

Sexual Attraction and Phobic Dread in the Countertransference

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Since the middle of this century, countertransference theory has steadily evolved to a point where we now find abundant references in our literature involving extremely useful self-disclosive examinations of a broad spectrum of potentially disruptive countertransference responses. Our collective attitude of openness and even excitement at the potential usefulness of such responses in deepening our understanding of our patients, ourselves, and the nature of our work has been profoundly beneficial. And yet despite our advances from the early days of psychoanalysis when powerful countertransference was viewed strictly as an impediment, an atmosphere of disapproval and dread continues to pervade the phenomenon of erotic countertransference, which in turn contributes ironically to the alarming incidence of sexual abuse of patients by therapists of every orientation and level of experience. The roots of our collective intolerance are explored, beginning with Breuer's treatment of Anna O and Jung's entanglement with Sabina Spielrein. Case material is presented involving erotic countertransference, and a position is taken regarding future directions that are vital to our profession.

My inspiration for organizing this symposium came from my work with a woman whom I had been treating for many years before I gradually found myself experiencing sexual and romantic feelings that were unfamiliar and quite disconcerting. In turning to the countertransference literature, I found little that was helpful in any way.

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Since about 1950, we have benefited from an ever-increasing number of papers involving open acknowledgment and self-examination relative to a broad spectrum of difficult and potentially destructive countertransference responses entailing such feelings as hate, rage, despair, boredom, greed, fear, anxiety, and envy. We have been able to learn of their efforts not only to avoid destructive enactment but also to make constructive use of their countertransference responses, thereby deepening their understanding of themselves, their patients, and their therapeutic interactions. We have come a long way toward overcoming what Little referred to in 1951 as our "paranoid or phobic attitude" toward countertransference. Even among ardent classicists, the blank screen ideal has been replaced by the understanding that countertransference, broadly defined as the therapist's total response to the patient, is a universal and potentially useful element in all treatment relationships (**Abend, 1989**).

Yet, despite our advances, our profession remains paralyzed by phobic dread of countertransference that is sexual or desirous in nature and by a glaring and deeply unfortunate absence of self-examining papers on the subject. Although in recent years we occasionally find papers involving fleeting reference to erotic countertransference material (e. g., **Scharff, 1992; Weinstein, 1988; Wittkin-Sasso, 1991**), the only substantial investigations of this topic of which I am aware are a truly remarkable and courageous paper written by Searles in 1959 and a very recent panel presentation by Kernberg (**1992**). The absence of papers reflects an implicit, pervasive opprobrium that is actually made explicit in a 1992 paper by Wolf that states unequivocally that a therapist's sexual arousal or attraction is always indicative of psychopathology, whether or not the erotic urges are acted upon.

I am not speaking here about a matter of comfortably abstract theoretical proportions. It is my contention that our collective intolerance and dread of erotic countertransference paradoxically contributes heavily to the appalling, documented incidence of sexual abuse of female patients by roughly 7-10% of male therapists of every stripe and level of experience (**Carr and Robinson, 1990**) and has done so since the earliest beginnings of psychoanalysis.

Sexual transgression by therapists with patients represents a fifth column sabotaging our profession from within. It is neither an accident nor a manifestation of collective resistance to psychotherapy that our profession

is repeatedly vilified for this in film and in the national media. To a large extent, we have brought this treatment upon ourselves, not only by inadequate policing, as some would suggest, but by our failure openly to acknowledge, examine, and understand erotic countertransference as it exists prior to its blatant enactment in the form of sexual transgression.

Although a percentage of abusing therapists is unquestionably predatory by design, studies indicate that a larger percentage become swept up in powerful transference-countertransference enactments in which all perspective is lost and grossly misguided action occurs. Gabbard (1994) has identified two such dynamic patterns of abusing therapists, referred to as “lovesickness” and “masochistic surrender” on the part of the therapist. It is especially disquieting to note that research indicates the majority of sexually abusive therapists believe that, in general, sexual involvement with a patient is destructive but that somehow theirs was a special case that was not harmful and possibly was even therapeutic to their patient (Carr and Robinson, 1990).

Many of the papers that are appearing represent postmortem case studies of abusing therapists who have subsequently entered treatment, often involuntarily. Although such papers may serve some purpose, the emphasis upon the extreme psychopathology of the abusing therapist also serves to add to the atmosphere of collective opprobrium and dread of erotic countertransference and may make it more difficult for the independent practitioner who is struggling to acknowledge and understand erotic responses to a patient before they spill over into destructive enactment. As Twemlow and Gabbard (1989, p. 73) assert, it is common for therapists to consider unethical colleagues as “impaired, sick, and most of all different” from ourselves, but none of us can safely assume that we are “immune to the temptation for exploitation,” sexual or otherwise.

Gutheil and Gabbard (1992) point to the recent trend to politicize sexual transgression by therapists, supplanting systematic investigation with the “politically correct” view that “thoroughly evil male therapists prey on helpless female patients.” The notion that we are all vulnerable to committing some form of transgression is replaced by the false reassurance that we need only “eradicate the bad apples” (Gabbard, 1994).

Similarly, Gabbard cites Averill et al. (1989), who propose that our view of therapist-patient sex is heavily colored by the sexual stereotypes of our culture in which men are the seducers and women are the

seduced. In their study of female therapists' sexual involvement with male patients, the male patients were typically seen as victimizing their female therapists.

Unable to benefit from the constructive experiences of others because they go unreported in journals and meetings, well aware of the existing atmosphere of collective intolerance, the “good enough” individual practitioner who is not predatory by design may understandably become fearful of sexual feelings for a patient and try to drive them underground. This in turn sets the stage for destructive enactment, either in the form of seductive behavior and outright sexual transgression or compensatory distancing under the banner of technical neutrality and abstinence.

The source of our collective resistance to the awareness of erotic countertransference appears to have its roots in incest taboo. As I have suggested in a previous paper (Tansey, 1992, p. 551), our resistance may be compared with the resistance of the parent who feels guilty about having become furious with his or her child. Although those feelings might be difficult to acknowledge to another person, I believe they would be far less difficult than discussing even fleeting feelings of sexual arousal for one's child, even at the level of fantasy and feeling that is not in any way acted upon. Anyone who has had to contend with erotic countertransference understands that similar incest taboos apply to therapists. As Searles (1959) pointed out, the risk is that the therapist will be charged “with trying to portray as natural and necessary to the analytic process generally certain analyst-responses which in actuality ... are dangerously out of place in his own work with patients, and which have no place in the well-analyzed analyst's experience with his patients” (p. 299).

To understand the history of our collective dread of erotic countertransference, we must return to the treatment of Anna O by Breuer, the very case that launched psychoanalysis in 1880. As discussed by Gay (1988), Breuer treated Anna O for about two years. His written case summary indicated that she was completely recovered. But as Freud would reveal much later in a letter to Stefan Zweig in 1932, Breuer subsequently told Freud in strictest confidence that, in their final session in her home, Breuer found Anna O “confused and writhing with abdominal cramps. Asked what was the matter, she replied, ‘Now comes Dr. B's child’” (p. 67). Breuer immediately fled the room, transferred Anna O to his Swiss colleague, Robert Binswanger, and

left the following day on a second honeymoon with his wife. Gay (1988, p. 68) suggests that Breuer's terror of what we would today call his erotic countertransference was clearly the cause of his distress. Although Breuer had been Freud's close friend, mentor, and financial supporter, their differences over the treatment of Anna O and the underlying sexual causes of neurosis contributed to their bitter rift in the 1890s.

Breuer's response to Anna O undoubtedly held as much interest for Freud as did Anna O's transference to Breuer. Yet Freud did not introduce the term countertransference into the literature until 1910, referring to it as an impediment to be overcome. Obscure by comparison, as Carotenuto (1982) reports, the first known usage of the term was in a letter to Jung on June 7, 1909, regarding Jung's prolonged and potentially scandalous sexual entanglement with his patient Sabina Spielrein. Despite our neglect of erotic aspects of countertransference, the passage demonstrates beyond any doubt that the very origin of the term itself emanated from Freud's efforts to account for sexual urges on the part of analysts, himself prominently included:

Such experiences, though painful, are necessary and hard to avoid. Without them we cannot really know life and what we are dealing with. I myself have never been taken in quite so badly, but I have come very close to it a number of times and had a narrow escape. I believe that only grim necessities weighing on my work, and the fact that I was ten years older than yourself when I came to psychoanalysis have saved me from such experiences. But no lasting harm is done. They help us to develop the thick skin we need and to dominate the "countertransference," which is after all a permanent problem for us; they teach us to displace our own affects to best advantage. They are a blessing in disguise. The way these women manage to charm us with every conceivable psychic perfection until they have attained their purpose is one of nature's greatest spectacles [McGuire, 1974, pp. 230-231].

Acutely sensitive to public opinion of his new science of psychoanalysis, Freud's insouciance reflected in this passage appears to mask what must have been his genuine alarm to learn that his "crown prince" had become hopelessly involved in a sexual affair lasting many years with

one of his first patients. Spielrein's diary, her correspondence with Freud, and her letters to Jung have recently been made available to us (Carotenuto, 1982). With cross-reference to the Freud-Jung letters (McGuire, 1974), it is possible to gain fascinating entry into what Jung himself, after several years of dishonesty and dissembling, finally admitted to as his "piece of knavery" (McGuire, 1974, p. 236) with his young, attractive female patient, who would later become a distinguished analyst in her own right. Only the letters from Jung to Spielrein are missing, prohibited from publication by Jung's heirs for what appear to be obvious wishes to avoid incrimination.

As the diary and letters make all too clear, neither Freud nor Jung behaved well in the Spielrein affair, both tending to blame her for what had occurred and to downplay the seriousness of the issues involved. Not long afterward, of course, Freud and Jung parted bitterly. Like the break with Breuer 20 years earlier and with Ferenczi 20 years later, the rift with Jung is attributable not only to theoretical differences regarding underlying pansexuality, but also to tensions arising as a consequence of erotic countertransference.

We know, of course, that Freud wrote conspicuously little about countertransference, mentioning it only a handful of times in all his voluminous writings despite its painfully apparent salience to the analytic process. In attempting to account for this glaring lacuna, Cremerius (1989, cited in McGuire, 1974) cites a letter from Freud to Jung near the end of their friendship in which Freud says, "I believe an article on 'countertransference' is sorely needed; of course we could not publish it, we should have to circulate it among ourselves" (p. 476). Cremerius asserts that Freud's coyness reflected his fear of "the double standard of Victorian morality ... which would have considered the fact of a doctor being sexually excited by a patient an occurrence meriting legal action" (p. xiii).

Although very different from what he actually practiced, Freud (1912) recommended "emotional coldness" on the part of the analyst, who must put aside all his feelings and emulate the surgeon (p. 115). In his "Observations on Transference Love," Freud (1915) made several incisive comments regarding countertransference, so much so that were the paper written today, it could very well be titled "Observations on Transference-Countertransference Love." Throughout the paper, he emphasized the need to "keep the countertransference in check" so that "we may not suddenly one day go further than we had intended" (p. 164). In

an evident reference to Jung, he refers to those analysts “who are still youngish and not yet bound by strong ties” and may fall to “the danger of making a man forget his technique and his medical task for the sake of a fine experience” (pp. 169-170).

But as Gabbard (in press) points out, Freud (1915) was not consistent in his insistence that the analyst recognize that his patient's love “should not be attributed to the charms of his own person” (p. 164). Gabbard cites Gay (1988, p. 565n) in the case of Horace Frink, a favorite patient of Freud who he wanted to head the psychoanalytic movement in America. In 1923 during his analysis with Freud, Frink decided, with Freud's encouragement, to divorce his wife and marry one of his own patients. The consequences were disastrous; following his first wife's death only a month after the divorce, Frink suffered a psychotic breakdown, and his marriage to the patient collapsed after only a year.

Gabbard (in press) refers to a number of distinguished analysts who have crossed over into sexual relationships with patients. He mentions Otto Rank with his patient Anais Nin; August Eichhorn with his patient Margaret Mahler; Karen Horney with a much younger male candidate in treatment; and Frieda Fromm-Reichmann, who stopped her analysis with a patient in order to marry him. We can be certain that this constitutes only a partial list of familiar names.

Clinical Discussion

Having strongly advocated the need for open clinical discussions, I now turn to the case mentioned earlier in which I found myself having decidedly sexual and romantic feelings for a particular patient roughly three years ago after several years of thrice weekly treatment. Most disquieting was that I had never before experienced anything even remotely similar in intensity or duration. Prior to the development of my erotic countertransference, I discussed my work with this woman in terms of the management and understanding of countertransference despair in working with severely depressed, hopeless patients (Tansey, 1990). At that time, I wrote of a repeated sense of myself as feeling like a parent “hearing a small, very frightened child crying out for help from somewhere off in the darkness,” and yet this parent finds himself “inexplicably paralyzed and unable to move or even call out, only able to remain still and listen to the cries that gradually faded away to whimpering and then silence.”

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This imagery was no doubt prompted by her pattern of frequent crying in my waiting room, faintly audible through the soundproofing. When I would come out for her, I would invariably find her struggling massively to compose herself and radiate her tears amidst profuse apologies for having become upset. Tears would be exceedingly rare in the sessions themselves, having been replaced by a sort of stiff, formal style of relating that no amount of interpretation or confrontation succeeded in penetrating. I described my attempts to break free of the feeling of paralysis and despair and become more active in interpreting what had become my role as the advocate of hope. Soon after writing about the case, I became increasingly aware of sexual and romantic feelings, accompanied by apprehension and guilt that interfered with my ability to become curious about my growing response.

Although I do not consider myself ever to have been in danger of actual sexual transgression with my patient, the attraction was undeniably strong. I found myself wondering what it would have been like had I met her under other circumstances. She is single, five years younger than I am, very bright and accomplished. Though many would find her physically attractive, she had never really captured my attention in this way over all the years of previous work.

My patient has always conducted herself with me in an extremely formal manner. Although her deep attachment has always been evident, she has steadfastly resisted my attempts to explore this with her, typically responding with derisive replies such as, “Oh, I see, here we go again with the vacation interpretations. That just explains everything so neatly, doesn't it?”

Searles (1979) maintains that many therapists who actually become sexually involved with their patients do so out of feelings of frustration at not being able to help in the ways they have been taught, leading to “the illusion of a magically curative copulation” (p. 431). Certainly I had been experiencing chronic frustration at not feeling able to penetrate the defensive barriers with which I was confronted. In addition to its hostile and aggressive elements, I believe the metaphor of sexual penetration also symbolically expressed my wishes to feel that I could more effectively reach this woman.

All along, she has demonstrated a powerful need to sterilize the relationship and to keep me at a safe distance. But the full extent of her overwhelming sense of danger did not become evident until shortly after

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the point in treatment when I found myself feeling erotic attraction and a bewildering experience transpired that has indelibly shifted the nature of our work.

For no apparent reason, the patient appeared for session in extreme distress. Although it was not uncommon for her to sob in my waiting room, when she could not stop herself, it was evident that something unusual was occurring. In response to her inability to compose herself, she repeated, "I'm sorry, I'm sorry, I'm so bad!" I remember leaning forward in my chair, making eye contact, and quietly asking her what it was about allowing me to see her so upset that made her bad. What followed was absolutely stunning. Suddenly, she rolled her eyes into the back of her head, wrapped her arms tightly around herself, leaned over the arm of her chair as far away from me as she could, and screamed, "No! Don't hurt me! Where can I go? Who will help me? Somebody's got to help me! Please don't hurt me!" Her cries were so loud that in my shock and surprise, I became anxiously aware that others in the building could very well hear her sounding for all the world like someone who was being raped.

I found myself confronted by a daunting array of emotions. Merely as a consequence of the manner in which she was interacting with me, I found myself feeling like an unwilling rapist, if such a thing is even imaginable. The person sitting before me was simply not the same person I thought I had come to know quite well over nearly a decade of treatment.

Her cries and convulsive sobbing continued the entire session, rapidly punctuated by statements in a disconcertingly composed and adult voice, "Don't believe me. I'm only faking. This can't be real. You have to believe me that I'm just faking." I had previously been highly skeptical of so-called dissociative states, viewing them as therapists colluding with patients' defensive tendencies to reify aspects of self in order to disavow responsibility. But I have undergone a diametric shift in my thinking as a consequence of my experience in that session and the regular interactions that have occurred in the ensuing three years. Although no memories of sexual abuse have ever been retrieved, my experiences with what can only be described as the terrified child-self of my patient who entered treatment with me on that day are reflected with uncanny accuracy in the superb paper by Davies and Frawley (1992), in which they movingly elucidate the dissociative phenomena of adult victims of childhood sexual

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abuse and the transference-countertransference patterns that tend to arise in their treatment. Although it is not possible to say with certainty that my patient was in fact sexually abused, such a history would be entirely consistent with the transference-countertransference experience as it has unfolded. This, of course, in no way certifies that abuse did in fact occur.

Since this session, my erotic attraction to my patient has subsided considerably. I now understand it to have signaled an important development in the treatment having to do with an intensification of my patient's massively dissociated feelings of affection and yearning for closeness with myself, with simultaneous feelings of true terror at the possibility that such feelings will break through into consciousness. My erotic countertransference appears to have represented a living response, as Racker (1957) says, to my patient's transference, signaling a complementary identification with role reversal on my part, which mirrored similar feelings of yearning toward myself that she herself appears to have disavowed (see Tansey and Burke, 1989, for a fuller discussion of these dynamics). If in fact my patient was sexually abused, my sexual attraction may also be understood as a complementary identification with the abusing object, activating powerful feelings in myself that would threaten abusive repetition of trauma that could not be remembered.

My erotic countertransference has been largely superseded by my awareness of a countertransference dilemma in which, on one side, I feel as if I am abandoning my patient and colluding with her conspiracy of silence if I do not push for the emergence of her dissociated child-self. Gabbard (1992) describes this as the wish to avoid enacting the role of the "uninvolved mother" who engenders a sense of nonbeing and deadness in the child by making no effort to stop familial incest. On the other side, if I do push for contact, given the initial tidal wave of my patient's fear with which I am predictably met, I have no choice but to find a way through the very disturbing experience of feeling as though I am sexually assaulting a helpless, terrified child. The literalness of my patient's experience at such times is highly unnerving for me. In addition, initiating this form of interaction goes against my own training and experience of remaining neutral and interpretive, and it constitutes what could be characterized as "manipulating the transference" rather than interpreting it. All that is required for me to enter the utterly different

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world of my patient's child-self is to move my seat closer, lean forward, and make eye contact. As Davies and Frawley (1992) have described with such patients, the therapist cannot effectively function as "dispassionate commentator":

The patient must experience herself as all: victim, abuser, and savior; and the analyst must do the same. Therapist will seduce patient and patient will seduce therapist as part of the natural process of intimate bonding. Both will think long and hard, during the course of this work together, about the nature of abuse and the differences between benign and malignant seduction [p. 30].

A relatively predictable pattern to our sessions has emerged, the regularity and structure of which I believe helps both of us to manage the powerful feelings that come up. Typically, there are a few minutes of ordinary analytic contact at the beginning of each session. Invariably the patient begins to flinch and roll her eyes. Once I lean forward and make eye contact, she will begin to behave much as she did in the first such session, placing her head on her knees and hiding her face in her hands. During the next phase of the session, I tend to speak to her in a very quiet voice, emphasizing that I understand that my closeness makes her very afraid, that it is my intention not to harm but to help, and that I refuse to believe that she is faking. In some sessions, there are long stretches in which I might sit quietly while she sobs uncontrollably, often repeating softly, "I hurt, I hurt." Increasingly, she seems at such times to be able to find comfort in my presence and my voice. What is starkly different from before is my feeling that I have finally reached her in some very important way, rather than being forced to listen helplessly from a distance.

As our work has progressed, the period of intense fear that marks our crossing of the threshold is clearly diminishing. Invariably, she oscillates between terror and expressions of extreme shame and apology. Repeatedly, she will ask in a very childlike voice, "Have I hurt you? I hope I haven't hurt you. Will you forgive me? Please, please forgive me. I'm so sorry." It is as though she fears that somehow, I will have been injured by coming into contact with her essential badness.

When about ten minutes remain, I quietly mention to her that she will "need to come up soon." Gradually she sits up and slowly makes eye

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contact. It should be emphasized that eye contact for her seems far and away to be the most difficult aspect of this entire process, which has an unmistakably hypnotic quality.

In the last few minutes of each session, I tend to be fairly vigorous in enlisting her collaboration about what we have just been through. During this phase the mutative effects of new experience give way to an overriding emphasis on interpretation and insight. My strong belief is that there is a critical need for us to build bridges between the two profoundly disconnected sides to her personality. It seems indisputable that a protective function is served by the dissociation. But rather than understanding my patient primarily in terms of a Winnicottian false self that has emerged to protect the true self, more important, as Davies and Frawley (1992) emphasize, I see the two sides existing as mortal enemies that desperately require mediation.

The process has demanded that I continuously ask hard questions of myself. There can be no doubt that the "kaleidoscopic transference—countertransference" picture (Davies and Frawley, 1992) has been heavily influenced by my patient's activating powerful concordant and complementary responses within me via mechanisms of projective identification. But as Hoffman (1983) points out, just as I am not a blank screen, neither am I an empty container. The patient did not simply "put these feelings there." I am aware, for example, that I am no stranger to the childhood experience of needing to bury sadness, loneliness and pain and that indeed, my need to find a place for my own softer side is one of the personal characteristics that drew me inexorably into the field of psychoanalysis. Although I reject the notion that my primary motivation for making contact with my patient's dissociated child-self is vicariously self-serving, I am well aware that as a by-product of our work I, too, have been profoundly influenced. It has led me to consider much more seriously the profound happenings that may be occurring within others that simply do not meet the eye. I find myself taking much more literally the existence of a softer, protected side, not only within my patients, but also within myself, my family members, and others who are close to me.

Although I am encouraged by what I consider to be a number of palpable improvements in the areas of work, love, and play in her life, many questions remain. Prominent among them is my concern that the intensity of the therapeutic involvement bonds her to me in a

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manner that creates more of a barrier than a bridge to more satisfying outside relationships.

In closing, my hope is that my presenting this material will contribute toward an opening up of discussion and dialogue about an area that too long has remained in the shadows. If we are to avoid recoiling in fear from our erotic responses to our patients, as Breuer recoiled, and if we are to resist succumbing to its sirenlike temptations and fatal illusions, as Jung succumbed, our path must be marked by open acknowledgment and investigation. As Benjamin (1988) has proposed, "The first step toward unraveling the bonds of love ... means not to undo our ties to others but rather to disentangle them; to make of them not shackles but circuits of recognition." Her words are no less true of therapeutic relationships than of those found elsewhere in life.

References

- Abend, S. (1989), Countertransference and psychoanalytic technique. *Psychoanal Q.*, 58: 374-395. [→]
- Averill, S. A., Beale, D., Benfer, B. et al. (1989), Preventing staff-patient sexual relations. *Bull. Menn. Clin.*, 53: 384-393.
- Benjamin, J. (1988), *The Bonds of Love*. New York: Pantheon.
- Carotenuto, A. (1982), *A Secret Symmetry*. New York: Random House.
- Carr, M. & Robinson, G. (1990), Fatal attraction: The ethical and clinical dilemma of patient-therapist sex. *Canada J. Psychiat.*, 35: 122-127.
- Cremerius, J. (1989), Preface to Kant's Dove: The History of Transference in Psychoanalysis by A. Carotenuto. Wilmette, IL: Chiron, pp. ix-xvi.
- Davies, J. M. & Frawley, M. G. (1992), Dissociative processes and transference-countertransference paradigms in the psychoanalytically oriented treatment of adult survivors of childhood sexual abuse. *Psychoanal. Dial.*, 2: 5-36. [→]
- Freud, S. (1910), The future prospects of psychoanalytic therapy. *Standard Edition*, 11: 141-151. London: Hogarth Press, 1968. [→]
- Freud, S. (1912), Recommendations to physicians practicing psychoanalysis. *Standard Edition*, 12: 109-120. London: Hogarth Press, 1968. [→]
- Freud, S. (1915), Observations on transference love. *Standard Edition*, 12: 159-171. London: Hogarth Press, 1968. [→]
- Gabbard, G. O. (1992), Commentary on "Dissociative processes and transference-countertransference paradigms ..." by Jody Messler Davies and Mary Gail Frawley. *Psychoanal. Dial.*, 2: 37-47. [→]
- Gabbard, G. O. (1994), Psychotherapists who transgress sexual boundaries. *Bull. Menn. Clin.*, 58: 124-135.
- Gabbard, G. O. (in press), On love and lust in erotic transference. *J. Amer. Psychoanal. Assn.* [→]
- Gay, P. (1988), *Freud: A Life for Our Time*. New York: Doubleday.

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- Gutheil, T. G. & Gabbard, G. O. (1992), Obstacles to the dynamic understanding of therapist-patient sexual relations. *Amer. J. Psychother.*, 46: 515-525.
- Hoffman, I. Z. (1983), The patient as interpreter of the analyst's experience. *Contemp. Psychoanal.*, 19: 389-422. [→]
- Kernberg, O. (1992), Love in the analytic setting. Presented at annual meeting of American Psychoanal. Assn., New York, December.
- Little, M. (1951), Countertransference and the patient's response to it. *Int. J. Psycho-Anal.*, 33: 32-40. [→]
- McGuire, W., ed. (1974), *The Freud/Jung Letters*. Princeton, NJ: Princeton University Press. [→]
- Racker, H. (1957), The meanings and uses of countertransference. *Psychoanal Q.*, 26: 303-357. [→]
- Scharff, J. S. (1992), Projective and Introjective Identification and the Therapist's Use of Self. Northvale, NJ: Aronson.
- Searles, H. (1959), Oedipal love in the countertransference. *Int. J. Psycho-Anal.*, 40: 180-190. [→]
- Searles, H. (1979), *Countertransference and Related Subjects*. Madison, CT: International Universities Press.
- Tansey, M. J. (1992), Countertransference theory, quantitative research, and the problem of therapist-patient sexual abuse. In: *Interface of Psychoanalysis and Psychology*, ed. J. W. Barron, M. N. Eagle & D. L. Wolitzky. Washington, DC: American Psychological Assn., pp. 539-557.
- Tansey, M. J. (1990), Countertransference despair, the hopeless patient, and the capacity to be alone. Presented at annual meeting of Division 39 (Psychoanalysis) of the American Psychological Assn., New York, April.
- Tansey, M. J. & Burke, W. F. (1989), *Understanding Countertransference*. Hillsdale, NJ: The Analytic Press.
- Twemlow, S. W. & Gabbard, G. O. (1989), The lovesick therapist. In: *Sexual Exploitation in Professional Relationships*, ed. G. O. Gabbard. Washington, DC: American Psychiatric Press, pp. 71-87.
- Weinstein, R. S. (1988), Should analysts love their patients? The resolution of transference resistance through countertransference exploration. In: *Love: Psychoanalytic Perspectives*, ed. J. F. Lasky & H. W. Silverman. New York: New York University Press, pp. 192-199.
- Wittkin-Sasso, G. (1991), A female analyst's use of desire. *Contemp. Psychoanal.*, 27: 687-695. [→]
- Wolf, E. (1992), On being a scientist or a healer: Reflections on abstinence, neutrality, and gratification. *The Annual of Psychoanalysis*, 20: 115-144. Hillsdale, NJ: The Analytic Press. [→]

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