently become sexually excited when a female patient breaks into tears. It is not simply a coincidence that both Tansey and Hirsch report such incidents. While Tansey was able to contain his feelings so the frame was maintained, the male therapist who had previously treated Hirsch's first clinical example actually embraced and caressed the patient.

Field (1989) wrote of his own excitement when a female patient began sobbing in his office. He noted within himself that the patient's tears represented a form of capitulation or submission. Benjamin (1988) has stressed that in the course of development children learn to link dominance and submission to gender issues so that for males there is “the tendency of erotic love to become erotic domination” (p. 76). In Field's case, he acknowledged a feeling of sadomasochistic excitement associated with a male triumph when his patient crumbled into tears before him.

I wish to stress in this regard that I am not pathologizing this response in males. On the contrary, Stoller (1979) hypothesized that a desire to harm, humiliate, or degrade was at the center of most erotic excitement. He felt that intrinsic to sexual excitement is a personal drama designed to achieve active mastery over passively experienced childhood traumas. Hostility is central to such scenarios because often the trauma involves humiliation. Men may become excited in situations in which women are humiliated because unconsciously the sexual excitement may turn trauma into triumph, thus undoing the humiliation they feel they suffered at the hands of their mothers or other female figures during childhood.

The Perception of Deficit

The image of the tearful female patient provides a convenient bridge into an issue raised by Hirsch's discussion of the impact of theory on the analyst's approach to transference-countertransference enactments. Implicit in Hirsch's succinct but comprehensive overview of three different theoretical perspectives on the psychoanalytic interaction is the recognition that analysts are most prone to think about theory when they are experiencing disturbing countertransference feelings. Analysts who feel swept off their feet by a patient often turn to theory as a veritable life raft to prevent them from drowning in a sea of sexual and romantic longings. I have been particularly struck by misuses of the developmental arrest model in such circumstances.

Hirsch correctly states that the view of the patient in such formulations is that of a child in an adult's body. Unfortunately, the “adult body” part of this paradigm is an aspect of the theory that is often underappreciated. While sexual feelings in the transference are far overshadowed by longing for parental holding within this model, the patient may not understand this theory. The analyst cannot reduce genital arousal in the patient into “mere” wishes for love simply by fiat. A rose regarded as a tulip is still a rose.

The same is essentially true of the analyst's feelings except that the analyst may be more adept at engaging in self-deceit. I was once referred
a borderline patient who was a treatment failure in a seven-times-a-week “reparenting” process by another therapist. Although the female patient sat on her male therapist’s lap during the sessions, the therapist assured me that there was “nothing sexual” about it. He stressed that the relationship was purely of a “mother-child” nature. The patient had perceived it differently. In other words, in this example as in others, the external supplies that are required by such a deficit model are not intended to be sexual in nature, but the mature adult genitals of one or both parties nevertheless respond as though they were.

Hirsch makes a distinction between patients who need to renounce infantile wishes and those who cannot move forward until certain early needs are met. This distinction resembles Casement’s (1990) dichotomy between libidinal demands and growth needs. Casement stresses that the two dimensions of the patient can easily become confused. While libidinal demands can never be gratified, certain growth needs—addressed by the creation of the proverbial “holding environment”—must be attended to or a psychoanalytic process is not possible.

Hirsch’s division of patients into those who must renounce wishes and those who must have their needs met is, however, perhaps too arbitrary. Even those with deficits in early experience will need to renounce transference wishes that the analyst will supply the love and succor that were missing in childhood. In fact, this denial of the need to engage the patient in a mourning process is a central feature of many sexual transgressions by both male and female therapists. Analysts may sense that the patient is on the verge of a catastrophic grief reaction when certain needs are not gratified by the analyst. In an effort to avoid this painful and heartrending “dark night of the soul,” the analyst begins to gratify the patient with violations of minor boundaries. Hours are extended. Fees are reduced or dropped. A hug is offered as the patient leaves the session. The analyst begins to engage in self-disclosure.

As the therapist descends the slippery slope of minor boundary violations, the process begins to deteriorate further. The patient’s needs are bottomless and insatiable. To the therapist’s horror, gratification appears to make the patient worse, not better. Moreover, the patient’s enticement to be compensated for the horrible experiences of childhood appears to escalate (Davies and Frawley, 1992). The therapist’s narcissistic need to heal and rescue the patient and to provide what was missing is thwarted, and gratifications of transference wishes increase further in a futile effort to fend off the rage and sadism evoked by the patient’s refusal to be satisfied. When frank sexual enactments ultimately occur, the situation is often a repetition of incestuous experiences from the past (Gabbard, 1992, 1994a; Gabbard and Wilkinson, 1994).

Hence the perception of a deficit state in the patient that requires a heroic reparenting response from the analyst is powerfully evocative of erotic and erotized countertransference (Gabbard, 1994b). Contempt and hostility may underlie this perception of deficit and may contribute to the sexual arousal. The sense of dominance and triumph described by Field (1989) with his crying patient may also be experienced by the patient who appears to be helpless, dependent, and incapable of agency in his or her own life. The analyst’s fantasy of repairing the deficit by providing missing parts may be fueled by grandiosity and omnipotence that mask contempt for the patient’s own capacities. While I do not doubt the therapeutic value of Winnicott’s treatment of Margaret Little, I am all too familiar with instances in which the model espoused by Winnicott has been misunderstood and misappropriated to justify horrific transgressions of the analytic frame. I certainly agree with Hirsch’s point that this model discourages optimal awareness of romantic or sexual love by stressing maternal (nonsexual) love.

**Self-Disclosure**

In Davies’s provocative contribution, she beautifully describes how erotic countertransference may manifest itself as rumblings in the body prior to cognitive representation. She wisely cautions us against endorsing a disembodied sexuality in the realm of relationships. She further cautions that analysts may close off exploration of their sexual feelings for a patient in a manner that reenacts the defensive denial of the parents’ own erotic fantasy life vis-à-vis the child.

In this context she argues that self-disclosing to Mr. M that she had sexual fantasies about him was useful in facilitating the analytic process. Davies is an astute clinician, and she recognizes that her choice is a controversial one. She even suggests possible alternative strategies of intervention. She nevertheless defends her self-disclosure in the service of maximizing “the potential for newly constructed meaning within the present therapeutic space.”

Although I think she presents a thoughtful and sophisticated argument for her bold intervention, I must respectfully disagree with her
her analyst that he found her sexually attractive. In the same breath, he reassured her that he could not act on such feelings because it would be unprofessional and unethical. She told me that for many months she could think of nothing else, and she ultimately terminated abruptly with that analyst and sought out treatment with me. It soon became evident that her analyst’s self-disclosure foreclosed the possibility of her mourning him as a forbidden, erotic object that she could never have for herself. As a result, she became stuck and unable to move on to new attachments.

Sexual feelings in the analyst are different from other countertransference feelings (Maroda, 1991). While self-disclosure of such feelings has been reported in the literature (Gorkin, 1985, 1987; Maroda, 1991), the patients have generally responded poorly to such revelations, often with confusion and even terror. There appears to be something intrinsically overwhelming in hearing that your analyst has sexual feelings for you (Gorkin, 1987), perhaps in the same way that hearing your analyst would like to assault you physically is disorganizing. There may be rare instances in which muted forms of self-disclosure regarding sexual attraction may be useful, but I have yet to come across such circumstances either in my own clinical work or in the supervision of others.

Finally, as I read Davies’s account, I frequently wondered about the significance of the gender configuration of the analytic dyad. If the analyst had been male and the patient female, would Davies advocate a similar form of self-disclosure? The analytic setting is suffused with the same sexual stereotypes that exist in the culture at large (Shapiro, 1993). Roles such as seducer and seduced, victim and victimizer, are inextricably linked to conceptualizations of gender. Few of us would entertain the notion of a male analyst’s sharing the presence of sexual countertransference fantasies with a female patient in the same light as a female analyst’s sharing such fantasies with a male patient.

**Concluding Comments**

I would like to close my discussion with an expression of admiration for the courage and forthrightness of all three authors. These three contributions represent a clinically illuminating and heuristically useful starting point. It is incumbent on the rest of us to continue the dialogue begun on these pages so that the mysteries of the erotic in the analytic setting become accessible to rational discourse and systematic psychoanalytic
scritiny. While all three clinical accounts illustrate considerable command of technique and theory on the part of the analysts, they also convey the inherent messiness of the confrontation with countertransference feelings of love and lust while functioning in a professional role. Although many powerful affects compel us to action rather than reflection, erotic longings for a patient are particularly likely to do so. As George Bernard Shaw allegedly observed, “Love doesn’t make the world go ‘round—it simply makes the affected parties dizzy.”

References


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