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The Sexual Fantasies of the Psychotherapist and Their Use in Psychotherapy

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Discussion by Rosalea A. Schonbar

Fantasies consist of bits and pieces of memories, thoughts, images and sounds. They are a sequence of associations organized into various forms and shapes. They have personal meanings. They can tend toward a goal, such as building a house from the blue-print of a dream castle; they then serve as an intrapsychic rehearsal for a realistic undertaking. Other fantasies have the meaning of reliving the past. Or, fantasies can be sign-posts of internal tension, illness or sexual need; they translate a body message into psychological awareness. They help a person to become aware of need or danger (similar to the function of pain). Fantasies arise on the triple-track of sensations, emotions and intellect. Like dreams, they appear with relatively little effort, yet may have important meaning for the dreamer or day-dreamer (even prior to, or without, interpretation).

Sexuality, as one of the major life-forces, finds representation in the human fantasy life. Therefore, recognition of the therapist's and patient's sexual fantasies must be appreciated as an important element in therapeutic processes. The therapist, when he works well, is geared to the patient's needs. He is open to stimuli coming from his perception of the patient, as well as to stimuli from within himself; they include theoretical hypotheses, practical therapeutic and relevant personal experiences, and spontaneous fantasies. The patient's communications stimulate the intrapsychic work of the therapist. This includes his sexual fantasies which are likely to be meaningfully related to the patient's problem constellation. The therapist needs to understand the meaning of his own fantasies in relationship to the patient. They may represent induced reactions to the patient's transference to him; they may be symbols of his intuitive cognizance of as yet not recognized psychological factors; they may be illustrations of what the patient has said in other ways; yet they may also distract from the patient into the therapist's own unrelated private world.

Many preliminary steps in the therapeutic interaction are conducted constructively in the realm of fantasy life. The therapist uses the fantasy world as one of the doorways leading to understanding and interaction with the patient.

I believe that the basic creative factor in all psychotherapy is "recognition." The patient receives curative help if one or more aspects of his personality are recognized. Recognition may be given by therapists from various perspectives and points of view. If one essential part of the patient's reality is recognized in full by the therapist, a reintegration process of the patient is set in motion. Not only disease can spread from one vector of the person's organism, but also health. If one aspect of the person is recognized, health can spread on all levels. This explains why cure can occur through therapists of various schools of thought as seemingly contradictory as those of psychoanalytic, experiential, rational-emotive, and physical-postural thought systems. Recognition comprises more than acceptance; recognition is three-dimensional. The three dimensions are awareness of the patient, the therapist's self, and the theoretical frame of reference in which therapy is thought to occur.

Existentialists and experientialists recognize the patient primarily in the immediate encounter. Rational-emotive therapy seeks to recognize the patient's logical prejudices as derivatives of emotional confusion. Postural-physical therapy emphasizes the patient's tensions and disfunctions as expressions of importance. However, any and all intrapsychic or interactional recognition may promote the patient's reintegration.

Within all psychotherapeutic schools fantasies are one of the tools of recognition. As in all intuitive processes, the therapist's fantasies have to be in tune with the patient's reality. The therapist's emotional skill rests upon his ability to produce, recognize and sift his emotional experiences with regard to their realistic meaning of recognition of the patient's reality. Faulty intuition is error. Unrelated or falsely-interpreted fantasies are artistic psychological products, not recognition.

The following example may illustrate the therapist's relatedness to the patient through fantasies, showing how the dialectic process between the patient's inner constellation, the therapist's fantasy reaction, and the patient's therapeutic integration can come to pass. A former patient, a young colleague, had indicated, yet not explored,

his attraction to me, which, in my estimate, was largely of transference meaning. After some time, I responded by stating that he or I might or might not be attracted to each other and that our task was to be aware of our feelings but not to act upon them. After a period of stagnation about this topic, in which he insisted on his wanting to sleep with me, I stated that my fantasy of having intercourse with him was that he would stand outside of himself and watch the sexual performance critically. I imagine I would feel being tested. After experiencing some shock and distress, the patient came up with a previously untold fantasy; he was a robot upon me, counting the number of his strokes and watching my movements. Years later this colleague told me that my open, yet restrictive, statement and the disclosure of my fantasy had been one of the most important and accelerating incidents in his therapy.

In undisturbed therapeutic relationships, the therapist's fantasies remain fluid with the progress of the patient. It is often more difficult for therapists—and I encourage sexual fantasies in all students—to be aware of homosexual than heterosexual fantasies. However, even the predominantly heterosexual therapist can have homosexual fantasies, for instance, by pretending to be a member of the opposite sex or by promoting fantasies of living out one's own potential homosexuality.

In the last few years I have tried to convey psychotherapeutic techniques and skills through media other than merely academic speech. Norman Liberman gave me the idea to make up a skit. Dr. Alvin Goff, Vivian Guze and I have discussed the essence of a skit we will play here. We leave ourselves open to spontaneous interplay of our fantasies as method actors. The most interesting facet of our discussion about the skit was when Al presented various patients he might impersonate, and Vivian and I checked our fantasies toward the (play-acted) patient. Although the content of our fantasies was conditioned by our different personalities and experiences, the meanings of the fantasies as they related to the patient were amazingly similar. Our fantasies were congruent in expressing transference-induced anger, attraction, estimate of the patient's dependency needs, etc.

Vivian Guze, "the therapist's fantasy," will speak what I (the therapist) may think. Vivian's fantasies are not really mine, but we will try to fuse them as if they were. Al, my patient, supposedly does not see or hear her, but reacts to my behavior and communications.

Since inner processes are a continuum, which could not be verbalized throughout the skit without disturbing overt expressions, Vivian will speak out the sexual fantasies of the therapist only. Components of these fantasies are derived from both the portrayed therapist's own needs and drives and her knowledge and intuition of those of the patient. The imagery then has to be understood as a combination of both.

Skit

(Patient enters and is greeted by the therapist.)

Patient: This is going to be my last session.

Therapist: Really? What happened?

Patient: I got a job, and I'm afraid that since it's in California, in San Francisco, that I'm going to have to stop seeing you.

Fantasy: I have great conflict. I want him to go take the job in California, but it's very frustrating to be interrupted in our work. It's like being interrupted in the middle of intercourse.

Patient: My father's friend got me this job and it's really a great opportunity.

Therapist: It sure is.

Patient: You know how difficult it's been for me to have been out of work the last few months. But I'm kind of scared about this now. They've asked me to be the manager of a liquor store in San Francisco, and all day long I've been kind of thinking about it, and it's been kind of spinning around in my head.

Fantasy: I'm really going to miss him.

Patient: And I think about this new store and I think about how clean it's going to be, and I see lots of bottles, all kinds of liquor, Scotches and gins, Vermouths and Ryes.

Fantasy: His voice makes me think of the rolling waves of the ocean.

Patient: And I get a bubble inside when I think about it. And when I think about San Francisco and what a beautiful clean white city it is, and how dirty New York gets, and how good it will be to get away, you know? I'm going to miss you.

Fantasy: I see the blue Pacific Ocean, and I have the feeling of having intercourse with him in a sailboat.

Therapist: I am glad you have the job, but I will miss you too.

Patient: You will? That kind of surprises me. But I'm glad. I haven't told my folks about this yet. I don't worry so much about my

father. I'm going to show him that I can do something. But it's my mother. You know how she's always been kind of protecting me and feeding me, and I can just hear her already when I tell her. She's going to worry, she's going to say I'm going to get sick. And you know, I may very well. What if I get an ulcer? It's going to be rough. But then I begin to think about those bottles and that store. And, you know, the climate, it's great, great climate out there. And I kind of get excited about it, more than I've been excited about anything for a long time.

Fantasy: I am beginning to feel better and better about his going there. He's going to be all right.

Therapist: You will have much more there than you have had here—for instance, you'll be able to buy things you have wanted. You can even pay my bills—in fact I expect you to pay my bills, which you haven't for many months. I'm glad I didn't push, but now you can pay them, and I expect to be paid soon. And then you can buy all the things you wanted.

Patient: Yeah, you know you've been very nice letting me build up this bill. And the salary I'm getting, did I tell you? It's going to be about $11,000 to start with. I should be able to pay you up real quick and maybe even save a little. You know, I like to sail, and maybe, who knows, in a year, year and a half, I might even be able to buy myself a little sailboat.

Therapist: You know, I'm just thinking, in a year from now there's a conference in San Francisco. Maybe I'll drop in to the store and see how you are doing.

Patient: Would you?

Therapist: Is that surprising?

Patient: Yeah, but . . .

Therapist: You really don't believe that anyone could miss you.

Patient: That's right. I don't. I don't believe it. But I wish you would if you are out there. Come in and I will show you the store. Why we might even go down to the beach. Maybe I'll have my sailboat by then. Maybe we can have a sail for a couple of hours. I would like that. I would really like that.

Therapist: It's strange that you just say that because before, when you told me about the job, I had the fantasy of being in a sailboat with you.

Patient: You did? How come?

Therapist: I wonder how come.

Patient: It's strange.

Therapist: I think the sailboat represents something to you.

Patient: You do?

Therapist: I think it's something you have wanted—to have two things at the same time, to enjoy yourself and to be responsible. You have never felt you could. It was either, or. Either Daddy, who says you will never be anything unless you work and work and you won't make it, or mother who says enjoy yourself, enjoy yourself, enjoy yourself. I think the sailboat in some way may bring the two together.

Patient: That's right. Maybe for once I can finally become myself and be a man and really do for myself. And, you know, I'm very grateful to you.

Fantasy: I really am going to miss him.

Patient: You know, I would not have been able to even begin to think about going out there if I hadn't known you.

Therapist: There are other analysts in San Francisco, and I think you should see one. I will give you some names for you to look up and—(getting up) maybe you'll send me a Christmas card.—Goodbye then and good luck.

Patient: Thanks, and goodbye.

Discussion by Rosalea Schonbar

This presentation was as new to me as it was to you. Its dramatic impact stimulated many thoughts and feelings in me, which I would like to share with you.

I believe that close attention to the fantasy from its first partial appearance to its being shared with the patient will reveal a number of therapeutic steps which eventually form the fabric of the interview and its resolution.

First, the fantasy relates the cessation of the therapy to the interruption of intercourse; this moves to a specific image of having intercourse in the sailboat; and, finally, the therapist shares a selected part of the fantasy with the patient. The first step is the therapist's awareness of her fantasy response. Without awareness, the therapist's defensive operations may interfere with the therapy; the therapist may unconsciously try to bind the patient to her, thus interfering with his decision-making progress. With awareness, the therapist is free to

utilize the fantasy to help free the patient. There is another way in which the conscious sexual fantasy may serve as a therapeutic tool. The sexual fantasy of the therapist in terms of whether or not he sees the patient as a sexual being, whether or not he responds to the patient sexually, can be used by the therapist as a gauge, to some degree, of the patient's functioning as a sexual being. One frequently can notice within oneself fluctuations in sexual responses to a given patient as the patient himself fluctuates in this dimension. I don't think it makes too much difference whether it is the same sex or the opposite sex. But the therapist can get and use these clues only if he is open to his own sexual responsiveness. Obviously this observation is not limited to fantasies and responses in the sexual area alone, but this is an area in which such openness is particularly difficult for some therapists.

In the vignette, the final step was sharing part of the fantasy with the patient. In this instance, the specifically sexual content was omitted, for therapeutic reasons which I hope Ruth Cohn will elaborate. But there are times when the sharing of fantasy material in general, and the sexual content in particular, may be very helpful within the context of appropriate timing, patient needs, and the particular stage of the therapy. At these times the therapist may accomplish several things: He not only treats the patient as a human being, but he also tells him that it is all right to be a human being, in the sense that he communicates: "I have sexual fantasies too. They don't scare me. I am sharing this with you. This means that I respond to you, I respond to the man in you. This is not frightening to me. You can respond this way to women. It doesn't mean that you have to act out. It doesn't mean that you will get sexually out of control if you allow yourself the freedom of your fantasies." In short, I think that the use of the fantasy by the psychotherapist may provide a model for some kind of identification so that the patient can incorporate this into himself.

I have outlined a couple of the things which struck me about the therapist's behavior. I'm sure that the fantasy was used by the therapist during the interview in ways which I cannot discuss, since they reflect the therapist's previous experience with this patient and her understanding of the ongoing meaning of the interview as it progressed. I'd like to ask Ruth Cohn to share some of this process with us.

Ruth C. Cohn (final comment)

I always appreciate Rosalea's unusual ability to perceive and conceptualize speeches and events spontaneously. In response I may add that all along the dynamics of the patient were clearly in my mind: the conflict between being babied by his mother into an infantile, hedonistic way of living, and being mercilessly prodded by his father to be a duty-performer who could not succeed anyway—synthesized in a personality who had to keep distance. Both homosexual and heterosexual desires remained fixated on an infantile level and forced the patient to remain distant and threatened by any kind of contact. The therapist's sexual fantasy, from the very beginning, was a fused image of her own wish to have intercourse with this basically attractive man in the romantic setting of a white sailboat in the blue ocean, and her knowledge of his wish for a sailboat as a substitute for a human relationship. From the moment that I conceived the fantasy I guided the patient, through my questions and comments, into the direction of health: to fuse the wish for enjoyment (mother) and the necessity to take on responsibility (father). My statement that he could buy, through the new job in San Francisco, what he wanted so much all along, was hopefully directed to the reply he made: "I will be able to buy a sailboat." It was, therefore, appropriate that I did not bring out my own fantasy prior to his consciousness of wanting the sailboat at that time. To express the therapist's wish prior to his statement would have been overriding the patient's need for distance and would have put me into the transference situation of being the seductive mother to whom he would have had to respond with anxiety or his usual defense mechanisms of denial, distance in ineffectuality. The same considerations for his need of distance, as well as my wish not to stir up new questions and feelings in a last session, prevented me from sharing the sexual fantasy with the patient in an unveiled way. The main goal of this session had to be the transfer to another analyst and the communication that separation would not cut off this therapist's interest in, and good wishes for, the patient's progressive development.