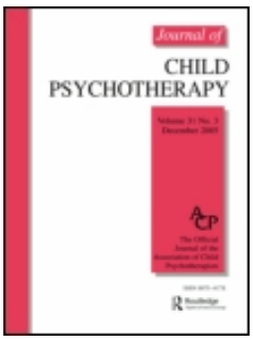

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Types of sexual transference and countertransference in psychotherapeutic work with children and adolescents

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The question of normal sexuality begins to arise in the treatment of severely sexually abused or sexually offending patients. The author suggests that it is an interesting and delicate moment during the process of recovery when less perverse, more normal sexuality appears mixed with, or even disguised by, the more habitual perverse fantasies. Writers in the adult field have drawn distinctions between perverse, eroticized and normal erotic transferences, and between Oedipal and post-Oedipal sexuality. Some have also distinguished between countertransferences in the analyst of an erotised versus a normal erotic nature. The paper discusses whether these distinctions could have any relevance for child patients. Freud and Klein have taught us much about the child's sexuality in relation to his interest in and attraction to his parents as sexual beings. But can we also detect some origins in earlier experiences in infancy of the child's later capacity to feel himself a sexual being capable of being wanted by an other? How might such a feeling of sexual self-worth differ from narcissism and from sexualised exhibitionism? The paper asks how therapists might deal with such problems and such possibly healthy developments.

Keywords: disordered sexuality; perverse sexuality; normal sexuality; transference; countertransference; psychotherapy; children

I became interested in the whole question of normal sexuality during the supervision of therapists treating severely sexually abused, or in many cases, sexually offending patients (Woods, 2003; Cottis, 2009). I then began to wonder whether I was recognising it in my own traumatised or corrupted child patients. It is an interesting and delicate moment during the process of recovery when less perverse, more normal sexuality appears mixed with, or sometimes even disguised by, the more habitual perverse fantasies. I shall have to start with some writings in the adult field first. There is relatively little written about what has been called post-Oedipal sexuality in the child field. A few writers in the field of adult psychoanalytic work have drawn distinctions between perverse, eroticised and normal erotic transferences (Wrye and Welles, 1989; Bonasia, 2001). Some have also distinguished between countertransferences in the analyst of an erotised versus a normal erotic nature (Davies, 1998; Gerrard, 2004, 2010). I want to think about whether these issues could have any relevance for our child patients. Freud (1905) and Klein (1945) have taught us much about the child's sexuality in relation to his interest in and attraction

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to his parents as sexual beings. But can we also detect some origins in earlier experiences in infancy of the child's later capacity to feel himself a sexual being capable of being wanted by an other? How might such a feeling of sexual self-worth differ from narcissism?

A brief history of psychoanalytic ideas on childhood sexuality

Just as Freud widened the term mental to include processes which took place in the unconscious part of the mind, so did he hugely widen the term sexual. First, he widened it beyond the sphere of the genital, to include various perverse impulses, which he found appearing in the fantasies and dreams of patients who did not practice such pursuits in their actual lives. He concluded that sexuality had many manifestations besides simply the genital union of coitus, and that the origin of these non-genital activities and phantasies lay in a pre-genital period in earliest infancy, a period of what he called polymorphous perversity. The source or instinct had an aim, and the aim was release of tension. At that early period of psychoanalysis, the objects of the aim, that is, other people, were seen as of relatively little importance (Freud, 1905). Tensions arose, as it were, in their own right, in the erogenous zones, where membranes were sensitive, such as the mouth, the anus and also the genital area: they were described rather like itches that needed scratching. Yet the later case study of Little Hans, like other case histories of Freud's, gives a very different, richer, more subtle impression: we read of painful conflicts between jealousy and tender love, for example (Freud, 1910).

Freud (1905) also identified what he called certain component instincts such as voyeurism, exhibitionism, sadism and masochism, which although perverse, only became perversions if they subsequently became fixed and exclusive preoccupations. Jones (1967: 317) says that Lord Tansey asked why hadn't Freud used a word like 'love' or 'desire for union', where he might have avoided the odium that came down on him for suggesting that infants were sexual, even perversely sexual beings. And in one way, with the hindsight of later studies and later theories, we too can feel irritated at the apparent pathologising – or even 'perversising', as it were – of the love-life of babies. But in another way, Freud was doing the exact opposite – attempting to find the normal elemental threads in the pathological. The problem is that the normal in the normal infant was conceptualised in the language of pathology. We still sometimes do it. We could try some alternatives, to respond to Tansey. Nowadays, instead of polymorphous perversity, we might want to use a word that conveys the global passionateness of babies; the way when they greet someone, their excitement and delight shows in every bit of their bodies. They greet us as adults do, with smiling eyes and mouths, but they also welcome us most eloquently with their circling hands and wriggling feet.

Freud thought that integration, when it came, arrived through the Oedipus complex, at around age three, whereas we would nowadays understand that it is the sheer otherness of the parents (even at the two-person, pre-Oedipal stage of earliest infancy) that first induces integration. The normal baby is attracted to his objects, and if they give him time to ponder and linger over his experience, this in itself is highly integrating. I shall also go on to remind us that he is also attractive *to* them. But returning to some limitations in Freud's concept of 'component instincts' here, written in beautiful, almost biblical prose a century ago, is William James' bow to complexity.

> The traditional psychologist talks like one who says a river consists of nothing but pailsful, spoonsful, quartpotfuls, barrelsful, and other moulded forms of water. Even were the pails and pots all actually standing in the stream, still between them the free water would flow. It is precisely the free water of consciousness [we could add, of unconsciousness too] that psychologists resolutely overlook. Every definite image in the mind is steeped and dyed in the free water that flows around it. With it goes the sense of its relations, near and remote, the dying echo of when it came to us, the dawning sense of whither it is to lead. The significance, the value of the image, is all in this halo or penumbra that surrounds and escorts it, - or rather that is fused into one with it and has become bone of its bone and flesh of its flesh. (James 1992, cited in Crapanzano, 2004)

Even the brain researchers and geneticists are warning us of the danger of thinking too much in terms of pails. The modern brain models and genetic models are extremely detailed and they are not simple. They describe an awesome complexity (Alhanati, 1992: 116; Solms and Turnbull, 1992). Of course, we cannot entirely dispense with pails either, but a word such as elements or aspects of sexual feeling seems better – or the notion that some feelings and thoughts take place in the forefront of our minds while others remain in the background, not always unconscious, maybe only preconscious as Sandler and Sandler (1994) have suggested. Maybe another term could be paraconscious – existing beside but a bit in the shadow as it were.

Freud, of course, did also have something to say about normal adult sexuality. Although in the three essays he did leave room for two currents in human libidinal life, the sensual-erotic and the affectionate, Likierman (2001: 90) points out that he did not regard the affectionate current as a primary, irreducible force. We had to wait for Klein to foreground that more object related rather than just anaclitic quality of the libido. Fornari has suggested (quoted in Lupinacci, 1998: 411) that the discovery of infantile sexuality dazzled Freud so much that it overshadowed his vision of adult sexuality – specifically of the transition, at the moment of sexual and emotional maturation, from the infantile type of sexuality, to the real existence of two genitals bound by a relationship of reciprocal symmetry. Lupinacci, agreeing with Fornari, says that

> we have here the idea of a creative and civilized complementary state of structures and functions in the male and female, in which each member of the couple taken individually, is limited and dependent, needs the other, and has in turn something to give to the other, to the mutual advantage of both (1998: 411).

Phillips (1993: 102–3) makes a related point about the nature of kissing, particularly in adolescents. He points out that there is more to kissing than the elements of sucking or eating. He suggests there is also the return of the primary sensuous experience of tasting another person, and that the kiss is the image of reciprocity, not of domination. 'When we kiss we devour the object by caressing it; we eat it, in a sense, but sustain its presence. Kissing on the mouth can have a mutuality that blurs the distinction between giving and taking.'

Klein, while holding to Freud's theory, in fact replaced the notion of component instincts with the notion of part-objects. The power of the otherness of people to attract us and affect our development was being emphasised. As is well known, the breast as the primary object of need and of desire became the focal point of Kleinian theory, although Klein also said that the baby took in understanding along with the milk. Later Bion (1962) wrote of the existence of a preconception in the newborn baby of a mind, what O'Shaughnessy calls an object that gives psychological

containment, a psychological object (O'Shaughnessy, 2006). Klein also wrote of the baby's interest in the mother's face and hands, but it is only now that we know that interest in people's faces arrive as early on the scene as the interest in breasts and bottles, that is, immediately after birth on day one (Hobson, 2002). The developmental research and Bion are immensely valuable, but we can see that moving up the body from genitals to faces and even minds may take us away from sexuality or obscure it. In any case, Klein thought that these early experiences of love and hate towards the primary object coloured and influenced the later developments in the Oedipal phase (Klein, 1945).

Green (2000) who has questioned whether infant observation and child development research has anything at all to contribute to psychoanalysis, is equally critical of what he sees as the Kleinian emphasis on infancy and what he thinks is its consequent neglect of sexuality. He certainly gets eloquently vituperative on the subject of infant research. He asked, 'What of the researcher who no longer calls the parent of the infant the love object, but rather 'the caregiver'? Do caregivers have sexual desires, do they love, do they hate, do they have fantasies, do they dream – who cares?' (Green, 2000: 58). And in a paper asking whether sexuality has anything to do with psychoanalysis, he suggests that 'The contemporary and fashionable focus on object relations, pre-genital fixations, borderline pathology and theories and techniques drawn from observations of child development have obscured the meaning and importance of sexuality in psychoanalytic theory and practice' (1995: 871). He also says that even the penis started to be seen as a giving and feeding organ, in other words a breast (1995: 876). He maintains that the role of a sexual relationship is not to feed and nurture but to reach ecstasy in mutual enjoyment. In Green's view the anal, oral or in other terminologies, the depressive position and the paranoid schizoid position being seen as older or deeper, means that they are equated with being more important and reflects 'an anti-sexual attitude which implies that sexuality is superficial' (1995: 879). Vituperation aside, Green also makes a very interesting theoretical point. He says that as a result of Freud's great paper, 'Beyond the Pleasure Principle', 'We have focussed on death instincts, but Freud, instead of sexual instincts, speaks of life instinct. Life or love instincts' (1995: 877). Interestingly, Edwards has pointed out that it is not so in Klein's paper 'On the Development of Mental Functioning' (Klein, 1958; Edwards, 2010).

I want to take account of Green's criticisms but to argue that he has left out something else important about Kleinian theory: the ways in which sexuality is intrinsically part of ways of conceptualising. As is well known, Segal (1957, 1981: 57) is responsible for the distinction in psychoanalytic theory between a symbolic equation and a symbol. The symbol is used not to deny but to overcome loss, including the loss of childhood passions. In this context it is worth drawing attention to the fact that the concept of symbolisation is different from the Freudian concept of sublimation. Symbolisation does not simply describe a transformation, that is, a change in the form of expression of an impulse or instinct, it involves a more fundamental change, that which results from a process of mourning and growth via internalisation – it involves facing the pain of the loss that the little girl can never marry daddy, nor be mummy, the little boy can never marry mummy nor be daddy. We have all had patients whose lives have been driven and ruined by a difficulty in accepting such relegation. Symbol-formation is costly: it involves relinquishing possession of, or narcissistic identification with, the primary object, and also, at the Oedipal level, relinquishing the role of being a full intrusive 'member of the wedding'

so that, as the American writers I will later refer to term it, post-Oedipal sexuality that can appear in its own right. Even if it is the case that many papers have concentrated on patients whose level of illness involves pre-Oedipal problems, I think Kleinian theory – with its concept of the depressive position, and also its distinction between pathological and healthy types of identification with the sexuality of the parents – leaves plenty of room for sexuality.

One point I do wish to make, however, is that the Kleinian thinking tends to lay stress on the self's feelings for the object. But what about the self's phantasies of the object's feelings, even sexual feelings for it? How are we to think about both aspects of the sexuality of our child patients? Can we distinguish between narcissistic self-evaluation and something like a feeling of sexual self-worth (Gerrard, 2004) which is sufficiently comfortable to enable self-forgetfulness, not narcissistic self-preoccupation?

The question of the normal erotic transference and countertransference

In 'Sexual Excitement and Countertransference Love in the Analyst', Gabbard (1994: 1083) noted that the psychoanalytic literature (since Searles in 1959) had been remarkably silent on the subject of erotic countertransference feelings. He made the interesting point that sexualisation may defend against feelings of love, which he said are relatively more difficult for many analysts to acknowledge than lustful feelings (Gabbard, 1994: 1091). He said that the value of consultation with a colleague cannot be overemphasised, but that, only by tiptoeing to the edge of that abyss can we fully appreciate the internal world of the patient and its impacts on us.

Davies (1998), a relational analyst, goes into the abyss. She explores the concept of 'post-Oedipal adult sexuality' and suggests that it challenges the fundamental assumption that, whenever erotic feelings enter the psychoanalytic space, the analyst always stands in the role of the oedipal parent. She says that this can fail to recognise significant developmental changes. Gerrard (2004, 2010), an English adult psychotherapist, takes a line similar to Davies, who points out that Oedipal desire is romantic and idealised, whereas post-Oedipal desire tolerates imperfections, and can experience disappointment without the death of desire.

Davies is talking about, not eroticised and therefore pathological infantile transferences, but what she calls 'that form of sexual aliveness that most often ... marks the termination phase of an analysis ... with the deepening intimacy and potential interpersonal space of successful analytic work'. She agrees with Searles (1959) that this involves a kind of mourning and relinquishment on the part of the analyst, a letting go of the patient to have his own adult sexual life; but she is stressing something more than the letting go: this is the analyst's responsiveness to the patient's possibly new aliveness. In particular her paper refers to when it first appears in a patient who was previously dead to his sexuality. Something similar may happen in despairing children and adolescents when they experience a new vitality. Davies' patient was an abused and previously profoundly depressed man who pointed out one day after he was finally beginning to show signs of recovery that she was flirting with him. She became aware that she had been. Then we have to wait to hear what happened.

Davies (1998: 753) proceeds to discusses the difference between the Oedipal child and the post-Oedipal child – who is struggling to experience the self as the object of another's sexual interest when the other is not the oedipally idealised parent figure

(1998: 759). Davies suggests that the post-Oedipal parent is in a constant state of experiencing, processing, and recognising his or her child's emerging sexuality and that the child is most acutely tuned into the parents' ongoing struggle. She gives a telling example from her own family. But back to the previously depressed patient who saw she was flirting with him. Davies then disclosed to him that she had indeed been flirting; he asked her what those people who wrote those books behind her would think of that; she suggested they explore this, and then he became nervous and wished to close the door on the subject. They returned to it in subsequent sessions. I agree with Davies' suggestion regarding the task of the post-Oedipal parent (in life or in the countertransference), but I think there is a way for the therapist which need not involve actual disclosure. I think Davies could have said something like, "You are beginning to feel you are a person that people feel like flirting with." I agree with her that a simple falling back on shoulds and shouldn'ts doesn't get us very far with deprived patients, and that it is important to be receptive, but equally it is not helpful to make the situation too over-heated for the patient. I think disclosure could really overburden any patient.

Nevertheless, I think Davies' and Gerrard's ideas on the role of the post-Oedipal parent in development are very interesting. One word about flirting: flirting need not be seen as a purely seductive act. If it is occurring on the symbolic level, it can involve a type of playing, of acknowledging attraction but under safe conditions where the internal Oedipal triangle of which Britton (2003: 55) has spoken is kept intact, respected and acknowledged.

The question is, is there anything at all relevant in these papers for psychoanalytic work with children? These are clearly delicate issues especially now that we are so much better informed about the ubiquity of sexual abuse of children. I want to ask some questions, and I shall also offer some speculation about some possible pre-oedipal origins of sexuality which may link some developmental research with sexuality. The research can be wonderfully illuminating, but much of it (although not all) has neglected babies' bodies, and it has certainly neglected infantile sexuality. But some of the newer work may have some relevance to these questions.

I shall begin with an attempt, through clinical examples from children, to distinguish perverse sexuality from disordered sexuality, and both of these from normal but delayed Oedipal sexuality. I shall follow this with an example where a budding adolescent sexuality allowed some important pre-Oedipal history to be rewritten via the post-Oedipal sexuality. I shall discuss the issue of the developmental implications of the parents' response to all of these levels for the way in which we transform and use the feelings at each of these levels in the countertransference. At the post-Oedipal stage, I am wondering about psychoanalytic technique in the presence of a child's real sexual feelings and sexual self, as opposed to when the child is sexualising some other feeling for defensive purposes.

An example of perverse sexuality in a child

Seven-year-old child David was diagnosed with pervasive developmental disorder with autistic features, and he was delayed in his language, thinking and symbolic capacities. The therapist gradually learned that he also had a foot fetish. I had noted that several therapists had started wearing sandals during the first warm week of summer, and there had been major reactions from almost all their patients whom I heard about in supervision. Some reactions were more radical than others. This one

child, David, began looking at his therapist's feet in sandals with a terrible leer. He accused her of having smelly feet, but he was clearly staring at them with a horrible fascination. Also, and we came to think this was very important, although his leer seemed to accuse her of collusion, that is, of liking being dirty and disgusting, it also seemed to invite loathing and disgust for him on her part. Thus, there was something cruel and sadistic but also quite masochistic in it. I had seen an almost fetishistic preoccupation with feet in certain deprived children, and although David's therapist and I discussed the possible origin of the original preoccupation in the history of babies left too much on the carpet watching feet come and go but never seeming to stop long enough, and yet never able to be forgotten about, because the baby was never enough up on the lap and looking at faces. But there was clearly far more to it than a reaction to, or defence against pain. We talked a lot about his own feeling of being loathed by and disgusting to his mother, which had been real, but also about what now seemed to have become the dangerously addictive quality of his preoccupation. This boy's leer evoked disgust. It was a bit similar to the way in which my own autistic patient Robbie could look at me not lustfully, but so lasciviously that although I felt no fear, I felt a powerful desire to brush him off. Uriah Heep and Caliban know they are despised. Making yourself ugly and distasteful is better than submitting to seeing that in someone else's eyes, as Sinason (1992: 119) has noted with physically disabled children. The child's pleasure in getting the disgust he expected and what he sought may even, in the worst cases, turn into sexual excitement. We puzzled a lot about this child. We were certain he was not sexually abused, and we wondered, not about how he came to feel disgusting, nor about why he might try to project that feeling into others, but about how he might have discovered the final twist upwards into the excitement.

The following material provides no answers, but it does at least give a sense of the steps in the progression of what amounts to a perversion:

David had been considerably improved in recent months, much less interested in feet, and much more interested in normal, although for his age which was six and a half, rather immature play: this play had given him genuine pleasure and delight, but not perverse excitement. Sometimes there had even been real symbolic play. On this occasion, he greeted his therapist whom I shall call Cathy, quite normally in the waiting room, with only the briefest of glances at her feet, while the look at her face as he greeted her was more lingering. The session started with one of these new, immature, but more normal pieces of play. He began by sitting on the swivelling office chair in her consulting room. He spun, and the game involved a situation where she would stop it intermittently, and say, "There you are!," at which point he would giggle and spin it again. It was a kind of peek-a-boo, and Urwin (2002) has suggested the appearance of this game often signals the child's emergence from autistic states. The therapist wrote, 'At times his grin seems somewhat fixed and slightly 'grimace'-like, although his giggle seems more real.' It was vital for her to monitor the difference in order not to collude with or escalate the more perverse moments. However, we must also leave room for our receptive response to more ordinary excitements when they finally come, for children who have previously known only the perverse kind. Otherwise we collude with the despairing patient's view that there are only two choices, the thrill of perversion or the emptiness of a too sober normality. They play this spinning game for a little while and at one point David spun the chair very fast, thereby bumping his knee on the therapist's chair quite hard. He then squealed in an excited laugh. The therapist knew about David's

language delay, and tended to keep her language simple but emotive, so she simply said sympathetically, "Ohh, ouch." But David immediately ordered, "Cry, Cathy!" She said that he bumped his knee but "he wants me to cry and that I wonder why he wants C to cry". He says "stu-pid" and laughs. She said "I think David thinks its stupid to cry but it's not stupid to cry if it hurts." She had many times before witnessed his cruel mockery of an injured child doll, but he may also have felt she was stupid not to get it that she was the one who should contain the projective identification, to suffer the hurt and do the crying for him (Usually, by the way, she did). In any case, the way in which he responded to her insistence that it was not stupid to cry was to announce with a leer that that he's smelled 'the guinea pig's feet'.

I think we can see here some of the steps in the progression to a fetish fairly clearly. First David is hurt, then he tries to project the hurt into his therapist, then when she doesn't fully contain it in herself, I guess he feels overwhelming self-disgust, and then the smelly feet have to belong to someone else, the guinea pig. A hurt baby self isn't just despicable, it is apparently also disgusting. And what do you do with a profound feeling of self-disgust? I guess one way through is to project, and control the disgust. How it got to the final stage of perverse erotisation in this child's development, however, we never quite understood. What is clear is that the technical response to a perverse moment needs to be very different from that to a defensive or protective manoeuvre, and certainly from that to more ordinary excitements (Alvarez, 1995).

I want to move on now to two examples of disordered, but not precisely perverse, sexuality. An autistic patient of mine had a repetitive preoccupation with making two dolls dance or jump up and down together while seeming to talk to each other in a pseudo-language. The game was far too private and exclusive to be called real pretend play, the jumps occurred always in one spot, and even the dance involved only the tiniest of circles around the dancers. There were never any leaps, because I think, there was nowhere interesting to go. Anxiety about the unknown was not the problem, I believe – the deepest of boredoms was. There was simply nothing or nowhere interesting enough to pursue (this may involve the difference between devalued and unvalued or stupid objects: Alvarez, 2006). On one occasion, Joseph came in, in what appeared to be a really quite loving mood towards me, and this time the animals kissed each other very gently on the side of the face, laying their cheeks against each other and murmuring tenderness. I did not feel this was perverse at all, and not even overly sensuous, but the point was, it didn't stop. It went on and on and on and on, and I began to think, it had started with what seemed like real love, but even Antony and Cleopatra must have got up occasionally and gone out for a breath of fresh air and a good long walk!!! The behaviour was addictive, but not actually perverse, but this certainly raises important technical issues, concerning how to unstick the patient from his habitual ways and to help him to move on.

This next example is from another case of my own, where I also think the sexuality is disordered, but not (as yet) perverse. As Viviane Green pointed out (personal communication) this is very much part of the Anna Freudian way of thinking about psychosexual development that was used in the Metapsychological Diagnostic Profile (1966). Disordered would be viewed as a lack of phase dominance where there is no age related expectable stable dominance of a libidinal phase. This little boy, Michael, was, like David, very turned on by my first sandal day: he lunged across the room, with the set closed grim mouth which I had learned held in a desire to bite. I suspect this began to occur when he was two months old and refused

feeding when his mother went back to work for a month soon after he had recovered – physically, but not mentally – from a series of traumatising surgical operations. He had often tried to grab my knees with that look and attempt to press his penis against me. And after a quick glance at my feet, he tried to do the same thing again. I felt he was experiencing a very confused, overwhelming, half suppressed, and hugely compressed set of impulses – oral and genital all at once but all of it somehow terribly condensed. I tried to clarify this a bit, but he was a child whom it was very difficult to slow down and to help to experience feelings one at a time, as it were. In any case, a few days later, a little calmer, he looked again at my feet very intensely, and asked if he could bite my toes!! There seemed to be no genital excitement this time, and I felt this was a bit of a development – there was only one desire, that to bite, and at least he could allow himself to experience it instead of suppressing it. Subsequently, returning from a summer break, he heard what he took to be a man's footsteps upstairs. He had always scampered to the other side of the room when he heard them. Michael was a very omnipotent and Oedipal child but his fear of a father was compounded, I think, by the early radical and intrusive surgical interventions. I spoke of his fear of the Daddy, especially when he was being so possessive and bossy with me today. Towards the end of the session he observed, both that the couch was not really a bed and that I did actually not go home with him or travel with him on holiday. He also asked a question about what might be upstairs, and I felt that another space/place was opening up. Klein suggested this referred to the mystery of the inside of the mother's body. Crapanzano (2004), an anthropologist, referred to the significance of that which lay beyond the horizon – imaginative horizons (see Britton, 1989 and Edwards, 1994 on the sense of space, within the Oedipal triangle, opening up). I am suggesting that the powerful compression of Michael's passions was disordered, but not really perverse. When he could slow down to experience one passion at a time, as it were, he could experience curiosity and think.

The normal sexual self and questions of technique, that is, use of our countertransference responses to these

Lupinacci (1998: 418) offered some interesting ideas on the role of the two sets of parents in the Oedipus myth. She pointed out that the narcissistic egocentric Theban parents tried to kill their infant, out of fear of his hostility, and that the Corinthian adoptive parents, while kind and loving, are somewhat idealised and sexless. She pointed out that both need integrating in the patient, or the child, but also in the analyst at work. She described the need for the analyst to struggle with his own Oedipal impulses and to integrate his or her softer Corinthian aspects with his firmer Theban ones in order to facilitate the patient's integration. Lupinacci, like Klein (1945), locates the origins of the oedipal fantasies of their patients in earlier pre-Oedipal experiences with the early mother and breast. Her technical recommendations have much in common with Britton's (1989) comments on the parents' response to the child's Oedipal or pre-Oedipal feelings in the course of development. But it is clear that Davies (1998) goes further than attention to a soft warm maternal countertransference response. She is clear that she is speaking of a normal erotic countertransference to the post-Oedipal adult sexuality occurring in the patient.

Up till now, I have been talking about developments in sexual feelings in the self towards a sexual object; now I want to look at the question of the development of

the self as a sexual being as an object of others' sexuality. I suggest that although this is partly linked to the baby's gradual identification with the parents, it is also likely to be linked with early developments of the baby's feeling of being potent enough to awaken responses, interest, delight in the caregiver. In this view parents do not only satisfy basic bodily needs for food and holding. Nor do they offer only mental containment. Laznik (2009) is interesting on the importance of the normal cannibalistic impulses that parents feel towards the edibility of their babies. Green's (1995) possible contention that this is a privileging of early infancy misses the point that feelings of self worth in adulthood may have their origins in and be traceable back to infancy. Clearly, as I just implied, symbol formation and a resultant capacity for identifications (not pathological over-identifications) with the sexuality of the parents plays a huge part, but is there something else too? Are there some elements which need to be examined in addition to the familiar ones concerning the importance of feelings towards the breast, and the facial and vocal reciprocity we hear so much about from the developmentalists. Is there room for actual infantile sexuality, without reducing sexuality to dependency or infantile needs?

First, I want to mention the sense of agency and potency (not omnipotence) (Alvarez, 1992). Studies have shown that babies enjoy finding that they can be the cause of events, and become considerably withdrawn when they fail and experience a feeling of inefficacy (Papousek and Papousek, 1975). The studies let the babies make bells ring and lights come on, but we know that the main causal effects for the baby take place in his interactions with human beings. It is fun to make rattles shake and any sort of stuff happen, but in the earliest months, one of several things that matters most is to be able to make someone's eyes light up. The capacity to entertain and give delight is being studied by Trevarthen (2001) and by Reddy (2008), and I want to stress that this relationship is different from the need for a feeding or even a containing object in either the Bion (1962) or Bick (1968) sense: it concerns the need for a responsive interested object capable of being delighted. Here is an observation of a baby with a certainly good enough mother, who had in the first seven months of his life seemed a little too passively accepting of his mother's busyness with other things. Around eight months, as she prepared to return to work, the two seemed to have formed a stronger and more vital bond. He had found more power to attract and keep her attention through smiles, coos and vocalizations, and she seemed to have more desire to be thus captivated. Then at nine months they were both just beginning to recover from the flu and quite subdued again. The baby tried two different methods of getting his mother to gaze at him and to respond. Both methods failed, but it is the difference in the methods to which I wish to attend. First, he cried a few times, but gave up when his mother carried on with her weary tidying in his room and did not respond. (His cries had never been long or loud.) Then, at a moment when he saw her standing in front of him looking vaguely in his direction, he smiled widely and blew a raspberry; a month before, she would have laughed and/or imitated him, but now she simply continued looking beyond him at something in the room. He then turned over to his dummy and went to sleep. The crying baby asks for comfort, the smiling and performing baby asks for something like delight, to bring a light to someone's eyes. This need not involve a manic defence. He needs comfort, but he also needs an accessible and reachable object; impressible, interested, pleased to be entertained (Trevarthen, 2001; Reddy, 2005). Elsewhere I suggested we need a word for a process which may be a foundation for, and a prelude to reparation – the wish to give something to someone, not in order to

repair a damaged object, but to add to the pleasure of an already intact object (Alvarez, 1992).

Trevarthen thinks the emotions of shame and pride shown in infancy are central to development (2001). Bion distinguished between arrogance and pride (1957) as did the Greeks between hubris and philotomo (Lynd, 1958). A very depressed boy in the past had been very skilled, like David, at getting attention by behaving or speaking in a manner designed to evoke disgust, but did not know how to use more ordinary methods of getting attention. After a few years of treatment where he had given up his old ways, he said one day to his therapist, ''I like it when your eyes are wide.'' It seemed to mean that then he could be sure that she was interested. This involves an early integration between both self and object but also within the self – 'I have the power to make an impact (a positive impact) on you.' It arises as an important development in children recovering from lifelong depression, and it is important to be clear when we are seeing simple manipulative and narcissistic seductiveness, and when we are seeing a desire to show and give pleasure rather than simply to show off to make someone else feel inferior or helplessly ensnared. Attracting need not involve seducing.

Childhood sexuality: the question of the parental objects' role

What is the line between an all too seducible parent and one who allows the sexuality without being seduced or seductive? A child, or for that matter a baby, can feel himself capable of giving pleasure to others. How can we respond to showing without encouraging showing off and narcissism? How can we facilitate self-forgetful showing where the thing or activity being shown is more important than the shower, but the shower is appreciated too?

A clinical example of delayed Oedipal development

A little boy patient of mine, Toby, had been born blind in one eye, a condition which necessitated several operations. He recovered, was cared for by his very devoted parents, and his trauma from the surgery and limitations on his early life was not as terrible as it might have been. However, he was a difficult child, and at times his feeling of being extremely precious to his objects was compounded by an arrogant feeling of being special, and all too precious in the other sense. However, as he began to feel stronger psychologically (he already was quite recovered physically) his masculine identification started to grow. At age six, just before a break, he developed a taste for pop music, and performed with a great stamping of feet, and a certain macho thrust to his gait, the song, 'Don't stop thinkin' about the S club beat!! Also, he roared, ''Super star, with your big guitar!'' not exactly sexily but with a new sort of stomping vitality. He was really monitoring my expression, and I am sure it showed some pleasure; it was so much more spontaneous than his usual very controlling approach in the room. He seemed to be having something of a recovery from a deep sense of damage and helplessness and was showing me his slightly delayed, Oedipal (and still quite narcissistic) potency and sexuality. I found myself thinking that it could be very difficult for the parents of a baby born in such danger to see him as potent and to allow themselves the safety and confidence to dream of his future as a healthy strong and sexy man, a dream every male child probably needs his parents to have for him. Here we need to be interested, not in the acorn in the oak

tree, the baby self in the adult, but the oak tree in the acorn. I wonder now if their capacity or his mother's capacity to find him attractive as a baby was limited by his facial imperfection. What you would feel looking at him was concern, which is not the same as the parent's pleasure and pride in her baby's healthy body and face.

I think this raises the question of the importance of the positive countertransference. I enjoyed this dancing, although my response, though positive, was not particularly erotic. Another child whom I saw some years ago at the Clinic, Nicola, had been extremely deprived and rejected in her infancy and had become chronically depressed but also dissociated and hard in spite of having been adopted at 18 months by very loving parents. There came a point when, after about a year's treatment, at aged 11, she showed me a dance she was doing at school and also some steps from the one the older girls were doing. Her dancing gave me a new pleasure – she seemed much softer, shyer and less defended than usual – the dancing was modest, but the lightness and grace and yet sexiness was very attractive and I am sure my eyes and face – and my words – showed my pleasure and appreciation of this new her. I do not think she was being seductive. I think she was trying out something new in our relationship and trying to give the kind of pleasure she had not been able to give as an infant to her extremely rejecting mother. Puberty was possibly being experienced as a kind of new birth where her painful history could be partially re-written via a tactful appreciation of her new found attractiveness. Certainly, more work was necessary to move beyond a situation where sexuality could be the main vehicle for positive experiences. She needed to find other ways of opening up and pleasing her objects.

In conclusion, I think there is much work to be done on an exploration of our countertransferences to our patients' bodies and sexuality at all the levels, the pre-Oedipal, Oedipal, and post-Oedipal. I have speculated on some possible origins of all this in the baby's ability to give pleasure, to make an impact, to entertain by the use of his body, his facial expressions and vocalizations. I have not had time to discuss his wit and intelligence. When someone makes us laugh or says something intelligent which is not pedantic or exhibitionistic, it gives us pleasure and is certainly attractive, and sometimes even sexy. Sometimes the positive transference is harder to take and stay with than the negative – and when it is sexual too, it demands much courage, honesty and respect from us in our countertransference responses.

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