Working with Sexual Transference

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Introduction

My interest in this area of sexual transference became focused several years ago, through a series of conversations with my colleague, Vivian Guze. We began discussing several incidents of mishandled process around sexual issues—in a couple of instances by trainees and in one case by a long-established therapist. We wondered how helpful bioenergetic training is in preparing therapists to deal with difficult situations of a sexual nature. And after considering all the programs that between us we have been involved in, we concluded that for the most part, while we teach how to open up the pelvis and deal with the immediate response that occurs, we have neglected to focus on the *process* of working through the sexual issues. In addition, we have been remiss in addressing directly the problems that arise around counter-transference and the acting-out of therapists. Because these issues are so difficult and complex and evoke such enormous depths of feeling, from anxiety to rage to guilt and shame, it's no wonder there may be considerable avoidance around the subject. But by omitting specific attention to this area in our training programs and our continued learning, we are perpetuating a lot of unclarity and *unconsciousness*—which all too often results in some degree of abuse of the patients, and sometimes of trainees. Also, it means that therapists are left feeling isolated when confronted with problems and questions in this area. It is treated like incest in the family; the feeling may be there's no one to talk to when faced with such a dilemma.

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So my goal in presenting this material is to provide a *beginning* and a *direction* for further exploration and clarification. In addition, I want to make a very strong plea for more thorough and systematic attention to these issues in our training programs.

The Task of the Oedipal Phase

When a patient enters the therapist's office, he or she is coming as one with needs or problems to an authority for help and is about to engage in an intense and intimate relationship. The nature of the situation sets the stage for a parental transference. At some point, if not immediately, oedipal feelings and oedipal issues are going to be a part of that transference.

In working with the sexuality and sexual feelings of the patient—whether of the same or the opposite sex—it seems to me necessary that from the beginning, whatever the developmental level of entry, the therapist must be clear about the oedipal phase and the oedipal task. So I want to begin by reviewing what we all know very well.

The child, from roughly age three to five or six, when more of his energy is focused in the genitals than prior to that time, experiences an intensification of feelings for the parent of the opposite sex. Also intensified are his desires to be special, to be the only one, and all others are seen as rivals. He is thrown into conflict by his rivalrous feelings toward the same sexed parent whom he also loves and from whom, at the same time, he fears reprisal. Inevitably he experiences rejection by the object of his desires. During this tumultuous time, the seeds are sown for his functioning as a sexual adult; and when the conflict reemerges in adolescence, the pattern will become set. For normal, satisfying sexual functioning, the task to have been accomplished in *this* phase of development is the following: *One needs to have had one's sexuality and sexual feelings acknowledged and affirmed, freed from the oedipal object, and claimed as one's own. Then one can move toward appropriate expression and fulfillment of desires.*

Most of us can readily bear witness to the fact that this task is rarely fully accomplished. What we experienced as children and adolescents was denial instead of acknowledgement, and punishment instead of affirmation; or we were victimized by the unmet sexual needs of our parents. So chances are we are still caught in a pattern of *recreating* the original situation, trying to get what wasn't given then, or trying to undo the harm that was done, and finally making it all right.

If we *had* had the ideal situation for accomplishing the task, it would look like this:

The opposite sexed parent is secure in his/her sexuality; his needs are satisfied and therefore he makes no demands on the child. The message is clear and unambivalent: "I affirm, accept, and take pleasure in your sexuality. I am not frightened by your feelings, and I make no demand on you to meet *my* needs. *And* I am *emphatically* and *unequivocally* unavailable. Therefore you are completely safe to have and experience *your* feelings. I can wholeheartedly support your movement into the world to find the right object for your passion and your love."

The same sexed parent, in the ideal situation, understands the projection of threat. Secure in him/herself, he sends this message: "I take pleasure in our likeness and similarity, and delight in the power of your sexuality. I stand behind you and support you as you confront the object of your desire, ready with understanding and empathy for the rejection and loss you will experience, and with joy and delight as you move on to find happiness and completion."

I don't need to belabor the fact that not many human beings experience anything close to that ideal with their parents. Yet when patients come into our offices, whether they are conscious of it or not, that is what they want to experience. How can we, who haven't resolved our own conflicts, offer those who come to us an ideal relationship for working through their oedipal/sexual problems? We can't. Hopefully, we can be *aware enough* of our own issues and how they may impinge on the relationship, so as to keep them out of the way, and clear enough about the nature of the task so as not to simply recapitulate the initial

trauma. We can acknowledge our limitations, and seek help for ourselves through therapy and supervision, accepting the fact that we never outgrow the need for such help.

I would like to talk about some of the things that get us into trouble. First of all I feel that a lot that goes wrong—resulting in everything from abuse to just a big mess where nothing gets accomplished—is due to a lack of understanding of the nature and power of transference.

The Nature and Power of Transference

The nature of the patient-therapist relationship is that it is an intense, intimate dyad wherein the therapist is perceived as being in control and having the power. The patient is in a dependent position. There is no mutuality in that the therapist reveals comparatively little of himself, leaving huge blank spaces that invite projection. The dyad is removed from the social context of each of the persons, and each is viewed primarily against the backdrop of the powerful emotions that are evoked. There are no external comparisons readily available, no external checks and balances. That the patient can project onto the therapist the aspects of the longed-for object means that it is the most powerful tool we have for healing and for righting the wrong. It also can be the source of the greatest destruction. It is humanly difficult *not* to misuse that power in an attempt to repair one's *own* oedipal damage. The therapist has the possibility of either seducing *or* rejecting which *he* experienced as a child.

When a therapist is faced with the ego-flattering, id-titillating force of adoration and passion, he must remember what the patient may not know consciously: that when the patient falls in love with the therapist he or she may feel she has surely found in the therapist the ideal partner, and if her love could be returned, everything would be magically okay. But on the deepest level, what she wants is to repair the damage; and if she *wins*, she loses—again.

The oedipal situation is a losing proposition. Here are the words of one woman at a conscious stage of development:

> I came to understand that, in order to work through my sexual problems, what I needed was to find a male therapist in whose presence I could be "turned on to the max" and be absolutely certain he wouldn't come on to me. He would just be there and enjoy my feelings and not get in there for himself. That was what I didn't get from my father. I had bad experiences with two male therapists. The first I felt in love with, the second I just felt wildly attracted to. Both came on to me one way or another. I hated them for that, for not understanding what it was I really needed.

Believe it or not, sometimes the response to the above account has been, "Well, what did she expect? If she's seductive, she got what she asked for." Transference is appropriate. Acting-out of countertransference is not. Whatever a patient brings is appropriate, and he or she is never to be blamed for activating the therapist's issues. Keeping the therapist safe is not the job of the patient.

When there is acting-out on any level, whether or not there is any covert blaming of the patient, the patient almost always *assumes* blame. And just as the child takes the blame by way of protecting the abusive parent, so the patient protects the therapist. And the patient, like the child, assumes the therapist must know what's right: "He must be doing it for my own good."

A few years ago, I had a female patient who, after more than a year, began to talk about her former therapy. She had been working with a man for a short time when they acknowledged a strong mutual attraction and ended up going to bed. Thereafter, they had sex during every session for about a year. She was excited and overwhelmed at first. Finally she began to realize that she was paying her therapist to have sex with her, and very little else was happening. She began to be angry, but she had great difficulty confronting him. She would rationalize and feel helpless and enjoy the ego gratification. Finally she managed to leave the relationship. When she opened up in her therapy with me, it was six or seven years later. She realized that she had

withheld this story on the one hand to protect the therapist and, on the other, out of her deep sense of guilt and shame. She felt responsible for what had happened. After she had told her story she was able to experience her rage and the sense of betrayal and of being used. The strength of these feelings hadn't abated a bit during the years in between.

I want to reiterate: *The patient is never to blame for what happens, any more than the child is to blame.* We must remember that the sexuality and feelings of the patient are on a three-to-five-to-thirteen year level, even if they are expressed in an adult body.

Duration

Sexual transference doesn't have to be acted on to be strong and deep and long-lasting. And, unless it is worked through, it lasts a lifetime. This is a point which I feel is often overlooked.

In thinking about the duration of transference, I remembered an occurrence from my own life. When I was a senior in college, I was quite smitten by an English professor who was dazzling in his brilliance and captivating in his charisma (a combination for which I've always had a weakness!). I knew nothing about him personally except that he was married, and he had several children. He was probably in his mid-thirties. After graduation, I didn't see him again, nor did I fantasize about him. I had several years of psychoanalysis a few years later, but I don't remember that he ever entered into my dreams or my therapy. Then about twelve years later, when my husband was a professor at a nearby institution, he had a colleague who was an attractive, single woman about my age. One day we got a wedding announcement from her and my old English professor. You can't imagine the inner tumult of feelings that letter provoked. I didn't know the details, but I was livid to think that this woman—my age—had wrenched him away from his wife and kids. I was in a state of anger, upset, and indignation for days. Now, clearly, this schoolgirl crush on a man with whom I had no close contact was a very strong transference. And twelve

years later I experienced just *how* strong. It hadn't disappeared, and it hadn't even diminished!

I recall a therapist saying once, commenting on the behavior of another therapist who had seduced his patient, "If he wanted to fuck her, he should have terminated her therapy!" Such a statement shows a fundamental lack of understanding for the nature of transference: *transference ends when and if it's worked through.* Stopping therapy in itself doesn't change anything. It only satisfies the letter of the law.

Teacher-Student Relationship

I've used an illustration of transference occurring in a teacher-student relationship. We know that this is a very frequent phenomenon. Because our teaching modality includes so much therapy, and transference is apt to be as salient a factor as it is in therapy, I think we must take as seriously the responsibility of the trainer toward the trainees. The norms for the teacher-student relationship are not the same. But the dynamics frequently *are* the same. The emotions can be just as strong, and the consequences of acting-out or mishandling just as great. Also, when a trainer singles out a trainee as a sexual choice, whether any acting-out takes place or not, then all hell breaks loose. All the feelings of a family are evoked: jealousy, rage, betrayal, disappointment, bitterness. Sometimes the "parent" is protected and the "child" is blamed and ostracized. All the primal stuff is evoked if not enacted. When trainers/teachers have become involved with trainees, it is *necessary* that trainers and the group have the courage and take all the time needed for careful, thorough working-through of all that is raised up. Otherwise, the destruction to the group process and the obstruction to the learning process is immense. And that is in *addition* to the damage done to the individuals.

Our responsibility as therapists and trainers is first and foremost to understand our own unresolved issues and how these may manifest themselves in countertransference.

Understanding Our Character Issues

Of course the most important way we have of connecting to our own issues is through our personal therapy. But the therapist doesn't often have direct access to the way we interact in a social context.

During the past couple of years, in working with training groups around sexual transference, I've discovered that there is a great deal of unconsciousness about how one in fact responds to the sexual energy of another person. And there is also an absence of self-perception about signals and messages sent through body language and verbal cues. For example, I recently worked with a trainee who had a very sensuous body but was quite unidentified with it. She was completely focused on early narcissistic issues in her therapy and issues of sexuality rarely came up. When she brought in her male client for supervision, she was totally unaware of the seductive gestures she made or the effect she had on her client when she sat on the couch and stretched back like a sensuous cat. The session was taped so she was able to see, and was quite shocked.

I've used a simple exercise to help trainees get in touch with these issues. In a patient-therapist dyad, I give the therapist the task of charging the pelvis, without making any direct contact. He is to work only ten minutes. The only other directive is that the therapist is to pay close attention to what is happening in *his* own body as he works. When processing that ten minutes, more often than not he discovers that his character issues have come into play. It is amazing to see how quickly the characteristic responses are activated: blocking, tightening, cutting off, going into the head, becoming overactive, becoming seductive. They may be subtle, but they are there.

Another technique I've used is that of role-playing. This exercise, too, helps to pinpoint how the characterological issues impinge on the process in the form of countertransference. And it gives the therapist a chance to get some very valuable and direct feedback from the patient about the effect of his interventions!

Overall, what is learned about working with sexual issues is: it's fraught with anxiety, it isn't easy, and it brings up all our "stuff."

Setting Clear Boundaries

In the feedback from patients in the role-playing situations, one issue that came up over and over again was the need for clear boundary-setting on the part of the therapist. To get a firm idea of just how important this is in therapy we need only to consider the effects upon the child of a parent's unclear boundaries around sexuality. In therapy the process inevitably goes awry when the limits are not clearly and unambivalently defined. What follows is the account of one woman's experience:

> In the initial session, I found the therapist attractive. When I told him about my childhood, he pointed out certain things we had in common. It felt like a bond. In the third session in a reaching exercise, after struggling, I was able to overcome my difficulty with reaching out. I took his hand and then experienced the most incredible sensations of streamings through my whole body. I felt open and expanded like never before in my whole life. He commented that the whole room was filled with energy. In the fourth session I began by saying I had for the first time allowed some angry negative feelings for my husband to surface. He then said he wanted to put his cards on the table: he was attracted to me. And I was the kind of woman he was looking for. He said he wasn't going to act on his feelings, because that would ruin the therapy. I was terrified! By the next session, I felt hopelessly in love. After that he never made any advances that could really be called sexual. But there was never a patient scheduled after me, and frequently after the session he would invite me to talk about astrology or listen to music. Once we lay side by side on the carpet listening to Ravel's Bolero.
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> An enormous conflict was raging inside me. I was experiencing feelings of intense passion for my therapist I didn't have in my marriage. I was psychologically aware enough to know that my relationship with my father was all mixed up in this. I knew I couldn't tolerate the guilt of having an affair with my therapist. So I struggled for several months, fighting my passion, wanting to set it free. Finally, I came in to a session ready to declare the

> love I felt. At that point the therapist said to me that he wasn't available. Over the weekend he had renewed a relationship that had broken off just before he met me. I felt stunned and hurt and betrayed. From then on, there was a marked change in his behavior toward me. There was always a client in the hour after mine. I tried to be understanding and rational. But the hurt turned to rage. I couldn't release it. Finally, the therapist and I met with a supervisor who lent enough support that I could vent my feelings. In the discussion that followed, my therapist came to the realization that, while he had decided not to seduce me, unconsciously he felt that if I seduced him, it would be okay! I realized I had repeated my childhood experience. *I* was made responsible for keeping the limits.

Here was a situation where the therapist verbally set limits of sorts. "I won't sleep with you." Yet because he unconsciously decided he would be seduced, he was constantly leaving the gate open, so to speak, and was really seducing her to seduce him. When he suddenly behaves professionally after going back to his girlfriend, it's clear the "limits" were defined by *his* needs, not his patient's. What this woman needed, as do all patients, was *safety.* The patient cannot work through the early conflict if there is not *complete safety.* And safety means that the therapist is *unequivocally, emphatically unavailable* as a sexual love object, just as surely as the parent *should* have been unequivocally unavailable.

I want to push this point further with another illustration from my own practice. (The illustration also points up the problematic aspect of dual relationships.)

The importance of paying close and constant attention to boundary-setting throughout the process—not just initially—came home to me in working with one of my male clients.

We were working very deeply on oedipal issues and a very strong transference had developed. In the midst of this, some external changes took place: I became his trainer as well as his therapist. In our therapy session following the first training weekend we discussed his reactions. He had had feelings of sibling rivalry, which I expected. But there were other feelings I didn't quite expect. Due to certain circumstances, the training

group had to meet for one weekend in my office, in my home. I had tea and coffee available in my kitchen, which was never so with my patients. My trainee-patient suddenly had access to more of my living quarters. At lunch time the group went to a nearby restaurant, and we happened to walk together on the way. These two occurrences gave him an increased sense of intimacy with me. He felt also that as a trainer I related on a more equal basis. All this led him to fantasize that when he was certified and we were colleagues, then maybe down the road we would meet at a conference and have an affair: the circumstances had changed, and the boundaries didn't feel as firm as before. They needed to be restated. I took this opportunity to say to him what I believe to be the truth about the therapeutic alliance: Because I am therapist and he is patient, we cannot have a sexual relationship—*not now* and *not ever*—no matter how the circumstances change. I believe that if the way was left open for any hope or illusion about the future, then there would be no possibility of his working through his oedipal issues in the present *with me.*

When I stated this, the patient went into very deep crying. And after a period of what amounted to mourning, he realized he was giving up the illusion of someday winning and having his mother.

Now, when we consider the effects on our patients and students of our slightest words or actions, we can feel pretty *overwhelmed* by the responsibility.

The *other* side is: the fear of one's own feelings can cause us, as therapists, to cut off, pull back, and become completely unnatural and stilted in our interactions.

Many of us had parents who handled their feelings of attraction that way.

That is *not* the answer.

Acknowledging and Affirming the Sexuality of the Patient

The most crucial and important part of the working-through

of sexual issues is acknowledging and affirming the sexuality of the patient. The child needed to hear from the parents:

> You are a sexual person.
> You are attractive.
> Your sexual feelings are good.

That affirmation is needed before it can be so. But the feedback that was given over and over in the role-playing—which the patient *didn't* want to hear from the therapist—was: *I am attracted to you*. That was uncomfortable, unsettling, and mixed things up.

The child needs the parent to see and acknowledge his sexuality without getting involved with it. What this requires of us as therapists is that *we stay connected to our own sexuality.* We can't really acknowledge and affirm if we are cut off. The patient senses that.

When the patient is over the stool or in an exercise has opened up and has connected to the energy in the pelvis and is experiencing his sexual energy with that joyful, expansive feeling that accompanies it, we need to have the courage to be fully connected to our own sexual energy, to stay fully present and completely separate, wanting or needing nothing from the patient. *That* is the affirmation! And that is the bioenergetic approach to working with sexual transference.