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Please (Don't) Want Me:

THE THERAPEUTIC ACTION OF MALE SEXUAL DESIRE IN THE TREATMENT OF HETEROSEXUAL MEN

Abstract. In certain clinical situations, desire and arousal are significant components of the intersubjective field. In these cases, the analyst's wish to bear witness extends to both mind and body. This article will explore the impact of absent, violent, or otherwise unavailable fathers on their heterosexual sons and the resulting longing for male attention, admiration, and love, which often includes a need to be admired physically and romantically in ways their fathers could not provide. When this desire emerges in the treatment, the male analyst who experiences an erotic countertransference response and can manage potential anxiety and shame is in a unique position to provide the patient with these necessary supplies. Two case examples will be considered.

Keywords: erotic countertransference, desire, love, therapeutic action, father hunger, gay, heterosexual, psychotherapy, psychoanalysis

Love, Sweet Love

SHORTLY AFTER MY UNCLE DIED, his widow came to visit us. Only in her 50s at the time, I remember that she seemed old to my 5-year-old self, perhaps sad but also vibrant and very much alive. As she took me for a walk through the courtyards of the large garden apartment complex where we lived, my aunt sang a song that has stayed with me ever since: "What the World Needs Now, Is Love, Sweet Love. . . ." Sadness and longing etched the sounds and rhythms into my soul—they have never left. Looking back, I'm certain that I learned something on that walk, and not only about my aunt's experience of pining and loss: now I, too, had a piece of music that resonated and articulated an already familiar part of my experience. In later years, that grew to be only one component of a larger musical repertoire that holds these feelings for me.

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It sometimes troubles me—though perhaps it shouldn't—to consider the possibility that many of us may be drawn to this field in search of love. If we subscribe to the notion, put forth by Alice Miller (1981) and others, that what draws us to our work is in large part an attempt to rescue and heal our parents, then I don't see it as being much of a leap to suggest that part of what motivates us is the hope that we will be able to instill or restore a capacity for nurturing and loving, which often springs from or leads to our own loving feelings. Of course, if we're speaking of love between parents and children, we must also speak of Oedipal dynamics and Freud's (1900) mention of the mother's and father's sexual partiality for their sons and daughters, respectively; Ferenczi's (1925) efforts to explore the full range of analyst–patient love; Loewald's (1960) focus on the analyst's use of love as a necessary part of therapeutic neutrality; Reik's (1967) discussion of the emotional stakes for parents on their side of the love affair; and, more recently (whether parent or child)—as Jody Davies (2003) and others point out—simply falling in love. Whether or not we believe a quest for love is part of what drives some to become analysts, we would probably agree that our work is often intimate, and, at its core, intersubjective, dyadic, and, though perhaps not always and certainly not exclusively, loving. Not surprisingly—all in a day's work, I might add—we sometimes fall in love.

In the Beginning

Almost from the beginning of psychoanalytic time, much has been written about the (usually) female patient's tendency to fall in love with her (usually) male analyst (Freud, 1958b/1915). Freud's early writing and the later literature address the analyst's erotic experience as well, though until recently it was mainly presented as a cautionary tale (Blum, 1973; Jacobs, 1986; Kernberg, 1994; Gabbard, 1989). Freud himself was clear about the dangers inherent in acting on erotic feelings that arise as part of the treatment, although the advice he gave to at least one analyst who wanted to marry a patient (Kramer, 2006), as well as examples set by key and lesser-known figures in the history of psychoanalysis, were at odds with Freud's teachings (Crews, 1998). Though an important part of our work has always been to emphasize the difference between thought or affect and deed, so severe were the dangers and repercussions for sexual acting out as a result of love or lust, that this freedom to acknowledge

and explore our sexual and romantic stirrings was mostly denied us—save, I believe, for a brave and revolutionary article by Searles (1959)—until the interpersonal, relational, and intersubjective systems perspectives began to take hold. Today, there is writing that explores the full range of the analyst's affective and fantasy life, including the erotic, and a literature that examines this still relatively new frontier of the analyst's psyche for diagnostic and intersubjective data. In a few instances, predating and certainly paralleling and emerging from this literature, is a small body of work that addresses the therapeutic action of analytic love, though still mostly split from the erotic (DeForest, 1954; Tower, 1956).

Early Stirrings

Davies (2003), building on Searles's pioneering work, discusses the rarely articulated mutual erotics of the Oedipal phase, and compares the analyst who experiences an erotic response to the Oedipal parent in the throes of passion and fantasy. The analyst, however, usually contains these feelings (although not in one controversial case that she shares in an earlier article [Davies, 1994]). Davies is one of the first to elaborate the therapeutic benefits of recognizing an erotic countertransference position. Like Hirsch (2010) and Celenza (2010), Davies mentions the curative aspect of Oedipal and (later) clinical erotic love for the patient who may never have had the chance to be adored and be the object of the parent's idealized romantic interest. As it can be for the parent in love with her child, the analyst who may be feeling not only love, but deep attraction for a patient, can utilize this subjective state in a way that leads to experiences of hopefulness, agency, and contentment for patients, even (or perhaps especially) if these feelings are contained by the analyst rather than articulated. More recently, Atlas (2012) writes about the diagnostic data that can be gleaned from an erotic countertransference and used in service of the therapeutic action.

Both Ogden (1997) and Bollas (2001), writing about the therapeutic process, note the value of unconscious-to-unconscious communication rather than direct self-disclosure. Indeed, enigmatic (and therefore unconscious) seductive elements are likely to be present and part of the therapeutic action being described (Laplanche, 1995). Therefore, "in offering hope . . . that relationships can be nourishing and not abusive, mutual and not exploitative, in recognizing and affirming . . . we inevita-

bly encounter the borders of our own seductiveness, a seductiveness that requires no sexual words" (Davies, 1998, p. 807). Slavin (2007) suggests that in order to help our patients love more fully, the analytic relationship must be able to contain and embrace both the imprisoning and the liberating potential of love, including the benign and malignant aspects of the seductive component that Davies explores. In separate responses to Davies's (1994) article in which she acknowledges erotic feelings to her patient, Slavin (in press) mentions it can sometimes be important to move beyond mere containment and unconscious-to-unconscious communication to directly share "moments of truth," whereas Gentile (in press) notes that the dialectic we aim for in treatment occurs in the space between desire and dialogue, a figurative if not literal place that feels closest to my own understanding of where I believe the therapeutic action of the analyst's erotic desire resides.

All of these writers also note the importance of the associative value of our fantasies and reverie, and the data that would be missed were we to close ourselves to the erotic in our patients or ourselves (see also Dimen, 1999). Indeed, we need to consider the clinical dangers inherent in rejecting any aspects of the patient's or analyst's subjectivity. When it is missing, we must also wonder about the absence of not only the patient's, but also the analyst's erotic fantasy and energy, and the deadness that may be filling the space instead.

Gender and the Erotic

In turning our attention to the erotics that arise in the treatment of men and, more specifically, men in treatment with male analysts, Hirsch (1997) notes that socially and otherwise, heterosexual men commonly prefer the company of other men. We might understand this preference in a number of ways, including positive identifications with or longings for a father, and fears of submission to, dependence on, and engulfment by female figures. For similar reasons, male analysts may prefer to work with male patients, though as is true outside of the consulting room, both parties are likely to be warding off the emergence of erotic material. There seems to be little mention of the male or even female analyst's homoerotic experiences in the literature. I will discuss, later in this article, how this may differ slightly, though in some ways not significantly, in work with homosexual patients and/or analysts.

Several writers have noted that erotic material is likely to be dissociated and therefore remain unrecognized by heterosexual, and in many cases even homosexual, male patients or analysts (Person, 1985; Thomas, 2003). Hirsch (1994) discloses an awareness of his own erotic affective experience with a male patient, which he believes fell just short of sexual arousal only because of his own anxiety and inhibition. As Benjamin (1995, p. 60) states, "The practicing toddler's 'love affair with the world' turns into a homoerotic love affair with the father, who represents the world. The boy is in love with his ideal. This homoerotic, identificatory love serves as the vehicle of establishing masculinity, both defensively and creatively; it confirms his sense of himself as subject of desire." Hirsch believes that the male analyst who cannot be open to this aspect of his subjectivity deprives the male patient of an opportunity to experience the aforementioned homoerotic love affair with the father. The analyst's fear mirrors or induces the patient's fear, a sure sign that unacceptable desire is being blocked from the treatment. If the analyst cannot go there in the countertransference, we can assume the patient will not be able to go there in the transference or otherwise.

Corbett (2009) notes that although there is little contemporary discussion of the erotic fantasy lives of male analysts working with female patients, there is even less written about the erotic lives of male analysts treating male patients. According to Corbett, absent from the developmental or psychoanalytic literature is any consideration of:

> the luxury of the paternal embrace, the potentialities of the paternal "yes," the paternal body as a site of sustaining growth . . . the paternal remains a site of "no": the guard against incest, the usher of separation. Male-to-male eros is materializing only as it sets in play the identificatory antecedents of separation . . . largely devoid of father-son erotic exchange, other than to stand as an example of mature heterosexual desire. (pp. 231–232)

To summarize, the male analyst's difficulties in the countertransference may be in the area of tolerating the patient's need for or expression of sexual love, or aggressive, competitive dynamics that may be a defense against this love. In many such cases, the analyst might need to face his own unresolved issues around gender and sexual identity, including fears of intimacy, love of or attraction to other men, and/or issues concerning aggression and envy.

Sexual Orientation and the Erotic

Just as we cannot separate gender from our conversation about erotic experience in the subjectivity of the analyst, neither can we overlook sexual orientation, as fluid and nonfixed as that may sometimes be. Until this point, we have focused primarily on the heterosexual analyst. But what of the gay male analyst? If we bypass outdated reports of assumed pathology, we find almost nothing in the literature about gay male analysts prior to the 1980s or 1990s (Isay, 1989), and even recently, only minimal reporting or exploration of the analyst's erotic experience. Notable exceptions are Drescher (2003) and Blechner (2006), as well as Sherman's (2005) examination of his erotic feelings for a gay male patient that, once recognized, allowed for the patient's eventual ability to explore previously dissociated sexual and historical material, which then became a crucial part of the treatment and his growth.

Likewise, the gay male analyst's clinical work with heterosexual male patients has been barely mentioned until the last decade, and even then very little has been published on this topic, and almost nothing that deals specifically with the gay male analyst's erotic responses to his heterosexual male patients. The one exception I could find is Sherman's (2005) book. In one passage, the author discusses his sexual arousal to one straight male patient as an antidote to an otherwise deadened clinical experience. He believes that his fear and shame around these sexual feelings prevented the erotic from being as accessible and useful as it might have been had the patient been gay, and the analyst less terrified of being discovered and less vulnerable to embarrassment and rejection.

Indeed, shame, fear of discovery and rejection, vulnerability, and a host of other painful remnants of childhood, adolescence, and the early stages of adulthood are familiar feelings for gay male analysts. Hiding from oneself and from others is often *de rigueur* and, until recently, necessary at most psychoanalytic training programs, many of which did not admit openly lesbian or gay trainees (Aron & Starr, 2013). Although no longer politically correct or legal, some of these programs are still unofficially concerned about training or referring heterosexual patients to lesbian or gay candidates and graduates (Kuchuck, 2008). Thus, these are likely factors that have contributed to the dearth of published material about erotic feelings experienced by gay male analysts. Though not the main focus of this article, shame and concern about vulnerability of ex-

posure and accusations of pathology have made it difficult for straight female and male, and lesbian analysts to publish in this area as well, though to a lesser extent. This article, though foremost an attempt to answer theoretical and clinical questions that have arisen over the years and to address an underexplored area of research, also springs from a deeper well. It is also an effort to sublimate and compensate for my earlier experiences of shame, identity, coming out, and training-related traumas and the need to hide—for historical/developmental reasons, for training and referral reasons (especially as a young candidate and beginning clinician), and under the burden of a classical first training that taught all candidates and member analysts to hide evidence of our subjectivity.

Hiding, of course, takes its toll. The very act induces shame, anxiety, fatigue born of hypervigilance lest one inadvertently disclose subjective characteristics such as "deviant" sexual orientation or "arrested development," as some of the assigned texts in my first training program described (Socarides, 1960; Siegel, 1988). I did not dare come out to teachers, supervisors, or in most cases, even to classmates. To a certain extent, and for an extended period of time at least, training and training analysis were even significant factors in my inability to come out to myself. My experience is far from unique (Drescher, 2008; Sherman, in press), although not one that is often discussed and, as noted, most likely a significant factor in the underreporting of same-sex erotic transference–countertransference dynamics.

Therapeutic Action of the Gay Analyst's Erotic Experience

These feelings of needing to hide and of "otherness" are an important part of my self-state constellation and overall identity. I find it interesting, but not unusual and certainly the result of work in later personal analysis, that these states are held in tension with an awareness of relative comfort and safety in the heterosexual world where the majority of family, friends, colleagues, students, and patients reside. Though I work with a significant number of female and gay male patients, a large portion—and sometimes the majority—of my practice is made up of heterosexual men. Consequently, a large portion, if not the majority, of my subjectivity contains an erotic element that I believe enhances the therapeutic work with many of these men. It is this phenomenon—the therapeutic action

of the gay male analyst's erotic experience in his work with heterosexual male patients—that will be the focus of the remainder of this article.

Some writers differentiate between erotic, quasi-erotic, loving, and romantic (Hirsch, 2010; Lichtenberg, personal communication, October 13, 2011) when discussing the parents' Oedipal feelings, and/or in later life with regard to what I call the analyst's erotic countertransference responses. Although I believe that to a limited extent these distinctions can be made in some cases, I also assume that there is usually an erotic component on both sides of an Oedipal love affair and in most intensely loving or romantic adult relationships. Therefore, I use the terms "erotic transference/countertransference" or "erotic experience" to mean the erotic, quasi-erotic, romantic, and deeply passionate, loving feelings that the analyst and/or patient feels emotionally, physically, and/or sexually. When present, the anti-erotic countertransference must be understood as well (Blechner, 2009). I believe that much of what follows can also be applied to the various gender and sexual orientation dyadic configurations. As I noted before, however, because others have written about those configurations, and because there are dynamics specific to this particular analyst/patient population, I will focus on the homosexual analyst/heterosexual patient dyad.

When I reflect on what factors in my personal history and personality are stirred by, and potentially enhance, my work with these heterosexual men, a number of possibilities come to mind, including Herzog's (2001) well-named notion of "father hunger" and how, in various manifestations and to various degrees, this has gnawed at and propelled me forward, always seeking, longing for male contact, for feeding that might sate. In my work, I'm often aware of a need and aptitude for making contact with and feeding the hungry boys—they and me—who inhabit the bodies of the men who sit before me. As Celenza (2010) says, we are in love with our little-boy and little-girl selves. It is not difficult to love or even to fall in love with these men, and as long as I am able to differentiate what I project from what is already there in these patients, the boundaries remain permeable enough for identification, but secure enough for sound clinical work.

To return to my aunt for a moment and what "the world"—or at least she and I—"need now," I believe that it may be this need to love and be loved that has enabled me to be attuned to a similar need in my patients and, in particular, to patients whose gender and core issues of paternal

absence and abuse resonate with my early history. Heterosexual identifications that live alongside strong female, nurturing internalized objects, which are easily accessed by many gay men (including myself), further the projection, recognition of, and compelling desire to care for and heal these wounded child states. This is an important part of the healing power of the erotic.

Clinical Examples

William

William, now 33, came to see me about five years ago after breaking up with his on-again, off-again childhood sweetheart and with a stalled career as a musician. Financial and career worries and concerns about his romantic future propelled him to accept the referral from his then girlfriend's therapist, though a great deal of embarrassment about seeking help delayed his start. He is a strikingly good-looking man, and a number of male and female patients who have seen him in the waiting room have commented on this. Part of me hesitates to present this patient or this aspect of him. I imagine some readers asking, "Who wouldn't feel erotically drawn to such a person?" I believe that what is of primary interest here is not so much the "if" or "why" of attraction, although that is certainly a tool for understanding ourselves and our patients' intrapsychic and interpersonal dynamics and how to approach the work. Rather, I want to focus on how my erotic experience of this man became a useful, integral part of the treatment. Over the course of time, though shy and hesitant to let himself be listened to and heard, William managed to tell the story of an isolated childhood, a sad and lonely one, in which a workaholic attorney father and beleaguered mother leave him for large parts of the day during latency and adolescence to keep an eye on the elderly, demented uncle who came to live with them, an older brother lost to heroin, and a younger sister left to her own devices. This uncle was prone to bursts of verbal aggression and, over time, physical aggression as well, and—though well-meaning—father was, too, especially as financial and other stressors began to mount. This was a chaotic house, one in which people were coming and going, father was rarely present and, when he was, he was often silent and brooding—sometimes frightening in his large and angry physical presence. Mother was scattered and overwhelmed, and William had a sense of being forgotten, overlooked,

retreating to his room or the mountains adjacent to their house. Fantasy became a refuge, and no one seemed to notice his absence. Speaking, at home and then in school, became fraught as William was acutely aware of feeling he was too much or too little for his parents, and not enough for his teachers. He felt self-conscious about his growing body and changing voice in early adolescence, and, as he experienced this daydreaming, body-based shame and other distractions, he found it difficult to follow along in class. Although baseball and clumsy, halting, tender first love came along to partially save him, he soon became a target of bullies, returning home with black eyes and other assorted bruises after being jumped on numerous occasions. His father was enraged that William did not fight back, at first encouraging him to do so, then threatening punishment, and on at least several occasions, hitting his son or locking him out of the house for his refusal to answer physical violence in kind.

I sit quietly with William. I'm aware that a still, focused presence invites and calms him in a way he needs in order to tolerate and, over time, cherish being heard. I like him from the beginning and, unlike his father, find his nonlinear, freely associating mind refreshing. Rather than feeling anxiety, anger, and a compulsion to force control and compliance, I appreciate his flow of thoughts and affects, and feel more naturally aligned with this part of him than with his internalized father/self-states that want to fight my acceptance. I admire his creativity and focus, his attempts to learn how to make room for his needs so that he can eventually create space to allow his girlfriend back in without fear of totally submitting to her. Like leads to admiration, attraction hastens love, and then moments when I am aware of feeling in love. It is that intensity of loving, erotic affect and bodily states that allows me to feel, and therefore to indirectly communicate, a level of attunement and intensely felt appreciation that comes close to replicating what I suspect he might have had at some point with his mother, but perhaps not with his father. On the contrary, as noted, William was ignored or subject to tremendous anger and criticism from his father, and his body was assaulted at home and outside. In fact, physical evidence of these attacks remains imprinted on his posture. Although this has somewhat shifted over time, he initially carried himself in an extremely hunched manner, shrinking his height and large frame as much as possible. Indeed, his father seems not to have been in love with him in the ways necessary for optimal development, or at least at some

point was unable to tolerate those feelings of love, perhaps fleeing from the homoerotic component of that love as fathers (or some male therapists) sometimes do from sons (and patients). These are not feelings or attitudes I directly articulate to William, because I feel that to do so would be overstimulating and disregulating, which is probably true for most treatments, regardless of analyst/patient gender or orientation. This is likely to be especially true with male patients, where the need to dissociate from such feelings is particularly powerful, especially in a dyad where the patient's sexual orientation would not ordinarily lead to a conscious awareness of such feelings.

Despite this lack of articulation, I believe that William knew he was loved by me and I believe that on a pre- or unconscious level, much as the Oedipal child knows whether he is passionately loved or not—in similar, albeit quasi-sexual ways, William was able to make use of my attraction and fleeting romantic fantasies (what Corbett, 2009, describes as a form of paternal erotic countertransference) in ways that, over time, allowed him to trust his capacity to love, to be loved romantically, and to begin to rework previously defeating and defeated internalizations. I also believe that, as is almost always the case with an erotic countertransference, my never sleepy or deadened state meant I could be with him more consistently and completely than we are sometimes able to be with patients, and probably contributed to my heightened state of attunement. Mirror neurons are at work at times like these: an awareness of my body in relation to his, leading to an awareness of his body in the presence of mine (Knoblauch, 2005), creating space in the treatment for us to explore previously dissociated or repressed feelings of shame regarding his body and physical self.

Most reports in the literature about the analyst's erotic experience are offered as a response to the patient's sexual attraction (Freud, 1958a/1912, 1958b/1915; Gabbard, 1994, 1996; Mann, 1997). If we consider the intersubjective nature of our work, however, we cannot always know with whom these feelings begin. My hunch is that it is often the analyst who first experiences these feelings, whether consciously or not, especially in the dyads I'm discussing; however, this is not always the case. Regardless of where the feelings begin, the important point is that the analyst's erotic state becomes part of the therapeutic action, and this awareness of the erotic often mirrors or creates space for a similar state in the patient. William and his girlfriend did date again, moved in together, got married, and had a baby. At various points throughout the treatment, I experi-

enced myself as his father, mother, siblings, accepted or jilted lover, and various additional self-other configurations. During a period of time when child care became a problem, William brought his baby boy to a series of sessions. Less a distraction than a new way of relating and an opportunity for each of us to feel our child selves and fathers in the room, the experience stirred fantasies for both of us. William would usually hold his son on his lap or upright on the couch next to him. Because of the intensity of his baby's eye contact and verbal communications and, later, crawling that brought him to my feet and on one occasion to my lap, I had the feeling of speaking more directly to and from very young child self-states and father self-states. Perhaps not surprisingly, I also had the fantasy of our being a couple, raising this adorable baby together. On some of these occasions, I felt a rivalry with my patient's wife. How could she possibly be as good a partner and co-parent as I would be? I suspect that to whatever extent this fantasy might have been sensed or shared by my patient, there was a therapeutic benefit to feeling the Oedipal father/therapist-lover on his side.

As I suspected, I was not the only one to occupy these transferential spaces. One day, William, knowing I had a patient waiting, and rushing to leave, found his hands overflowing with baby, toys, diaper bag, and coat. I asked if he needed help. William asked me to close the back of the baby harness. As I stood behind him closing the strap, both of us realizing we were sharing a moment of greater physical proximity and intimacy than probably ever before, he laughingly said what I was also thinking: that it felt like I was closing his bra strap and zipping him up while he rushed out of his lover's apartment lest he be discovered.

Jonathan

Jonathan first came to see me nearly 15 years ago when he was in his late 20s and struggling with issues of depression, intimacy, and social anxiety. A struggling painter, Jonathan's father left his mother and older siblings when he was 2, disappearing for years and reappearing for only occasional contact—usually amounting to no more than a birthday call each year until he reached his early 20s, when sporadic, minimal, inconsistent, and disappointing contact became established. Jonathan's mother pined for her ex-husband and fluctuated between neglect and overreliance, leaving Jonathan feeling exposed, vulnerable, and responsible for her physical and emotional well-being. In separate fits of rage less than a year apart, his mother threw his beloved oldest brother, and then his

other brother, out of the house, sending them to live with the father Jonathan barely knew. There were additional childhood traumas, including an instance of inappropriate sexual overstimulation and play with a teenage boy in the neighborhood, and anal penetration by a man his mother knew only minimally, but had asked to babysit one evening shortly after his father had left the home.

In sessions, Jonathan is terrified that I will seduce and penetrate him—physically, sexually, and otherwise. In the early days of the analysis, I kept my interpretations to a minimum and mostly to myself, aware of his fragility and attuned to his need for me to prove my benign caring even while feeling not only erotically stimulated at times, but also uncharacteristically predatory, which is not unusual when working with a survivor of sexual abuse. Jonathan was able to articulate that his fears of being penetrated yielded to simultaneous or alternative wishes to sexually and otherwise turn me on and be penetrated by me. I understood these efforts as not only residue of the sexual abuse, but also an inevitable remnant of intense father hunger, albeit more consciously sexualized than for many, though to some extent a normative desire of the pre- and Oedipal child. The wish is that I, unlike his real father, will want to claim him as my own, just as he longs to be my son and romantic partner, a buffer against and alternative to his erotically charged relationship with his mother and abusers (Atlas-Koch & Kuchuck, 2012). This scenario terrifies Jonathan during the early years of therapy while he questions his sexual identity, preferences, and safety around and hunger for a man; it is exciting and more pleasurable in recent years as he becomes more comfortable acknowledging his heterosexuality and exhibitionistic creative, erotic, and other urges—coming out of the closet, as he calls it with some irony. Dating, sexual fantasies, and sex itself, once tremendous sources of anxiety and shame, are now much better tolerated and even enjoyed. And for the first time in his adult life, painting is experienced as more gratifying than frightening, and has finally become a financially sustainable endeavor.

Even with a patient who has not been sexually and otherwise exploited like Jonathan, it can be difficult for the analyst to tolerate erotic feelings without feeling a preponderance of anxiety, guilt, and shame, especially if the patient does not share the analyst's minority-status sexual orientation. However, to the extent that I have been able to contain and at times even enjoy these feelings when they arise, I believe that I have been able to help Jonathan learn to contain and enjoy his own ini-

tially frightening erotic feelings, including a wish to sexually excite and allow himself to be sexually excited—by women primarily—without feeling that his sexual appetite will get out of control and be destructive. Even when abuse is not a part of an individual's history, power often becomes sexualized, and because of the inherent power differential in therapy, this is one reason why the erotic may become a central dynamic for analyst and patient alike. Stoller (1979) believes that hostility is a component of most sexual excitement, serving as "an attempt to undo childhood traumas . . . that threatened the development of one's masculinity or femininity" (p. 6). Jonathan and I have, in fact, been surviving enactments of power, sexuality, and hostility (Harris, 2006). Sexual desire, or at least his desire for me to desire him, plays out in his fantasy of purchasing me as he would a prostitute. With regard to having to share me with other patients, he wonders, "How can you have so many lovers? How can I ever feel okay with this open relationship?" I'm usually flattered and sometimes aroused by this attention, the beaming father-lover he always longed for.

Discussion

In both of these cases, and others I have treated or supervised, male patients who most crave (and flourish as a result of) the male analyst's sexualized responses have experienced some form of paternal neglect, rejection, or physical abuse. These factors, however, are not necessary for the analyst's erotic subjectivity to be of therapeutic value. It is the absence of physical appreciation, attraction, and holding, and the presence of what Herzog (2001) calls "father hunger," and/or childhood experiences of violent physical contact at the hands of the father or other men, that most creates the need for—and in some cases induces the presence of—this mirroring attunement and set of bodily and adoring responses in the treatment. As discussed, there is often a corresponding set of erotic feelings in the patient that might induce, parallel, or emerge in response to the analyst's own such feelings.

With both William and Jonathan, there were moments in my subjective responses during which I was acutely aware of becoming the sexually attracted, gentle (as opposed to physically abusive) father I never had, and the sometimes erotically attached brother that I have enjoyed being and relating to throughout my life; holding and loving as I wished to be held and loved, and attuned to what I perceived to be a corresponding

need for these elements in each of them. I also experienced an attraction to early, idealized heterosexual self-other states as embodied by and projected into each of these men. As with Green's (1983) child of the (emotionally) dead mother/father, the longing for physical and emotional intimacy became sexualized in each of these patients in an effort to awaken, resuscitate, and heal their and my abandoning and violent internal objects.

As is true for all subjective responses to all patients, although potentially more or less dominant and ongoing, these responses are rarely, if ever, totalistic. The erotic—as can be true with hate, sadness, or any countertransference response—usually comes about in fleeting or more extended moments during particular parts of sessions or phases of the treatment, as a result of specific self-states present in patient and analyst, and co-constructed thirds that arise as part of the work. I was not always aroused or fantasizing about romantic or sexual union with these two men. At times, I felt more fatherly, motherly (the nonsexual elements of the Oedipal and pre-/post-Oedipal parents), at times disinterested, angry, loving, helpless, or dependent: feelings I might have toward a sibling, friend, or my own parents. Except for particularly acute periods and intersubjective dynamics that may lead to an intransigent therapeutic impasse, this seems to be how the erotic countertransference and, therefore, the therapeutic potential of these states usually unfolds.

Conclusion

Although heterosexual male analysts (and female analysts, though there are different dynamics and therapeutic benefits) can also experience these erotic responses to male patients, it is because of the nature of the primary erotic attraction that the gay male analyst is more likely to experience, without dissociation, an erotic response. Therefore, if he is not too frightened by or ashamed of these feelings, the gay male analyst is likely to be in a position to consciously feel and make therapeutic use of them. Certainly, at times, gay male analysts do have similar erotic experiences with heterosexual or lesbian female patients and, of course, with gay male patients, but those configurations and resulting dynamics have not been the focus of this article.

Although I contend that analysts who do not experience an erotic, affective, and/or bodily response can still provide the mirroring, empathic attunement, and appreciation that these patients need, in some cases it

might not be enough to address and sate the kinds of deficits discussed. For the analyst who finds himself in the midst of an erotic countertransference, as with our patients' erotic transferences, we must also wonder about the possibility that patient or analyst deadness, aggression, or hate is being defended against by way of a sexualized or romantic experience. We must therefore consider the possibility that in some cases, these responses might serve as a defense against knowing or relating to our patients in more emotionally intimate, less sexualized ways, and might inadvertently blind the analyst to the patient's or analyst's non-erotically desired self and body states that also need to gain entrance into the room. Likewise, we need to investigate the opposite possibility, when the erotic seems nowhere to be found.

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