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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 daydreamer (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.

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.

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?

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.

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and Their Use in Psychotherapy

by

Ruth C. Cohn

ERRATA:

This paper is a very much abbreviated, edited version of a tape-recorded extemporaneous speech and skit given at the meeting of the Society for the Scientific Study of Sex on November 6, 1965. Through multiple editing and retyping several important points got lost -- among them the aforementioned fact.

Page 220 -- The author's point of view about the curative factor in all schools of psychotherapy lacks in clarity. The word "recognition" connotates the patient's recognizing something new about himself through the therapeutic interaction with the psychotherapist. Whenever the patient recognizes one element of himself clearly, such recognition can become the nucleus of positive re-evaluation of detached or distorted elements within himself.

Page 220 -- Beginning of first paragraph should read: "I believe that the basic curative factor in all psychotherapy is . . ."

Page 220 -- At end of paragraph 2, after sentence ending ". . . in which therapy is thought to occur." add the following sentence: "Psychoanalysts recognize present distortions and unnecessary defenses as representing unconscious ties to non-integrated past life experiences."

Page 220 -- Third paragraph, last line should read, ". . . interpreted fantasies are autistic psychological products, not recognition."