The Concept of Erotized Transference

Harold P. Blum, M.D.

IN THIS PAPER, I WILL REVIEW the concept of erotized transference and will explore its pathogenesis, dynamics, and some recurrent problems of its analytic significance and treatment. Because the term erotized transference has been defined and used in such a variety of ways in recent years, an exploration of its pathogenesis, dynamics, and analytic significance seems appropriate.

Freud (1915) devoted a paper to the subject of transference love "partly because it occurs so often and is so important in its real aspects, and partly because of its theoretical interest. What I have in mind is the case in which a woman patient shows by unmistakable indications, or openly declares, that she has fallen in love, as any other mortal woman might, with the doctor who is analysing her. This situation has its distressing and comical aspects, as well as its serious ones. It is also determined by … many … complicated factors" (p. 159).

Freud early recognized and understood erotic transference as a repetition of childhood experience and expectations. In his "Observations on Transference Love" (1915) he refers to love for the analyst as particularly blind, irrational, unrealistic, and infantile. The analytic situation and process foster the development of such erotic transference, with its demands for love and gratification. Freud knew that such love for the analyst was a defensive response and resistance, a childish attachment rather than mature
love. As distinguished from positive friendly transference, such transference love was not helpful, but a hindrance to analytic work and progress. Freud does not specifically refer to "erotized transference." Sexual desire was not a unique transference reaction, nor was Freud generally pessimistic about such transference demands. He indicated, however, that those patients who insist on transference gratification, who are oblivious to insight, "who are accessible only to 'the logic of soup, with dumplings for arguments," could not be analyzed. Freud refers to the elemental passions of this class of women and their refusal to accept surrogates. It is of historical interest that Freud does not discuss homosexual transference love or erotized transference to the analyst of the same sex. He was concerned about inappropriate countertransference to the appearance of transference love.

In contrast to Freud's careful and limited observations, it is my impression that the concept of erotized transference is now used to describe such diverse phenomena as turbulent demands for physical contact, craving for sexual relations disguised as adult love or assaultive antagonism, unlimited demands for approval and admiration, the need to please and comply, dependent clinging with fear of object loss, etc.

Rappaport (1956), (1959), citing Gitelson (1952), describes the demand to be loved in the absence of a capacity for love. Rappaport stresses the patient's omnipotent strivings and the intolerance of nongratification of the transference wishes. Erotization, in his view, is not so much an expression of a transference neurosis as a tenacious resistance which replaces a workable transference neurosis. He believes this develops for the most part in patients with deficient reality testing, such as borderline or psychotic patients who demand that the analyst be a parent, unable to distinguish between analyst and parent, between the erotized relationship and reality.

Swartz (1967), in his contribution on erotized transference, presents varied phenomenology. He includes as an example a socially isolated, narcissistic woman who insisted that the analyst answer questions or propose solutions. Although "erotization" is not manifestly described in this case, the narcissistic features of these patients can be crucial and require careful scrutiny. Among his cases, he also reports what I would consider the hallmark of erotized
transference, namely, a patient flooded with erotic transference preoccupations and fantasies about the analyst and hopes or expectations that the analyst shares in these feelings. Swartz (1967), like Rappaport, relates erotized transference to failure of development of the transference neurosis and of the therapeutic alliance. He generally regards erotized transference as a complication related to unmanageable transference reactions and dominated by pregenital factors.

Menninger (1958), while stressing the resistance via erotized transference, also considers a range of such erotized reactions which are not infrequent in analysis. My own observations confirm Menninger's dynamic discussion and are in many respects consistent with other investigators. Analysts may be influenced by their direct patient experience, and the varying related viewpoints could refer to different observations of the fixity and severity of erotization and associated psychopathology.

There are countless ways, more or less disguised, in which patients may be seductive—e.g., with gifts, financial advice, etc. These reactions and those of affectionate transference and usual erotic transference manifestations are related phenomena. The erotized transference is a particular species of erotic transference, an extreme sector of a spectrum. It is an intense, vivid, irrational, erotic preoccupation with the analyst, characterized by overt, seemingly ego-syntonic demands for love and sexual fulfillment from the analyst. The erotic demands may not seem unreasonable or unjustified to the patient. The frequent flooding with erotic fantasy may continue into daily life or be displaced onto situations outside analysis, or onto fantasies after analysis, etc. The focus may not always be exclusively on the psychoanalytic situation. The erotization may be intermittent, eclipsed by silence, sleep, resentment, or numerous other detours and defensive reactions. The mood and feeling of erotic arousal—sometimes accompanied by excited somatic responses—the urge toward real fulfillment rather than fantasied substitute gratification, are often associated with an altered sense of consciousness and reality. Disturbance of the relationship to reality may be primary or represent a transient regressive alteration.

The intensity and tenacity of erotized transference, the resistance to interpretation, and the continuing attempts to seduce the
analyst into a joint acting out, as well as the frequent acting out of such a transference with a substitute for the analyst, confirm the complicated infantile reactions of these patients. These are not ordinary reactions of transference love, and these patients can resemble intractable love addicts. Their erotized transference is passionate, insistent, and urgent. While conscious discomfort and guilt may be present, the guilt may be isolated and unconscious. The conscious fear is not of regression or retribution, but of disappointment and the bitter anguish of unreciprocated love. Through projection and denial they can assume their analyst indeed loves them. For the borderline patients manifesting this reaction, transference and reality may be dangerously confused. There is the threat of regressive loss of reality testing. An engulfing erotization can appear as a dramatic aspect of a transference psychosis. Patients developing such erotized transference delusions have been predisposed by early ego impairment. The analyst may be "loved" as the single most precious object tie and reality representative.

Pregenital conflicts, severe ego deviation, or developmental arrest are not invariably found in erotized transference. I have previously (1971) described a case of erotized transference in a nonpsychotic patient without marked preoedipal fixation; the erotization was a phase of the transference neurosis and eventually yielded to the analytic process. The patient was gradually able to understand the infantile origin and nature of her transference love and its incestuous core. Her oedipal love and disappointment were revived and recapitulated in the erotized transference, with avoidance of recollection. Her love for the analyst was, she thought, a romantic development rather than a regressive repetition. She gradually tolerated the transference abstinence and tenuously maintained the therapeutic alliance during a turbulent period of treatment.

Another young woman patient became increasingly flirtatious and seductive. She was intrigued and excited by any information about her analyst. Complimentary and ingratiating attitudes concealed her more than friendly persuasion and manipulation. She praised the analyst's speech and appearance, marveled at his empathy and understanding. Announcing her attraction, she finally invited physical contact and sexual relations on the couch. She
thought of the analysis as a clandestine affair. Sex with the analyst would be beautiful and therapeutic. She found it injurious and insulting that the analyst remained aloof and nonchalantly separate from her on weekends. This patient had been seduced in childhood sex play by an older brother and had repeated sex play with him in her early adolescence. These fraternal favors were related to her wish to be the analyst's favorite, his secretly beloved paramour. Her parents had not merely failed to protect her. Her mother, who had been both homosexually seductive and puritanical with the patient during her adolescence, had passively participated in the earlier incestuous play. There was intense conflict over oedipal and adolescent masturbation. The patient presented adult symptoms of frigidity associated with depression and a "pseudonymphomania." She was far more anxious and entreating than insatiable. In her compensatory daydreams, she was lovely and adorable, surrounded by admirers to whom she was loving or disdainful. Her narcissism was extremely vulnerable, her self-esteem fragile, her tolerance of criticism minimal. The avoidance of admonition and exaggerated admiration of the analyst were narcissistic idealizations. She acted out the erotized transference with physician surrogates who represented phallic magic and power.

During intercourse she frequently had rape fantasies. These were recurrent masturbation fantasies which reflected her own overwhelming impulses and precocious sexual overstimulation. The oedipal rape fantasy also condensed earlier influences of rigid feeding, enemas, and affectionate discipline. The analyst was woven into new versions of the fantasy, isolated from masturbation. She thought of herself as a slave of love, but unconsciously wanted to excite and enslave her devalued partner. Having submitted to her imperious family, she now wanted to coerce and control her love objects. She fantasied omnipotent irresistability, also claiming she could restore potency to the impotent. Her concealed, castrating attitudes were especially dangerous, inasmuch as she unconsciously blamed herself for her brother's anomalous genitals. She feared retaliation for her envy, rivalry, and masked contempt. Her conscious guilt and need to suffer rejection were related to both her castrating attitudes and her pleasurable participation in incestuous play. Proclaiming love and desire for the analyst, she was frustrated and disappointed in her marriage and
friendships. Her current sexual frustration may have contributed to her erotic fantasy, but did not shape her childish attitudes and reactions. Actually her disruptive inner conflicts both antecedent and aggravated her marital and social discord. Her seductive provocations constantly contributed to the loss of love and respect she experienced in reality.

Savitt (1969) graphically reports the analysis of a bisexual male who developed recurrence of peptic ulcer during treatment. The inception of treatment was characterized by an intensely erotized transference with an undisguised first dream about the analyst and similar to first dreams reported by Rappaport (1959). Savitt's patient dreamt that he and the analyst were on the floor of the analyst's office; the analyst has mounted him and has anal intercourse. The patient then gets up, buttons his trousers, smiles, and leaves the office. The patient spontaneously stated that the dream portrayed what he hoped would happen. He wanted to homosexually seduce the analyst and prove homosexuality an acceptable way of life. He had been seduced by a sailor at age five, with anal penetration, and had frequent fantasies of oral and anal incorporation of the phallus. His depressed mother had died when he was six, at the height of the oedipal period. He identified with her in a negative oedipal life role. In adolescence he acted out his fantasy of being his father's wife. The erotized transference in his analysis appears to have developed from an initial continuation of his perverse interest in the analytic situation. While this might be described as a "preformed homosexual transference," it represented his life style of perverse erotization which governed his current object relations. (Strictly speaking, the repetition of current reactions with any object is not transference, although falling in love or choice of lover involves transference. Clinical transference refers specifically to repetition of the past, with the analyst having the intrapsychic meaning of a childhood object representation.) The erotized transference which developed in analysis repeated with his analyst his bisexual conflicts. Savitt analytically traced the consequences of his feminine identification. Analysis repeated the patient's underlying inadequate symbiotic relationship with his mother, his hungry pleas for love and oral satisfaction.

A florid, overt erotic transference can certainly occur where analyst and patient are of the same sex (especially if there is such
predisposition as a perversion or the uncovering of latent homosexuality). The opposite reaction is more typical. The homosexual transference is masked by an exaggerated heterosexual erotization. Erotized transference may be a direct or disguised representation of homosexual conflict.

The cases I have mentioned as representative of erotized transference all have a number of genetic features in common. Sexual seduction in childhood, especially during the oedipal phase; instinctual overstimulation with deprivation of parental, phase-appropriate protection and support; intense masturbatory conflict; family toleration of incestuous or homosexual behavior in the bedroom, bathroom, etc.; revival and repetition of precocious and incestuous sexual activity in adolescence (see also Solomon, 1967). These patients have often participated in seductive childhood games—e.g., "playing doctor," group teasing and play in the parents' or grandparents' bed, etc. Analysis may be treated as a pleasurable and perilous "game" of seduction. Narcissistic injury and fragility were associated with parental insensitivity and lack of empathy. The erotization frequently masked the trauma of repeated seduction and overstimulation, with consequent distrust and sadomasochism.

I am not advocating a return to a seduction theory of neurosogenesis, but do wish to emphasize the pathogenic role of seduction and trauma in many cases of erotized transference. The patient may attempt repetition of the seduction pattern in exquisite detail, sometimes identifying with the childhood or adolescent object who was the original partner. The patient, as an observer, a "silent partner," may be identified with the childhood figures of primal scenes and perverse behavior. Traumatic injury may lead to the later pursuit of erotized conquest. The erotized transference can be viewed as disguised forbidden gratification, but also as a distorted effort to master trauma through active repetition.

My patients were exposed to primal scenes via parental exhibitionism and intrusion into their children's privacy. In the transference they expected from the analyst, as a parental figure, what they experienced with their own parents and families. Their oedipal fantasies had more than token validation in reality. This contributed to their sense of omnipotence and to the blending or confusion of fantasy and reality. One sometimes finds intense transference
repetition, with an altered sense of reality and inability to accept their reactions as a revival of the past. The family often maintained outer social propriety while denying their seductive complicity. The familial denial further distorts reality. This is a model for a seductive style, but also for the later isolation of erotic preoccupation from other interests and feelings. It is of interest that the less disturbed of these patients do not always display a general erotization of their attachments preceding or during analysis but may display characteristic flirting and flaunting and/or inhibited diffidence.

The parental seduction and exhibitionism undermine and corrupt superego development. There can be paradoxical permission and prohibition of sexual gratification by a superego modeled after contradictory parental behavior. This influences the sanctioned development of an erotized analysis dissociated from the inhibitions and interdictions of ordinary life. What later appears to be ego-syntonic may once have been permitted or practiced by parents.

The prominent narcissistic features of these patients are exemplified in their fantasies of being very special, the favorite. The narcissism of the "exception" may be associated with an inconsistent, weak superego. The patient can be a privileged character, an "exception" entitled to ever-loving care, and a condemned transgressor deserving of harsh punishment.

The child who is in one sense privileged may also be both an instigator and target of exciting abuse and sadomasochistic exploitation. The confused and overstimulated child cannot bind or discharge his excitement—a hyperirritable condition which may be repeated in transference. The mood and sexual arousal of masturbation may dominate the patient's feelings, without conscious awareness of his desire to act-in masturbation fantasies (Blum, 1971). At other times the analyst may be sought, not as a sex partner, but as a control in the struggle against masturbation. The excited and altered ego state of childhood masturbation, and particularly of traumatic overstimulation, may contribute to the altered sense of reality often associated with erotized transference (Dickes, 1965).

Through seduction, the patient may also seek both revenge and reparation for his real and fantasied disappointments and loss of
the object or object's love. Norton (1963) has movingly described a situation akin to erotized transference in a dying patient with metastatic cancer. A minister's daughter suffering excruciating loss of self and objects fell in love with her minister. The oedipal revival in the face of total loss and punishment might also be related to the entitlement of the exception and a desperate reaffirmation of self-regard and self-worth.

The analyst can be loved and idealized as a long-lost and newly regained love, while the hostility and devaluation remain repressed, or isolated and acted out in the patient's external life. Under the cloak of endearing love, the patient may act out concealed coercion and destruction. The need for victory over the analyst via erotic conquest, seduction of the aggressor or oedipal rival, is linked with fantasies of passive omnipotence.

Some impulse-ridden patients will repeat their characteristic dependent clutching and object hunger with the analyst. Here the pre-eminent oral insatiability, the vulnerability to disappointment and detachment, the underlying sadomasochism soon become apparent. Narcissistic needs may be disguised through erotized ingratiating in the service of maintenance of a fragile self-esteem. The offer of love is contingent upon narcissistic object relationship and continuous admiration and approval. Pregenital and narcissistic conflicts may be fused with or represented by an oedipal façade. These patients cannot reciprocate love and are devouring and consuming with fears of depletion and engulfment. Seeking comfort and contact, they struggle with problems of infantile narcissism, separation, and symbiosis.

It would appear that erotized transference has multiple determinants and a variable course. It resembles a vehemently exaggerated, distorted form of expectable erotic transference. Erotic transference is a relatively universal, though variably intense and recurrent phase of analysis. There is a continuum from feelings of affection to strong sexual attraction, from ubiquitous unconscious sexual transference wishes to conscious, ego-syntonic, erotic transference preoccupation. It is this insistent, conscious, erotic, transference demand that is "erotized transference" proper. The erotization would serve resistance and defend against hostility, homosexuality, loss, and a host of other unconscious conflicts, while representing a revival of infantile love. All patients have
repressed impulses and attachments and, depending upon their personality structure, the potential for an erotized transference. The erotization may be transient or persistent, mild or malignant, accessible to analysis, or indicative of ego defect.

I do not believe these patients are necessarily all borderline or psychotic. The erotized transference may be only an aspect of the unfolding transference neurosis, susceptible to analysis, and not invariably implying a poor prognosis or the need for parameters. Ego regression in object and reality relationships may be only partial and reversible. The erotized transference is not necessarily an initial reaction, nor is it always a dominant trend of the transference. It may recede and recur during the vicissitudes of the transference relationship. It is not necessarily presaged in the first dream or in the initial analytic hours. As overdetermined manifest content, its significance may not be understood early in the analysis. Early erotization does not absolutely imply ego defect or analytic failure. The transference form and content may be pregenitally determined, as might occur with an oral narcissistic character, but can often be a highly seductive oedipal constellation. It should not be overlooked that the Oedipus complex is the child's first advanced passionate love affair. A "loving" resistance need be no more insuperable than belligerent attitudes or protracted negative transference. This assumes preservation of the analytic pact and reversible transference regression in favorable cases.

The more intractable cases often have a long history of instinctualized relationships and impulsive, self-defeating behavior. Less common is the opposite history of withdrawal, detachment, and apathy. These refractory patients display defective object- and reality ties. They have primary preoedipal conflicts rather than core oedipal conflicts with defensive regression. They lack ego capacity for neutralization and delay. In erotomania—the malignant erotization associated with severe ego impairment—analysis is usually impossible or contraindicated owing to the presence of imperative impulses with an ill-defined sense of identity and reality. Erotophobia is the reciprocal of paranoia, to which it is closely related. A history of erotomania may be more indicative of the insatiable and inaccessible than the erotization which is first prominent as a regulated transference regression. The patients with characteristic promiscuity, or perverse or addictive tendencies will
try to continue these patterns in the treatment relationship. If a controlled and circumscribed erotized transference should later develop, with generally improved object relations, it is an analytic achievement implying developmental change.

Falling in love with the analyst is not a requirement for therapeutic success, nor is erotized transference always a harbinger of analytic failure. Analyzability of the transference depends upon intact ego functions and the patient's capacity for ego development. The erotized transference should be evaluated in terms of the quality of the transference structure, e.g., preservation of ego boundaries, fusion or splitting of object representations, etc. The patient's total personality is evaluated, including autonomous strengths and potential resources. The chance resemblance of the analyst to a childhood object has been cited (Rappaport, 1959); (Bibring, 1936) as an explanation for unmanageable transference which is too real. In my opinion, resemblances in appearance or attributes are primarily significant because of investment with transference fantasy. The analyst as a "sex symbol" requires symbolic understanding. The analytic problem is not realistic minor resemblance, but the differentiation of past and present, fantasy and reality.

It is certainly true that in an erotized transference the therapeutic alliance and the patient's ego autonomy are severely tested. These patients may have tendencies to severe regression and acting out. They prefer immediate pleasure and play to the difficulty of inner maturational change. They would like the object world to change or alter on their behalf. Magical expectations (and manipulations) are related to the fantasied "love cure," so popular now—and never entirely out of vogue. The patient may exchange symptoms for an erotized transference cure which evades the analytic work and discomfort in resolving infantile conflicts. They may have difficulty in understanding "transference illusion," the "as if" nature of transference, and that so much of the analytic relationship is a repetition of the past. The analytic situation is viewed as a seduction or a danger to be warded off by seduction.

Yet, with the neurotic character disorders presented here, the defensive pleasure ego never fully overwhelmed the sense of reality and reason. These patients did not inexorably demand more time, special arrangements, or appointments, let alone direct sexual
gratification. The imploring and insistent seduction could be tempered and tamed. The patients did not interrupt or quit treatment. When their yearnings were verbally integrated into adult awareness, they could take no for an answer. In many areas their functioning in external reality outside the analysis remained relatively mature and intact. Sometimes they spontaneously recognized the erotization of the transference as a treasured fantasy, an adolescent crush, an old erotic daydream. Psychoanalysis and the analyst may have been sought in terms of reward, rescue, or cure by love.

The erotization is usually neither fully accepted nor desired. Indeed, there may be profound unconscious condemnation and fear of loss of control. The analyst was blindly loved, but was also evaluated for reliability and emotional regulation. The analyst was teased to lose control, and tested to maintain control. The patients could gradually appreciate the benevolent neutrality and ethical safeguards of psychoanalysis. They had hidden respect for the integrity of the analytic pact, despite vocal deprecation. The patient protests the analyst's lack of response, and seductively protests too much (cf. Knapp, 1967). The same patient may propose and also disapprove of sexual activity in analysis. The reasons may range from the classical sexual tease who frustrates and cannot achieve or enjoy, to mature rational and moral judgment.

Seductive response by the analyst can have varied consequences, including corruption and disruption of treatment. A pathological relationship can be maintained under the guise of treatment and affection. Patients can "flee into health" from their own unconscious impulses, or from their therapist's conflicts. Even where erotized transference appears to be ego- and superego-syntonic, this may only be manifest content and only part of the picture.

It is not surprising that the disturbed and disappointed patient should want to be loved and fulfilled. The adult patient, however, also comes for help to adapt and achieve in the uncertain world outside the analytic setting. Gratification of neurotic transference wishes would reinforce childhood fixations and undermine reality and autonomy. In the unfortunate circumstances where sexual seduction is realized in the analytic situation, the pathological results

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are severe. Fixation to infantile modes of gratification and impairment of superego regulation of both patient and analyst occur, together with an inherent predisposition to betrayal and abandonment. Masochistic love may be linked to sadistic impulses to degrade and destroy the analyst. The omnipotent conquest is often a pyrrhic victory. Both narcissistic grandeur and narcissistic injury are reaffirmed. The traumatic childhood seduction can now be repeated in reality. Sexualization of the analytic process may impair or preclude all further analysis. The problem of abstinence in the exquisite intimacy of the analytic situation and the boundaries of legitimate analytic gratifications have been explicit issues of discussion and humor since the practice of psychoanalysis was instituted. Freud (1915), contemplating bilateral temptations for both patient and analyst, wrote: "It is, therefore, just as disastrous for the analysis if the patient's craving for love is gratified as if it is suppressed. The course the analysis must pursue is neither of these; it is one for which there is no model in real life" (p. 166). The unswerving analytic task Freud then proposed was to deal with these "most dangerous mental impulses" and "highly explosive forces" in order "to obtain mastery over them for the benefit of the patient" (p. 171).

Patients can be friendly, affectionate, grateful, even loving—in sublimated form—to their analyst as to others. Many patients have the objectivity and acuity to perceive the analyst's real personality, his limitations and frailties, as well as his talents and abilities. Appreciation of appealing personality or physical characteristics of the analyst may blend with erotic transference, but this realistic appreciation is, per se, neither infantile nor irrational. Analyst and patient do have a real relationship apart from transference. They also encounter each other as new objects, but under extraordinary conditions and in a unique situation. The "tilted relationship"—the analyst's anonymity and neutrality and the patient's regressive transference—is alien to mature social exploration. In the charged analytic situation, the pleasure of love and love of pleasure can be an all-too-welcome escape from analytic abstinence and the recurrent encounter with disappointment and hostility. The analyst can enjoy the aggrandized glory of the patient's childish attraction and adulation. The analysis can be silently stalemated by an unconscious
conspiracy of mutual admiration and endearment. There can be a subtle
repetition of the parents' use of the child for their own narcissistic needs.
Countertransference can divert the tensions of transference into shared erotic
fantasies or frightened flight. It can anchor the patient's fantasies and
transference reactions in the reality of actual seductive responses of the
analyst. Analysis can be deadlocked in the embracing arrest of
countertransference.

Nevertheless, countertransference is neither a necessary nor sufficient
cause of erotized transference. There is also no one-to-one relationship
between erotized transference and erotic countertransference. The erotized
transference, for example, can be employed as a characteristic defense of
masochistic love in the face of a sadistic countertransference. Analysis can
summon, stimulate, and support, but not artificially create an erotized
transference. The source of transference is in the endogenous fantasies and
unconscious past conflicts of the patient.

Erotized transference tested the therapist and complicated the treatment in
the pioneer investigations of Breuer and Freud. Breuer withdrew from the
prolonged intimacy of the "talking treatment" and fled from the erotized
reactions of the patient. Freud developed an analytic attitude and with
emerging insight discovered a new type of neurosis, the transference neurosis.
The analysis of the complexities of the transference neurosis, with its
fluctuating vicissitudes, may permit the unfolding and resolution of intense
erotized transference. The disguised repetition and distorted effort to repair,
the mobilization of regressively erotized ego states and seductive styles of
defense, can be worked through into a new adult ego synthesis. In favorable
cases psychoanalysis will permit the ego growth from erotized transference
into the capacity to love both wisely and well.

SUMMARY

The concept of erotized transference is differentiated as a subspecies of
erotic transference. Though more common in patients with impaired ego
function, erotized transference is not limited solely to these patients. The
erotization may recede and recur with transference vicissitudes. Analyzability
depends upon resources of
the total personality and capacity for ego growth. The significance and
meaning of erotized transference is explored, with special reference to
regressive repetition of childhood seduction and masturbation, and a
seductive style of defense. The analytic situation is a seduction or danger to
be warded off by seduction. Defense against hostility, homosexuality, and
narcissistic injury is prominent. Parental seduction and denial of complicity
are models of seductive style and superego corruption. The sense of reality is
frequently altered and the more severe cases display defective reality testing
and object relations. Narcissistic and preoedipal problems are formative
influences, sometimes with an oedipal façade. The narcissism of the
"privileged character" may be expressed in insistent favoritism as an
exception. Sadomasochistic exploitation may be disguised as erotic conquest.
Erotized transference can also be viewed as a distorted attempt to master
trauma via active repetition. In the more benign cases, oedipal passions and
disappointment may be the core conflict. Erotized transference is not
necessarily ego syntonic in depth, and can be anchored in countertransference
responses.

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