

# JOURNAL OF GAY & LESBIAN PSYCHOTHERAPY™

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## EDITORIAL

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*There are certain analytic axioms that influence psychoanalytic treatment. One is the notion that only women can understand other women and in particular that only women should analyze lesbians. Feminist influence has left us with the notion that differences as well as sameness exist between all patients and all analysts and these must be appreciated without pathologizing. In the past decade, there has been escalating attention paid by relational psychoanalysts to the development and clinical implications of the erotic transference/countertransference in psychoanalytic treatment. This paper discusses specific homoerotic transference/countertransference issues which arise between female patients and a female analyst. It presents clinical material on the erotic transferences of three female patients, one who identifies as bisexual, another who identifies as heterosexual, and the third who identifies as lesbian. The focus of this paper, however, will be on the erotic countertransference since it is in the erotic countertransference arena that the erotic transference often gets bogged down or eliminated.*

**KEYWORDS.** Countertransference, erotic transference, homosexuality, lesbianism, psychotherapy, psychoanalysis

Cross Gendered Longings and the Demand for Categorization:  
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*Barbara Tholfsen, CSW*

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*Patients who present with overlapping concerns about gender and sexuality tend to believe in a fixed, binary view of gender in which men should be men and women should be women. Psychoanalysis was born out of Freud's fascination with the hysterical symptoms that women were exhibiting at the turn of the century. He stated that there was no such thing as pure masculinity or femininity. But in the years that followed, Freud fled this psyche/soma, objectivity/subjectivity uncertainty and used gender to cap the fragmented, splintered word of knowing he had found and created a "highly differentiated," centered, integrated mechanistic self that was "distinctly male." By the 1950s, psychoanalysts had embroidered this stance into detailed, binary, rigid, inflexible, pseudo-scientific, and contradictory stereotypes of men and women. At first, feminists responded with parallel stereotypes, but by the late 1970s, they began to question the whole inflexibly dualistic set-up and to question whether anyone can successfully be "masculine" or "feminine." Contemporary analysts have set about deconstructing the gendered, binary, biological language of psychoanalysis: with passive and active standing for male and female, and heterosexuality and homosexuality standing for gender health vs. gender pathology. Analysts find themselves questioning all of the old psychoanalytic assumptions about gender and identity. The paper presents case material from the treatment of two men who struggled with binary, gendered issues.*

KEYWORDS. Countertransference, feminism, gender identity, postmodernism, psychotherapy, relational psychoanalysis, transference

Gay or Straight? Why Do We Really Want to Know?  
*Linda I. Meyers, PsyD*

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*Issues pertaining to sexual orientation, while always deeply personal, are most profoundly constructed along traditional lines by cultural factors. The dilemma—gay or straight—appears most frequently in treatment in its interrogative form: "Am I gay or am I straight?" The question is imbued with an urgency considered self-evident by the patient and the therapist. Why? Why do we really want to know? What can the answer mean for the patient? What does it mean to the therapist? What does the necessity of an answer illuminate about Western notions of sexuality? Inherent in this paper's thesis is the supposition that we are unable to clinically comprehend what we do not culturally comprehend. The cultural, like the psychological, is rarely manifest; it must be made visible before it can become comprehensible. Three approaches come to mind: the first method, most familiar to psychoanalysts, is the analysis and deconstruction of language; the second, most familiar to anthropologists, is the contrast and comparison with other cultures; the third, an integration between the cultural and the psychological, can be seen within the developing metapsychology of psychoanalytic theory. The way we use the question of sexual orientation with patients beautifully illustrates the importance of an integrative comprehension. A case vignette is used to illustrate these points.*

KEYWORDS. Anthropology, countertransference, homosexuality, lesbianism, psychotherapy, psychoanalysis, transference

On Homoeroticism, Erotic Countertransference,  
and the Postmodern View of Life: A Commentary  
on Papers by Rosiello, Tholfsen, and Meyers  
*Karen J. Maroda, PhD*

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*This is a discussion of three papers: Florence Rosiello's "On Lust and Loathing: Erotic Transference/Countertransference Between a Female Analyst and Female Patients," Barbara Tholfsen's "Cross Gendered Longings and the Demand for Categorization: Enacting Gender Within the Transference-Countertransference Relationship," and Linda Meyers' "Gay or Straight? Why Do We Really Want to Know."*

*The author agrees with Rosiello's point that the erotic countertransference often hinders the treatment, due to the therapist's discomfort or shame over having sexual feelings toward a patient. However, this raises the dilemma of how to interact with the patient about the erotic aspects of the relationship without being seductive or blurring the boundaries. Rosiello is criticized for both her seductiveness with her patients and for creating a highly-charged sexual atmosphere in an analytic session where the patient is encouraged to describe the intimate details of her sex life. The author wonders how much of what transpired between analyst and patient was actually countertransference dominance rather than a flowering of the erotic transference.*

*The author believes that Tholfsen's paper raises many questions. Among these are how much do we accept about who we are and how much can we change, both internally and externally? How do we determine what transformations are possible versus what must be grieved as unattainable? When patients are ardently seeking feedback during treatment, perhaps therapists fall into their own postmodern trap when they refuse to respond honestly. There is a difference between callously hanging a label on a troubled patient that will only arm him with a new insult versus compassionately helping him draw a portrait of himself that is real and that he may one day accept.*

*The author agrees with Meyers' contention that being "gay or straight" is a cultural construction. However she counters that what is not socially constructed is whether a person prefers to have sex with the opposite sex, same sex, both, or neither. It is one thing to accept that sexuality, along with gender identification, runs along a continuum, and another to deny that most people ultimately fall into one of two categories when it comes to sexual preference. To postulate two general categories, each containing a broad and diverse array of personalities, styles, and modes of sexual expression, is not nearly as restrictive and de-personalizing as many postmodern theorists would have one believe. What makes being gay oppressive is not the expectation that one is sexually attracted to the same sex, and rarely intensely attracted to the opposite sex. What makes being gay oppressive is what society says about the meaning of being gay.*

KEYWORDS. Countertransference, erotic transference, homosexuality, lesbianism, postmodernism, psychoanalysis, psychotherapy

The Analyst's Erotic Subjectivity: A Reply to Karen Maroda's  
"On Homoeroticism, Erotic Countertransference,  
and the Postmodern View of Life"  
*Florence Rosiello, PhD*

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*This paper is a response to Karen Maroda's "On Homoeroticism, Erotic Countertransference, and the Postmodern View of Life." One of the paradigmatic changes that has developed, particularly in contemporary psychoanalytic theory, is the use of the analyst's countertransference in treatment. Countertransference or*

*the analyst's subjectivity is used to inform an interpretation or an insightful response to the patient. Contemporary psychoanalytic literature is currently focusing on the advantages and disadvantages of self-disclosing with many authors determining that some analysts are better able to work with self-disclosure than others. The question of why erotic transference/countertransference develops between a patient and an analyst, and why they don't, is of particular theoretical interest. The development of a patient's transference cannot be separated from the development of the therapist's countertransference—both are mutually constructed by patient and analyst. Transference and countertransference are not linear. They develop together and are indistinguishable from the whole. The author goes on to further present clinical material of her work with three women patients.*

KEYWORDS. Countertransference, erotic transference, intersubjectivity, mutuality, psychotherapy, relational psychoanalysis, sexuality

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<i>A. Jay Beard, PhD</i>	
<i>Roger Bakeman, PhD</i>	

*Reported childhood gender nonconformity, parental behavior, and measures of narcissistic symptomatology were examined in a sample of 109 gay and bisexual men. Childhood gender nonconformity was not related to narcissistic personality but was related to feelings of impostorhood and self-esteem, two possible symptoms of narcissistic damage. This association was partially mediated by parental variables, especially reports of an accepting and supportive father. Psychoanalytic theory suggests that both homosexuality and narcissism stem from early family dynamics. These results provide support for an alternative theory which, recognizing that childhood gender nonconformity and same-sex adult sexual orientation are linked, posits that narcissism results from parental reactions to childhood gender nonconformity. Implications for clinical interventions are discussed.*

KEYWORDS. Gender nonconformity, gender identity, homosexuality, psychotherapy, psychoanalysis, narcissism, developmental theory

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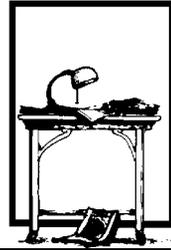
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## EDITORIAL



# Matters of Sexuality and Gender: The Therapist's Role

This issue of the *Journal of Gay & Lesbian Psychotherapy* features several papers which explore the therapist's participation in enacting sex and gender issues in treatment. While recognizing their inevitable contribution to the interactions that shape the therapeutic dialogue, the contributors also question the complex, over-determined variety of motives that position them in the emotional fray as they attempt to disentangle their own issues and needs from those of their patients.

As psychotherapists explore the realm of sexuality, the following questions are important to consider: When and how much should we disclose about our own erotic experiences of and reactions to our patients? How can we evaluate and distinguish when such disclosures are seductive and when they are responsive and clarifying? What are the possible ramifications of not articulating these countertransference feelings? To what extent and for how long should we engage in sexually charged interactions?

There are also questions to consider in the realm of gender: How

should we proceed when patients want to know our actual attitudes toward their gendered presences, their masculinity and femininity? What if patients believe that “real” men think, desire and behave in certain specifiable ways while we see sexuality and gender as multifaceted and independent from each other? Do we see gender and sexuality as fundamentally fluid or stable? How do we manifest our own attitudes in the room and how does this affect the therapy?

Florence Rosiello, Barbara Tholfsen and Linda Meyers offer piercingly honest observations of their own clinical work, and reflect with great thoughtfulness on their own impact on their patients. All struggle with the enormity of their influence in shaping the treatment, and thus the future course of the patient’s life. Karen Maroda then discusses these clinical papers. She agrees that our disclosures are necessary and enormously significant, but she also, at times, takes strong exception to the manner and the extent to which these disclosures are made. Rosiello then responds to Maroda’s discussion.

The open discussion of clinical and theoretical differences provides the reader with an opportunity to sharpen his or her own thinking on the matter, a crucial contribution in these times of post-therapeutic neutrality. For that, and more, the *Journal of Gay & Lesbian Psychotherapy* wishes to thank each of the participants for her openness and generosity.

The following references are provided for readers who are interested in further exploring issues related to the contemporary understanding of the uses and meanings of countertransference.

*Erica Schoenberg, PhD*  
*Book Review Editor*

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## ARTICLES

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# On Lust and Loathing: Erotic Transference/Countertransference Between a Female Analyst and Female Patients

Florence Rosiello, PhD

**ABSTRACT.** There are certain analytic axioms that influence psychoanalytic treatment. One is the notion that only women can understand other women and in particular that only women should analyze lesbians. Feminist influence has left us with the notion that differences as well as sameness exist between all patients and all analysts and these must be appreciated without pathologizing. In the past decade, there has been escalating attention paid by relational psychoanalysts to the development and clinical implications of the erotic transference/countertransference in psychoanalytic treatment. This paper discusses specific homoerotic transference/countertransference issues which arise between female patients and a female analyst. It presents clinical material on the erotic transferences of three female patients, one who identifies as bisexual, another who identifies as heterosexual, and the third who identifies as lesbian. The focus of this paper, however, will be on the erotic countertransference since it is in the erotic countertransference arena that the erotic transference often gets bogged down or eliminated.

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“On Lust and Loathing: Erotic Transference/Countertransference Between a Female Analyst and Female Patients, in *Deepening Intimacy in Psychotherapy: Using the Erotic Transference and Countertransference* by Florence Rosiello, pp. 43-64. Copyright 2000 by Jason Aronson Inc. Reprinted with permission of the publisher.

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**KEYWORDS.** Countertransference, erotic transference, homosexuality, lesbianism, psychotherapy, psychoanalysis

There are certain analytic axioms that influence psychoanalytic treatment. One is the notion that only women can understand other women (Freud, 1920) and in particular that only women should analyze lesbians. With unintentional volition, we often make a referral after speculating if the patient will work better with a male or female colleague. Still, most of us in the psychoanalytic community hold to the belief that the analyst's gender makes no difference in treatment. Feminist influence has left us with the notion that differences as well as sameness exist between all patients and all analysts and these must be appreciated without pathologizing. The current trend in psychoanalysis is to understand that our differences can mean an openness to managing our own body experience as well as our defensive constellations. These experiences and defenses are typically tinted by cultural and biologically-based gender considerations when we work with patients. This makes a great deal of sense to me, since I have always wondered if a male analyst really understands the emotional swing and bloated body experience created by female hormones and the intense need to rip off any restricting clothing and eat whatever the hell you want when estrogen is low.

To my mind, there are very different issues that arise in treatment with the female patient by a female analyst. I am speaking about the particular dynamics that arise between same-sex gender dyads which may be nearly impossible to create in a male/female analytic frame. In this paper, I will discuss specific homoerotic transference/countertransference issues which arise between female patients and a female analyst.

In the past decade, there has been escalating attention paid by relational analysts to the development and clinical implications of the erotic transference/countertransference in psychoanalytic treatment. For the purpose of this essay, erotic feelings are defined as all the patient's loving, sensual and sexual desires toward the analyst, as well as aggressive resistances that defend against erotic feelings. Of course, in truly looking at the erotic transference from a position of mutuality, the analyst considers and makes therapeutic use of countertransfer-

ence feelings aroused in them by their patients, as well as the analyst's own created emotions and subjective experiences. In this essay, I will present clinical material on the erotic transferences of three female patients, one who identifies as bisexual, another who identifies as heterosexual, and the third who identifies as lesbian. The focus of this paper, however, will be on the erotic countertransference since it is in the erotic countertransference arena that the erotic transference often gets bogged down or eliminated.

Lately, it appears that psychoanalytic literature on the erotic transference/countertransference has been written by female analysts, and they have mostly concentrated on erotic feelings between female analysts and male patients. There are fewer papers on erotic longings between female analysts with lesbian patients (McDougall, 1986, 1995; Siegel, 1988; Elise, 1991; O'Connor & Ryan, 1993; Davies, 1994; Wrye & Wells, 1994; McWilliams, 1996; Dimen, 1997 unpublished paper). And there is an unfortunate lack of analytic literature on homoerotic transference/countertransference when both patient and analyst are heterosexual. McDougall (1986, 1995) tends to be one of the very few exceptions. Let me give an example of what the literature contains: In McDougall's 1995 book, *The Many Faces of Eros*, she discusses homoerotic longings within a transference/countertransference enactment where she had an emotional deafness toward the patient's erotic material. McDougall thought this deafness defended her own repressed homosexual fantasies. During the analysis, McDougall has what she calls a "homosexual dream" (p. 25). On waking, she begins a self-analysis around her perception of denied erotic feelings toward her own mother. McDougall seems to understand her countertransference as a development related to the patient's projective identification and when she next meets her patient she interprets the patient's conflict about feeling loved by her mother.

McDougall's writings are a good example, and a rare clinical illustration, of homoerotic transference/countertransference in the analytic literature. Still, she tends to focus on transference rather than erotic countertransference and when she does, her erotic countertransference feelings are revealed through dreams or are masked or eliminated on the therapist's return to the consulting room. In other words, countertransference is subsumed under varying degrees of analytic neutrality. I have a feeling that this is very representative of how many traditional and contemporary analysts work with their erotic counter-

transference whether it is with same-sex or opposite-sex patients. How does this work in a more relational treatment where there is a mutual affective participation?

To my mind, Davies' paper (1994) is one of the few exceptions of mutually discussing erotic transference/countertransference feelings (albeit toward a male patient) as her countertransference developed in the consulting room. I understand such countertransference feelings or enactments to be an expected part of the analytic process. Countertransference enactments manifest as the analyst participates in collecting data about the patient's life. These enactments are co-created by both patient and analyst in the living-out of emotional experience within the boundaries of the analytic frame. Levenson (1992), in discussing how the analyst reveals herself in the process of gathering data about the internal workings of the patient, believes that all dialogue by the therapist is a metamessage about who the analyst is, i.e., comments, interpretations, nearly anything and everything the analyst says. "The ultimate issue . . . is not only what the patient says about his/her life to the therapist, nor is it only what the therapist says to the patient about the patient's life: but also, what they say about themselves—however inadvertently—to each other" (p. 562). In this way, the notion of enactments places countertransference closer to the notion of transference (Hirsch, 1994). But, how do we know when we've co-created this erotic transference/countertransference material particularly when it can be so well defended against by either the patient and/or the analyst?

Bollas (1994) states, and I disagree with him, that the "erotic transference is restricted to the analytic partnership that splits the sexes . . ." (p. 581). He elaborates that there is a displaced manifestation of the erotic transference in heterosexual same-sex treatments, one that could perhaps best be described as a form of "rhapsodic identification" (p. 581). In this particular relationship with the therapist, the patient falls in love with both real or imagined aspects of the therapist's character and perceived life, such as how the therapist expresses ideas, or mannerisms, or their sensitivities. "The patient develops an intense inner relation to the object of identification that gains its rhapsodic character from the analyst's . . . presence" (p. 581), a type of idealized love. In the heterosexual analytic dyad, the patient becomes immersed in a fantasized involvement, perhaps a voyeuristic preoccupation with the analysts' life. "The rhapsodic identification displaces erotic states

of mind even though the erotic transference [is what] organizes affective experiences . . . ” (p. 581). Is Bollas suggesting that there aren't any homoerotic transference/countertransference developments between heterosexuals that the therapist can work with? It seems to me that his 'rhapsodic identification' is an early phase of a developing or budding same-sex erotic transference, not an end in itself. It is more likely that Bollas is expressing his own discomfort with homoerotic transference/countertransference material.

So then, how in the world does the therapist work with this unconscious or consciously held defense against the erotic transference in the same-sex analytic dyad? Wrye and Wells (1994) contend in their experience that patients who develop erotic transferences evoke in the therapist powerful feelings and defenses that may include “manic, depressive, obsessional, schizoid, or paranoid elements” (p. 62). They suggest that such emotions are difficult to contain for the therapist and that we often cannot permit ourselves to participate in the erotic dynamic. Feelings of merger and the desire between the analytic couple with mutual penetration wishes toward the other, may create both longing and fear in both participants.

Intolerance of erotic countertransference in ourselves may result in enactments of it through mothering responses or in arrested feelings that are kept out of awareness, bringing about an altered therapeutic process. The most powerful erotic countertransference feelings are those fused with aggression since these inhibit the therapist's experience and can completely change the course of the treatment (Wrye and Wells, 1994). It is unfortunate that Wrye and Wells focus on the analyst's aggressive countertransference reactions to the patient. Are they agreeing with Bollas that you're fighting the odds or at least working against nature's elements when you work with the erotic transference/countertransference relationship? Wrye and Wells do give good clinical examples of a heterosexual, female patient's erotic transference but they understand the patient's narrative as “coalescing around issues of fusion, schizoid or obsessional distancing, and grandiose or manic treatment agendas” (1994, p. 64). They add that the female patient was experienced by the female analyst as a “toxic, parasitic infant who seemed bent on, and capable of, dismantling and devouring” the analyst (p. 76). Why is the erotic countertransference so slippery when the patient is heterosexual? Is it different when the patient is gay?

Frommer (1995) began his paper on "Countertransference Obscurity in the Psychoanalytic Treatment of Homosexual Patients," saying that within the psychoanalytic literature there is an absence of the analyst's countertransference in the treatment of same-sex patients where there is sexual desire. Frommer's essay is an important theoretical contribution to the literature on the treatment of gays, but unfortunately he provides no clinical illustrations of erotic transference/countertransference.

There are a few recent publications where a smattering of authors come close to discussing erotic countertransference to same-sex/lesbian patients, but more often the attention is on the erotic transference (McWilliams, 1996; Siegel, 1988; O'Connor and Ryan, 1993; Elise, 1991; Wrye and Wells, 1994). For instance, one author says she took her countertransference to an authority (I assume her analyst or supervisor) who understood and accepted her conflict of sexual longings toward her patient. Again, this is a rather traditional response to working with erotic countertransference feelings where the therapist returns to the consulting room with her own emotions intact. In addition, the therapist felt it was important that her patient not feel an erotic indifference and interpreted that her patient's "sexual interests were stimulating, delightful, precious, poignant, and safe" (McWilliams, 1996, p. 218). Why was it necessary to qualify that erotic feelings in treatment are safe? Doesn't saying something is safe in treatment mean to the patient "Don't worry, all this material we're discussing is unreal. It's just verbal dry humping; there's no chance of really getting affectively pregnant, because I won't penetrate you by taking any emotional risks." As it turned out, the patient started focusing on images of a future loving relationship with the analyst and wanted to leave treatment before analyzing it, to really 'have' the analyst. Does this mean the erotic fantasy broke down? Did it become stuck on the patient's actually loving the analyst with her hopes of the treatment ending?

In an unpublished paper by Dimen entitled "Bodies, Acts and Sex: Thinking through the Relational" she wrote about an erotic transference/countertransference development where she felt a female patient was about to unconsciously enact the therapist's erotic feelings by developing a destructive relationship outside the treatment. In this particular treatment, the patient had a history of cultivating disastrous relationships with men when the erotic transference/countertransference manifested itself in the treatment relationship. Dimen interpreted

this to the patient in the hopes of stopping the patient's acting out. In other words, Dimen told the patient she had sexual feelings about her and said she thought the patient had in the past unconsciously enacted the erotic transference/countertransference feelings in destructive relationships with men. To my knowledge, this is the only paper where homoerotic feelings were disclosed by the analyst to the patient in the hopes of developing treatment.

With the exception of Dimen's unpublished paper, analytic literature indicates that the erotic transference and countertransference feelings are altered through the analyst's interpretations into a more workable or sexually-neutered transference alliance, or that treatment is ended either by the patient or the therapist, which is what Freud suggested at the get go in his 1915 paper on transference love.

Kaftal (1994) in his paper on treating gay men, suggests that the heterosexual therapist subtly signals ambivalent feelings about homoerotic fantasy. He warns that transference fantasies need to be opened up and expanded before understanding and interpretation begins since "A simple push to move more quickly to the interpretive phase is more than enough to suggest [to the patient] that emotional expression and erotic phantasy are not entirely welcome" (p. 9). This is a different treatment warning from the traditional analytic stance, since Kaftal is saying be careful about interpretation diluting the erotic transference/countertransference into just unreal or real feelings and fantasies, or leading too quickly into discussions on infantile longings since this may lead to a premature ending of the erotic transference or of the treatment itself in order to be with the therapist.

But why is the erotic countertransference so difficult to work with, especially with same-sex female patient? Butler (1995) wrote an important paper, "Melancholy Gender—Refused Identification," where she wrote about "the foreclosed status of homosexual love that never was" (p. 156). Butler goes on to say:

For it seems clear that, if the girl is to transfer the love from her father to a substitute object, she must first renounce the love for her mother and renounce it in such a way that both the aim and the object are foreclosed. Hence, it will not be a matter of transferring that homosexual love onto a substitute feminine figure, but of renouncing the possibility of homosexual attachment itself. Only on this condition does a heterosexual aim become

established as what some call a sexual orientation. Only on the condition of this foreclosure of homosexuality can the scene emerge in which it is the father and, hence, the substitutes for him who become the objects of desire, and the mother who becomes the uneasy site of identification. (p. 169)

Butler uses the word “foreclosed” to mean a “preemptive loss, a mourning for un-lived possibilities; for if this is a love that is from the start out of the question, then it cannot happen and, if it does, it certainly did not; if it does [anyway], it happens only under the official sign of its prohibition and disavowal” (1995, p. 171). The heterosexual individual then disavows a constitutive relationship to homosexuality. And then, if this is so, what does it mean to erotic transference/countertransference feelings within the heterosexual therapist and same-sex patient dyad?

I have never struggled with the beginnings of an essay in the way I have with this one. I felt all over the place, way too fluid. I couldn't come up with an outline to save my life. I put off writing it for months because I was “thinking.” I told nearly everyone who would listen that I was writing it, almost to the point that I would introduce myself and within moments launch into the struggles I was having with this paper. Then I realized, it's like I'm coming out by writing about homoeroticism in heterosexuality. Do lesbian and gay analysts professionally present themselves as such or do we all have sexuality secrets? Are there professional or personal risks? Isay (1996) has suggested that gay therapists should acknowledge being homosexual when patients ask. Not disclosing compromises the truthfulness of the analytic relationship. However, Isay adds that such disclosure is complicated by shame. Is this just true about the therapist's sexual identity, or does shame relate to most sexual issues and feelings that arises in psychoanalysis and psychotherapy?

Lately, I have been giving some thought to whether or not we, as analysts and therapists, put our own emotions at risk when we treat patients. We ask our patients to question what they feel, analyze their experiences, and let us guide them—and maybe this is an emotional risk or seduction into the unknown parts of the patient's self. How can we do that if we aren't prepared to take a similar sort of risk? This got me to thinking about the risks I've taken in psychoanalysis and the risks I haven't. To my mind, taking a risk as an analyst means putting

one's own emotions on the line, of disclosing our own feelings at times, of stretching the boundaries of the analytic playground through emotional risk without being out of control.

I recently found an illustration of this in a class I was teaching at an analytic institute. I found myself intimately discussing my feelings about my work with patients, as well as my subjective experiences and countertransference. I was pleased at the innermost responses the candidates returned about their work and themselves. In the last meeting of the semester, we were discussing our thoughts about the readings and one of the candidates said she loved the class because it made her question her work and herself. Then she added she also hated me for having made her do that, meaning she hadn't intended to give so much of herself emotionally in and to the class. My having taken risks about my own feelings made her feel a desire to meet me at the threshold.

### ***CLINICAL ILLUSTRATION OF A FEMALE BISEXUAL PATIENT***

Pauline came to treatment to discuss her conflict about her sexuality. She has only been in heterosexual relationships, yet she believes she is bisexual and would like to fulfill her desires with a woman. She was one of six children from a Roman Catholic family. A female child, born dead eighteen months before Pauline was born, was also named Pauline. When she was five, Pauline and an older brother experimented with mutual masturbation without penetration. Pauline feels this was disgusting and sex as an adult, with men, has retained a vulgar edge for her. Pauline's longest relationship of seven years was with a verbally abusive man who shared her alcoholism. Since becoming sober nine years ago, she has only had "crushes" on women.

Pauline related an interesting memory about her mother. She remembered being about six years old, riding alone with her mother in their car. She said it was one of the few memories she had of being alone with her mother without the other children. Pauline stared at her mother as she drove in an attempt to get her to respond in some way to a multitude of stories and questions she was asking. Her mother was preoccupied and eventually told Pauline to be quiet. They drove on in silence with Pauline feeling humiliated at her mother's rejection and obliviousness to her desire. It's not surprising that Pauline is a rather isolated and emotionally withdrawn adult.

I remember in an early session with Pauline that she talked about a lack of any sex in her life. I asked if she masturbated. She didn't, saying it took too long and she got too tired before climaxing. "Don't you use a vibrator?" I asked. She giggled with discomfort and titillation and seemed thrilled at our topic. In the next session, she announced that she had gone to the Pleasure Chest shop in Greenwich Village and purchased a large dildo, not a vibrator, that had all sorts of special features and used it the night before our session. She felt pleased I'd given her permission to have this sexual experience. I realized that I was somehow involved in her fantasy, either as overseer, voyeur, participant, or maybe as the prey and she agreed.

At this point, she became intensively curious about my life. What did I do on weekends? Who were my friends? Was I married? She thought not, and hoped I had female lovers. Monday morning sessions were full of her questions about my weekend. I consider Pauline's fascination with my life to be an example of Bollas' "rhapsodic identification." However, a patient's preoccupation need not stop here if the therapist can allow or tolerate a further unfolding of the erotic transference as it can organize affect and create intimate experiences.

Pauline became increasingly flirtatious in the successive sessions. Adam Phillips declared "Flirtation keeps things in play, and by doing so lets us get to know . . . [people] in different ways." "[Flirtation] plays with, or rather flirts with, the idea of surprise . . . [it] confirms the connection between excitement and uncertainty, and how we make uncertainty possible by making it exciting" (1994, p. xii). Pauline took her flirtation to courtship and started bringing small presents from the store where she works and began writing letters and calling between sessions. I asked if she was trying to emotionally seduce me, she thought so and punctuated this session with a long letter. "To answer your question from Friday," she said, "the feelings I have for you are sexual, which scares the hell out of me to tell you that. I fear that it will disgust you to know my attraction is sexual."

I am certainly not disgusted by Pauline's sexual desire and have told her so. She appeared less humiliated on hearing that. Perhaps she has learned that I can be engaged through her presentation of erotic material. Through my work over many years, I have slowly come to the realization that I speak a very passionate language. Words that to me feel warm and intimate, are sometimes experienced as seductive, enticing, and alluring to others. Patients quickly learn their analyst's language

and seem to know what topics spark our interests whether it's narratives about aggression, separation/individuation, sex, or whatever, and often patients will consciously or unconsciously engage the analyst by evoking such topics, and of course, vice versa. Pauline's engagement of my attention is a different experience than she had riding in her mother's car as a child. I feel quite comfortable with Pauline's sexual wishes and fantasies. She came to treatment with a longing to be with a woman and, for now, I have become the object of her desire. I assume her sexual longings will become more and more explicit as we continue to work together, and that I will feel attracted to her in the erotic transference/countertransference matrix. What concerns me is the possibility of the patient's unconscious enactment of the erotic transference/countertransference outside the treatment, i.e., Dimen's clinical illustration. If Pauline develops a relationship with a man or a woman is this an erotic transference/countertransference enactment or is it an expression of the patient's maturation or is it a regression?

What I find curious in treating Pauline, is the lack of conflict I experience regarding my erotic countertransference. I do not feel troubled by Pauline's sexual longings. Our work has a very intimate, warm quality in that I feel very emotionally engaged and related to her stories and memories. Pauline's sexual desires and my comfort with them are a part of our mutual relationship that allows for an unfolding of both the patient's and the therapist's creativity and opens opportunities for emotional risks. Pauline has desires for women, as do my lesbian and heterosexual male patients, and I am, therefore, an object of her desire.

### ***CLINICAL ILLUSTRATION OF A FEMALE HETEROSEXUAL PATIENT***

Simone began treatment eight years ago after she found out her husband had a brief affair. Years passed with the two of us struggling with her failed career as an interior designer in relation to her husband's business success. Treatment was uneventful, easy, I thought, and Simone was funny and entertaining and I enjoyed her visits. She was also quite beautiful with large saucer eyes and blonde hair and a lovely smile. This was a psychotherapy case and the transference was rather calm and maternal for many years, much the same as she de-

scribed her life in Kansas as a child. Her mother sang in the church, her father was a teacher and her only sister was her closest friend.

About four years into the treatment, Simone decided to take a temporary assignment as a secretary at a construction company. She had never been exposed to this environment, where her boss cursed up a blue streak and screamed at clients. The receptionist was openly having an affair with the boss's partner who videotaped their sex and showed it to the men at the office. Mobsters showed up for private meetings with the boss and sexual harassment in the office was expected and casually accepted or elicited, and on and on. It was as though squeaky clean, church-going Dorothy from Kansas had stumbled into a licentious, den of inequity.

Simone was fascinated, frightened and mesmerized with their behavior. Sessions became weekly recounting of unusual relations between co-workers which she told in a hilarious way. The two of us would roar with laughter as she described feeling like Michelle Pfeiffer in the movie *Married to the Mob*. She then began talking more specifically about her boss, Tony. He was a big, gruff, burly but good-looking Italian guy who was becoming charmed by Simone's innocence, appearance, and humor. They began having lunches together and then drinks after dinner and finally he told her he was falling for her.

At the same time, Simone was very busy being a corporate wife in her husband's career. His boss began inviting them to the Hamptons for weekends and after one evening meal, Simone found herself followed into a bedroom by her husband's boss. He professed a sexual desire as he pulled her on the bed and attempted to seduce her. She decided that something sexual was in the air, kismet or karma, and she told him she wasn't interested. A few days later she told Tony she was.

In her treatment, Simone's stories had heated up. I anticipated the coming attractions of her narratives and found myself musing and fantasizing about the upcoming events outside the hour. When Tony finally propositioned her, she came to the session and asked what to do. I wondered if she wanted my consent to have an affair and she said yes. After an exploration of her desires and fears, and after discussing how she would be living a secret life, she decided to have an affair with Tony and asked if I would help her through it. I told her I would always help her and she interpreted this as permission. At this time, I wondered about the homoeroticism inherent in triangulations, specifically about those in Simone's decision. Certainly, when Simone went

to bed with her lover, she took her thoughts about his wife. In a sense, theirs would be a very full bed and I assumed I would be present in some form, as well.

Simone began a very passionate affair with Tony and her relationship with me became equally steamy. It often felt like we were mutually visualizing porno flicks as she narrated weekly events with her boss. We were both becoming sexually aroused by her stories. In Benjamin's book, *The Bonds of Love* (1988), in the chapter entitled "Woman's Desire," she writes that the developing child wants more than a plain satisfaction of need, instead each specific "want" is an expression of the child's desire to be recognized as a subject. "What is really wanted is a recognition of one's desire; what is wanted is a recognition that one is a subject, an agent who can will things and make them happen" (p. 102). Desire is often framed by gender—women are frequently the object of desire in that someone else, the subject (often the man, in heterosexual relations) gets pleasure, and the object of desire (usually the woman) gets sexual enjoyment from pleasing the subject. Being the subject of desire, however, would mean that a woman had her own wants.

My own fantasy about how I am perceived is that I have my own wants. This is conveyed in the way I dress, my manner, sensitivities, how I use language, and my attitudes—all of these have a sexual component or edge. Benjamin suggests that the "'real' solution to the dilemma of woman's desire must include a mother who is articulated as a sexual subject, one who expresses her own desires" (1988, p. 114). This was true of my relationship with my mother, and now in my relationship with Simone as she began to identify with a female therapist who has her own desires.

Simone wanted to be able to want. She wanted sex, she wanted to be sexual, and she wanted to have an affair. She was the subject of desire, and through my recognition of her desire, I became a co-conspirator. Yet, because I facilitated her becoming a subject, the real affair was with me since I had also facilitated her subjectivity. And the same for me, since this facilitation was out of the realm of men and their objectifying selves.

Benjamin (1988) suggests that it is "recognition of the other that is the decisive aspect of differentiation" (p. 126). In recognition, there is a sense of self and other that evolves through an awareness of shared feelings and experience, as well as the sensation that the other is

external and dissimilar—a mutual recognition that provides a point of self differentiation. When we have erotic feelings toward another person, we desire, want, and experience the other as being inside and outside us. It is as though our mind and body are made up of aspects of the other and this often gives us a sense of wholeness as well as a differentiation of self in relation to the other. The erotic transference can be a powerful arena that can help many patients differentiate.

In erotic unions between men and women, it has been my experience that while men may desire a loss of self in an erotic relationship, they are least likely to tolerate too much of it. It is more usually women who can merge with the other temporarily. Yet, merger is a core issue in lesbian relationships and often results in sexual bed-death. A merged relationship defuses the shared, mutual power of two individuals engaged in the erotic fantasy of being swept away by the other, and often results in a lessening of erotic feelings.

Very quickly into the affair, Simone's boss arranged an apartment for the two of them and let her decorate it. They would meet there frequently during the week and perform an unusual sexual interaction. Tony did not undress himself, nor did he entirely undress Simone, but he would instead perform oral sex on her. This is a rather different outcome of a heterosexual affair where typically it is the woman who performs oral sex or where the man penetrates the woman. She was happy with the arrangement and so was he. To my mind, it was Tony who was objectified by this woman's desire.

Still, was Simone in more control than I knew, both outside and in the treatment? Where her stories of their meetings meant to seduce, dominate, control and/or objectify me? Was Tony performing my part in his surrender to the subject? Simone wasn't sure, but said I was definitely in the room when they were together. I remember feeling uneasy when she said this. Just how large was my part? How much was I colluding or not colluding? I felt caught up in the events at this time and I couldn't seem to interpret the transference successfully. Yet, what kind of reality would an interpretation of this enactment have? More and more, I felt like a participant in her stories and as though I was being masturbated in the sessions. Or, was I was manipulating her, like Svengali. With whom was Simone having sex?

As she shared her sexual fantasies with Tony in the office, and with me in the sessions, she spoke about an experience she had as an adolescent. She and a very close girlfriend had taken to spending time

talking as they lay on her friend's bed. As they shared intimacies and secrets they found themselves fantasizing and telling the other of their sexual as well as non-sexual desires. She said they both began to feel aroused and eventually began affectionately touching each other. In a matter of time, their thinking and talking about sex had become action as they progressed to kissing and then sexual exploration and eventually mutual masturbation. She then confessed to recently having masturbated to the fantasy of two women together and when I asked if she meant us, she said yes.

In Simone's mind, she was imagining having sex with me. On the one hand, I could consider her feelings to be an unreal erotic transference experience. We weren't really having sex and we weren't going to, and one way I could understand her reactions would be to attribute them to infantile longings. And, while I wouldn't rule out such an interpretation, I didn't feel it was enough in my relationship to Simone. Our affiliation seemed more complex, more mutual, more intimate, and the sexual stimulation that we both felt in relation to her narratives was very real. As long as we didn't engage in the action of sex, did that mean there was no sex between us? What constitutes a sexual relationship? Is actually having sex, real sex? Or, is imagined sex, real sex, too?

In an as yet unpublished paper, Kaftal posed the question "What makes sex, sex?" I feel this question relates very much to my experience with Simone. For instance, is sex in transitional relating, such as in the analytic relationship, different than imagining having sex with someone? Is imagining having sex the same as really having sex? Some people might answer 'yes' and others might say 'no' to that question. But the next query might be: Is phone sex, sex? Many of us have an immediate answer to that question, and to my mind, phone sex is sex. So bear with my "yes" answer, "phone sex is sex," for a moment as the questioning continues: How does phone sex differ from imagined sex if imagined sex is not sex? So where do we draw the line, what makes something sex?

The answer has to do with the intention of the people involved. If we think that imagined sex is helpful in dealing with the patient's other issues in treatment—for example, a patient's sexual feelings are defending against other non-sexual feelings, i.e., aggression, intimacy—then sexual feelings between therapist and patient are diffused. In other words, the sexual feelings between both individuals are imagined and

unreal. But, what about the experience of two individuals in the same room, bedroom, backroom, who are jerking off together? Isn't that sex? If the room is a consulting room and one of the individuals is a sex surrogate and if there is a clinical reason for the other person to jerk off or masturbate, is it sex? Or is it the same as just jerking off?

In psychoanalysis or psychotherapy, there is a whole different rule for physical actions. In both, our actions are verbal and there has to be a matter of intention for both people, and then how we read these intentions. What constitutes sex is not fixed in any certain way. In this moment in our current society and culture, what really matters to us is what we really do—not just what we intend to do. For instance, when someone asks “Do you really love me?” while it matters what you say, it matters more what you do. It's the way we understand what sex means, what meaning system we use to understand sex, that matters. In my mind, there a certain kind of mutuality in what constitutes sex. For instance, sex need only be a sharing of similar sexual stimulation or experience at the same time. For me, it was sex between Simone and me and it is my interpretation that for Simone it was sex for her, too. Simone and I co-constructed or created our sexual feelings for each other, with each other. It's not because I uncovered a clandestine closet that was full of secret fantasies that she'd always had and psychotherapy brought it to the surface, rather we created these sexual feelings together, and maybe I started them.

Certainly, my experience with Simone felt this way when she talked about her affair and about her sexual fantasy to be with me. We weren't really having sex, but sexuality had become the theater for getting the point across between us, we were definitely sharing emotional intimacies. Our mutual recognition, the encounter of our separate selves, had become the context for desire.

I then told her that I had wondered for a long time about the extent of her sexual fantasies about me, particularly since I had recently become aware of mine about her. I continued saying that we were involved with each other in many ways and levels, and our relationship felt deeply intimate, sexual and loving. Simone and I had developed and shared a mutuality of affect and a sense of the other as entirely engaged and saturated. Mitchell (1988) remarked “There is perhaps nothing better suited for experiencing and deepening the drama of search and discovery than the mutual arousal, sustaining, [of] . . . sexual desire” (p. 108). Our intimate feelings climaxed and were

maintained after my disclosure of this particular countertransference vulnerability. Benjamin states that “Women make use of the space in-between that is created by shared feeling and discovery. The dance of mutual recognition, the meeting of separate selves, is the context for their desire” (1988, p. 130).

Tony showered Simone with gifts and she delighted in showing me all of them. On her birthday, he gave her beautiful pale pink roses which she brought to the session and left with me, saying she could not take them home because of her husband. Interestingly, her husband, around this time, began pressuring her to have a child. He began a subtle seduction of spending more time with her, he bought her a sexy teddy, began dominating her in bed, and penetrating her in the way Tony did not. (Simone and her husband had a history of satisfying sex until he became overinvolved in this new job.) While she felt seduced back into his bed, Simone thought her husband could not possibly raise a child because he had been so isolated in his own childhood, but she let herself be swept away and immediately became pregnant. Tony promptly fired her.

Throughout the pregnancy, Simone became very interested in finding a way to raise the baby without having her husband too involved. She thought he had no experience with children and she wasn’t too sure about her own abilities. She decided I would help her raise the baby by telling her what to read and catching her if she did something wrong. In a way, the erotic transference was facilitating Simone’s sense of herself as powerful and she experienced my penetrating qualities as offering her a new intersubjective perspective on what she could want or desire. She wanted an inner space into which her interior self could emerge.

She missed her session one week, called me from the hospital, and brought the newborn baby in the next week. He was colicky and she was having trouble nursing which she showed me during the session. I realized that as soon as the baby fussed she pulled him off her breast and stopped feeding. I also realized that I was seeing Simone’s exposed breast. Next week, the baby looked horrible and she complained he cried all the time. I told her not to take him off the breast entirely, but to let him breathe a little and feed him until he was full. Next week, he was much better and she sobbed saying she had been starving him and I think she was. I was now deemed an official parent. Each week for the next year, she brought the baby in to session and nursed him at

some point. At the end of the session, she would hand him over to me while she went to the restroom and he and I would play together for a bit. In a way, we were married in our transference/countertransference enactment and we had a child, and like some couples with children, the sexual tension was somewhat reduced as we focused on the baby.

Had the erotic transference just become maternal? I don't think so because there was still such a powerful erotic component in our relationship. In sessions, we discussed the emotional closeness we felt with each other, and Simone told of an ongoing internal dialogue where she imagined telling me her feelings about everything that happened or everything she wished would happen to her. At times she questioned her heterosexual identity and wondered if she might be bisexual saying a woman had more emotional potential with another woman, than with a man. In a footnote in *The Bonds of Love*, Benjamin says, "Ideally, in the psychoanalytic process, analysand and analyst create a transitional space, in which the line between fantasy and reality blurs and the analysand can explore her own inside. The analytic relationship then becomes a version of the space within which desire can emerge freely, can be felt not as borrowed through identification but as authentically one's own" (1988, p. 127). In this treatment, Simone and I were maintained in our subject to subject space. In our relationship there was a recognition between self and other self.

### ***CLINICAL ILLUSTRATION OF A LESBIAN PATIENT***

June has been in psychoanalysis for 4 years now and the transference has until recently been lustfully erotic. I receive multiple letters per week from June, many of them with drawings of the naked torso of a woman who she says is me. Often she speaks about her wish to watch me have sex with a man and/or a woman while she looks on and masturbates. She frequently fantasizes about parts of my body and tells me details of how she will arouse me sexually. June often wistfully looks up from the couch stroking her chest bone as she relates her sexual desires. Recently she told me the following joke: " 'Doctor, Doctor please kiss me.' The doctor, she said, answered 'No, no, I can't.' 'Please Doctor, kiss me.' The doctor replied, 'I can't kiss you, I shouldn't even be lying on the couch with you.' "

June was quipping about her awareness of our mutual erotic transference/countertransference relationship. I have repeatedly asked her

what meaning she makes of sexually arousing me, and she has interpreted that our mutual sexual stimulation is akin to actually having sex.

June doesn't believe in making love, rather she takes pride in "fucking like a man." She recounts affairs where she has seduced a woman, usually one who identifies as heterosexual and married, has sex with her and leaves while the woman is still naked in bed. Is this an analogy of our relationship, I asked her. She thought so and said it expressed her desire to control me—an enacted triumph over her fear of abandonment/wish for merger and achievement of intimacy through sexuality.

A few months ago, June's transference turned from lust to loathing. June had been obsessing about getting a new job and feeling very out of control. Concurrently, I began experiencing a deadness in the treatment, a countertransference reaction I had successfully interpreted in the past. However this time, the more she obsessed, the more I felt sleepy and angry at her for making me struggle to stay awake. Sessions seemed to drag on and even though I tried to interpret the emptiness in the hour/in her/in me, how her obsessions were burying/defending her, nothing brought the dead back to life. Finally after a few weeks, I just couldn't tolerate it or her any longer and grappling with my grogginess, I angrily told her to stop it. I said, "I hate your obsessionism, I hate feeling sleepy, and I hate being controlled. You're treating me exactly the way your mother treats you—killing me with deadness and obsessionism. You're trying to make it impossible for me to work." In a fury, she called me a "fucking cunt" or variations on that theme for the remainder of the session. Throughout the day, June called my office leaving additional messages about my being a "fucking cunt," and threatened to take a break from treatment. I called her back, told her she had to come back, that she was in psychoanalysis and not finishing school and she couldn't take a break. She kept cursing at me, but agreed to return—maybe in her mind she wanted an opportunity to berate me to my face.

In the subsequent sessions, my name seemed forever linked to "fucking cunt." Had the erotic transference just been a defense for an underlying aggression waiting to erupt? Or, had we both created a mutual narcissistic injury in the other and were both seeking revenge? June had wounded and obliterated me through her obsessionism which made me feel unnecessary. And I had not contained or success-

fully interpreted June's underlying feelings about envy, control, and abandonment.

Mitchell asserts (1998, 1993) that sexuality is an essential human experience because it is a powerful vehicle for developing and maintaining relational dynamics—and the same is true of aggression. “Aggression, like sexuality, often provides the juice that potentiates and embellishes experience” (1993, p.165). Both aggression, as well as sexuality, can be fundamental organizing elements among multiple self-organizations. “It is universal to hate, contemplate revenge against, and want to destroy those very caregivers we also love” (1993, p.170).

In the next few sessions, my subjective experience and countertransference was of hating June for hating me. I wanted the return of her sexual attention and love. I wanted her to stop her aggressive feelings, just as I had previously wanted her to stop her obsessionism. Who was dominating whom, who was exploiting whom, who was possessing whom? Then, June wrote in a letter, “Give me ambition. Real ambition. I don't wanna be sent off to track down a piece of cheese in a labyrinth. I'm scared of you because you're in the world and I think you like it. How do you know where I am?” June envied me for my place in the world and in her life, and I felt envy about her skill in controlling me. I told her this and added that I really did not know exactly ‘where she was’ and I should have been much kinder to her. I then asked if our mutual aggression felt comforting to her—I wondered aloud if we had both taken sanctuary in the other's powerful involvement. With hindsight, it seems that our aggressive feelings deepened our relationship in that we now knew the other could not be easily frightened off when we showed the worst of us.

She then wrote a note that said: “As time goes by, as time will do, we get closer, not further apart. So it fucking only makes sense that I'd wanna stay with you. That's the fucking nature of a relationship. The more you do the more you want to do. A relationship wouldn't be pleasurable if all you had to do was push a button. The downside of a human relationship is that you just can't eat a person, smoke, inject, or snort them. I wish I could just come in there with a lighter and a pipe and by god, I'd like to smoke you. But when I tried that you nearly died in the process when you felt clouded over by my obsessions. I think a relationship is like breakfast cereal in that it sort of satisfies the desire to smoke or eat people.”

In the transference/countertransference matrix, June and I enacted her early relationship to her mother. In a sense, I became a participant in the reenactment of an early trauma and became June's abuser. It is within such disruptions and the ensuing repairs that relationships and analysis progress. In *The Clinical Diary of Sandor Ferenczi*, he said, "I have finally come to realize that it is an unavoidable task of the analyst: although he may behave as he will, he may take kindness and relaxation as far as he possibly can, the time will come when he will have to repeat with his own hands the act of murder previously perpetrated against the patient" (1932, p. 52). He added that the deepening of any relationship is promoted when the analyst acknowledges her own mistakes and limitations—since this aids in mutual forgiveness. Ferenczi was one of the first analysts to realize that the patient observes and reacts to the analyst's countertransference, as the analyst enacts a role framed by her own character traits in response to the patient's resistance. In so doing, the analyst becomes a distinct and real person whom the patient genuinely affects and is affected by.

In one of June's most recent notes, she wrote: "It fascinates me that there is no gun at my head, yet I return day after day, week after week to you."

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# Cross Gendered Longings and the Demand for Categorization: Enacting Gender Within the Transference- Countertransference Relationship

Barbara Tholfsen, CSW

**ABSTRACT.** Patients who present with overlapping concerns about gender and sexuality tend to believe in a fixed, binary view of gender in which men should be men and women should be women. Psychoanalysis was born out of Freud's fascination with the hysterical symptoms that women were exhibiting at the turn of the century. He stated that there was no such thing as pure masculinity or femininity. But in the years that followed, Freud fled this psyche/soma, objectivity/subjectivity uncertainty and used gender to cap the fragmented, splintered word of knowing he had found and created a "highly differentiated," centered, integrated mechanistic self that was "distinctly male." By the 1950s, psychoanalysts had embroidered this stance into detailed, binary, rigid, inflexible, pseudo-scientific, and contradictory stereotypes of men and women. At first, feminists responded with parallel stereotypes, but by the late 1970s, they began to question the whole inflexibly dualistic

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set-up and to question whether anyone can successfully be “masculine” or “feminine.” Contemporary analysts have set about deconstructing the gendered, binary, biological language of psychoanalysis: with passive and active standing for male and female, and heterosexuality and homosexuality standing for gender health vs. gender pathology. Analysts find themselves questioning all of the old psychoanalytic assumptions about gender and identity. The paper presents case material from the treatment of two men who struggled with binary, gendered issues. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>>]

**KEYWORDS.** Countertransference, feminism, gender identity, post-modernism, psychotherapy, relational psychoanalysis, transference

*I'm always trying to please people. Is that common? I've heard that that's common to incest survivors to feel that way.*

*I wonder what you're looking for with that question.*

*It's important to feel not-unique. In group, the stories are all different, but the feelings are the same.*

*I think there's some concern that I'm going to see you as a freak—as ultra unique.*

*I want to be reassured that I'm not alone. It's comforting to see that I'm not alone. I can consider myself lucky when I see it that way. The shame is crippling. My secret desire to be a woman. To say that, to hear myself say that is really something. It's almost. . . it gives it less power, but that shame thing covers a little. Are we done?*

*We actually have some more time. Is there some reason you want this to be the end of the session?*

*I lie here and I talk about it and I think: Is it all worth while? Is this another crap shoot?*

*You're wondering whether I can help you.*

*Are you taking notes?*

*Yes.*

*Can I expect you to come up with your own conclusions?*

*Is that what you would like?*

*(He sighs and then there is silence)*

*How am I being difficult?*

*It's hard to pin you down. I want that a lot. That concrete definitive answer.*

*How would it feel if you got that definitive answer from me?*

*Part of me says 'relief.' Part of me would say 'She's full of shit.'*

“MARTY”

*Yesterday my wife brought home flowers. She just left them there on a counter. I put them in a little vase. This is something I shouldn't be doing . . . I still have a need to do these things but how will it be read? . . . People will say it's not masculine. So I say—should I avoid it? Should I say that's the way I am and I'll do it? Is this a gender identity problem? People who cook—the greatest chefs might be men. If I cook because I'm hungry or to be creative or I make wedding cakes . . . What do you do? Where do you draw the line? Where are the demarcation lines?*

*I'm in a turmoil because I don't want to do these things that might put me in a different category which may make me convinced that there is something strange about my personality that I don't admit to. I don't allow myself free rein. I restrict myself. I'm afraid of what people will say or what it will confirm in my own mind about me. As I stuck those flowers in the vase today, I thought if I left it to Linda, she would have let the flowers lie. But she goes to baseball games. I don't. It's like I have the feminine part and she's got the masculine part to some degree. Or am I a female in a male body or is she a male in a female body? I don't know . . . I feel like now I don't have anything I'm excelling at . . . I feel like a robot.*

“TED”

I am at an impasse with Marty and Ted. It is a familiar place. I have felt stuck like this with other men who have presented with overlapping concerns about gender and sexuality. I long to feel empathic, helpful, flexible; but instead I feel pushy, impatient, judgmental. I'm

uncomfortable, confused, unsure of what's going on and so is he, but there seems to be no way out of the confusion. It's like I'm choking on some kind of epistemological double bind that he and I have constructed as a team, but it's constructed out of several different languages and he only knows one of them. Maybe I know two.

Men with concerns about gender often ask, with both desperation and ambivalence, to be categorized. They frequently ask: "How freakish am I?" or "How abnormal am I?" which often translates into "How masculine and/or heterosexual am I?" My un-stated, but conscious response to the pressure from patients to categorize them can be dismissive. I want to say: All your suffering would cease if you would just see that men who are primarily attracted to other men are about as widely dispersed on the masculine/feminine scale as those who are primarily attracted to women. I want to say that men who are primarily attracted to women have dreams in which they have breasts, or have sex with men, and fantasize about feeling sexy in heels. I want to say: "Let's figure this out together. There is no normal. Forget normal. I am not the judge of what is normal in the room." Whether I say this or imply it, the result tends to be the same: he continues to try get me to tell him what he fears is true and fixed and shameful about himself, and I resist doing so. He comes to believe that I am holding back what I really (objectively) know, perhaps out of a desire to protect him from the "awful truth." I start to embody this "awful truth" for him, this fixed system of men and women and nothing in between, gay and straight and nothing in between. I know he's really gay, but I won't tell him. I know that he's a woman trapped in a man's body, but like him, I cannot face it.

I think one reason Ted and Marty and I get stuck like this is that we think about gender and about knowing quite differently. Men who present with overlapping concerns about gender and sexuality tend to believe in a fixed, binary view of gender in which men should be men and women should be women (Shapiro, 1991). Marty and Ted each ask for "objective" answers to questions about how his genitalia (sex) and his gender (what we expect from people based on sex in a particular culture) are related. Each assume that there is some "natural" way gender and sex and sexuality must be related and that I, as his hired expert on psychological health, must know what that relationship is. But I, the "expert," come from a feminist/psychoanalytic/postmodern

tradition that tends to consider concepts like “objective,” “natural,” “masculine,” and “feminine” illusory.

Historian Mary Jo Buhle (1999) notes that “feminism and psychoanalysis developed dialogically . . . in continuous conversation with each other” (p. 3). During this development, there were times when feminists and psychoanalysts conceived of gender and objectivity in much the way Marty and Ted do. At other times, both groups questioned the dichotomies of objective/subjective and masculine/feminine, finding ambiguity in both gender and in knowing. Psychoanalysis was born out of Freud’s fascination with the hysterical symptoms that women were exhibiting at the turn of the century (see Benjamin, 2000).<sup>1</sup> There was no “physical” cause for the blindness, the seizures, the inability to walk or talk that these women complained of. Their bodies bound psyche and soma into an undifferentiated mass that challenged the body/mind, subject/object dualism of the day. Freud listened and came up with, in Chodorow’s (1989) words, a “wounding . . . blow to human megalomania.” He made it “impossible to think about the self in any simple way, to talk blithely about the individual” (p. 154). He stated baldly in 1905<sup>2</sup> that there was no such thing as pure masculinity or femininity—“either in a psychological or a biological sense” (Buhle, 1999, p. 31). Chodorow (1989) sums it up this way:

According to Freud, then, we are not who or what we think we are: we do not know our own centers; in fact we do not have a center at all. [p. 154]

But in the years that followed, Freud fled this psyche/soma, objectivity/subjectivity uncertainty and used gender to cap the fragmented, splintered word of knowing he had found. In what Muriel Dimen (1997) calls “a failure of nerve” he “dissociated what he knew” (p. 533) and created a “highly differentiated,” centered, integrated mechanistic self that was “distinctly male” (Buhle, 1999 p. 355). By the 1950s, psychoanalysts had embroidered this stance into some of the most detailed, binary, rigid, inflexible, pseudo-scientific, contradictory (and I must say goofy) stereotypes of what men and women should be—ever.

Women had vaginal orgasms if they developed properly (the clitoris being too “masculine” to be properly “feminine?”) and penis envy if they didn’t (and if they did). Men were aggressive and therefore mas-

culine if they developed properly and “defending against passive, feminine and masochistic wishes” (Greenberg, 1991, p. 60) if they did not. At first, feminists responded with parallel stereotypes (men have womb envy; women are more relational), but by the late 1970s, they began to question the whole inflexibly dualistic set-up (see Buhle, 1999; Grosz, 1995). Feminists began to question whether anyone can successfully be “masculine” or “feminine.” Gender was no longer seen as a “sinecure for any of us.” In Shapiro’s words, “we are all passing” (p. 257). Gail Bederman (1995) spells out this point of view clearly and succinctly:

At any time in history, many contradictory ideas about manhood are available to explain what men are, how they ought to behave, and what sorts of powers and authorities they may claim as men. Part of the way gender functions is to hide these contradictions and to camouflage the fact that gender is dynamic and always changing. Instead, gender is constructed as a fact of nature, and manhood is assumed to be an unchanging, transhistorical essence consisting of fixed, naturally occurring traits. [p. 7]

This feminist/postmodern take on gender is illustrated in a cartoon that pictures two children standing in front of a picture of Adam and Eve. One child says to the other, “Which one is the man and which one is the woman?” The other child says, “I don’t know, they don’t have any clothes on” (Shapiro, 1991). Such a cartoon is actually a pretty good representation of a toddler’s view of gender. Before we have understood the biological differences between men and women, we “know” that hair length and clothing style are as fixed as a penis or a vagina.<sup>3</sup> The language of the toddler as s/he learns his/her grammar for the first time, is rigidly dualistic: Good and bad; fair and unfair; strong and weak; right and wrong; pretty and ugly; normal and abnormal; sick and well; male and female. Working analytically, one comes across these dyads operating problematically in adults, both inter- and intrapsychically. Often, in analysis and psychotherapy, this binary way of looking at the world or feeling about oneself begins to shift. But the problems that can be associated with internalizing a rigid notion of gender as pairs of fixed opposites are not always acknowledged. In some treatments, they are still propped up.

But things have been changing. For the past fifteen years, many analysts have set about deconstructing the gendered, binary, biological

language of psychoanalysis: with passive and active standing for male and female, and heterosexuality and homosexuality standing for gender health vs. gender pathology. Taking a critical look at how concepts as basic to psychoanalysis as “health,” “self,” “body,” “identity,” or “integration” get constructed (see Hoffman, 1991; Mitchell, 1993; Silverman, 1994), analysts find themselves questioning all of the old psychoanalytic assumptions about gender and identity: Is there really a link between identifying with the “right” parent and developing a “healthy, evolutionarily-determined desire to reproduce” (Schwartz, 1999)? Do boys who identify with their mothers really tend towards gender identity “disorders”? Is there any fixed relationship between gender identity and sexual preference (Burch, 1993)? Must an adult really develop a single integrated gender identity to be considered “healthy” (Dimen, 1991)? Maybe it is the attempt to develop a single integrated gender identity which creates psychopathology (Goldner, 1991). Under this kind of scrutiny, psychoanalytic categorization based on gender has lost its theoretical base and most psychoanalysts have “set aside their search for . . . characteristic family history, structural conflicts, internal object relations or psychological developmental lines than lead to . . . same sex . . . sexual attraction” (Magee and Miller, 1999).

Knowledge is thus seen as “less encompassing” rather than more (Grosz, 1995). Knowing, expertise and objectivity are now viewed with a psychoanalytic skepticism traditionally reserved for a patient’s free associations, dreams, and slips of the tongue. Transference is no longer seen merely as distortion on the part of the patient that the “objective” analyst interprets to the “subjective” patient. The countertransference is no longer seen as a neurotic stumbling block that an analyst must work through and expel in order to maintain objectivity. The transference/countertransference relationship is seen as a place where patient and analyst co-create enactments, where subjectivities merge and interact (see Mitchell 1988, 1993). Words seem poor tools to describe these spaces (Harris, 1996) and analysts often resort to metaphors of paradox when making an attempt:

. . . the solution to the problem of splitting is not merely remembering the other poles but being able to inhabit the space between them, to tolerate and even enjoy the paradox of simultaneity. [Dimen, 1991, p. 348]

It is . . . what each of the patient's selves does *with* each of the analyst's selves that makes transference experience usable . . . As the patient's dissociated self experience becomes sufficiently processed between them . . . the patient reclaims . . . his sense of dynamic unity—what I call “the capacity to feel like one self while being many.” [Bromberg, p. 310]

This repositioning in respect to objectivity and knowing can also be seen among feminist theorists. Elizabeth Grosz reflects on Luce Irigaray's reconception of knowledge:

Irigaray's work thus remains critical of such traditional values as “truth” and “falsity” . . . she does not present a more encompassing knowledge, but rather a less encompassing knowledge . . . her texts are openly acknowledged as historical and contextual, at strategic value in particular times and places, but not necessarily useful or valid in all contexts . . . She shows that there are always other ways of proceeding, other perspectives to be occupied and explored . . . the fact that a single contested paradigm (or a limited number) governs current forms of knowledge demonstrates the role that power, rather than reason has played in developing knowledge. [1995, pp. 41-43]

Many therapists working today attempt to bring these new ways of thinking about gender and knowing into their consulting rooms—to look beyond the manifest in ways that are, in the end, quite Freudian. Aware of multiple meanings, shifting identifications, camouflage, breakage, splinter (Butler, 1990), analysts hesitate warily before the gendered language of psychoanalysis and do a double-take. Freud scratches a breast and gets a penis. Melanie Klein scratches a penis and gets a breast. If you call the object a phallic mother and move on, you may be missing a lot. If you turn over the object, you may find another dimension where gender, genitalia and sexuality are related to each other like elements in a dream—where gender can camouflage your patient's transference distortions or your own.

### **MARTY**

Marty approached treatment asking whether he had “gender dysphoria.” Recently divorced, primarily attracted to women, Marty had

wondered since early adolescence whether he “should” have been a woman. He connected these wonderings to childhood memories of a mother he described as strikingly beautiful:

My mother used to rock me until I would go to sleep on her shoulder. (This went on) until I was four or five. There was a lot of nudity. She would go to the bathroom with the door open. She’d scold me with her vagina in my face with a little, short shirt on. And thinking about all this with the transexuality, it’s connected.

Marty was fascinated by talk shows about transsexuals and aroused by magic shows that showed a woman being cut in half. He sometimes dressed in women’s clothes to promote sexual excitement while masturbating or just to feel more relaxed when at home doing chores. This was always done in private and he would more often than not throw the clothes away, hoping to prevent himself from repeating the behavior. Though it became clear that Marty was highly ambivalent about hearing my “definitive answer” to his questions about who he “really” was, I felt the pull, both from him and from myself, to give us one. Just as Marty wanted a definitive answer from me, I wanted a definitive place to sit in the room with him. I wanted to ease my own discomfort with ambiguity. I wanted to ease his terror. But what were my options? A clinician specializing in sex change operations, the treatment prescribed for gender dysphoria, could have agreed with Marty that the task at hand was to determine whether his gender just didn’t properly match his genitalia. Questions would focus on how “female” Marty feels in order to determine how strong his “feminine” identity is. Such a clinician might even figure into the equation his own guess as to whether he, as a man, might feel attracted to Marty (after the operation of course!) (Stone, 1991). But Marty seems quite “masculine.” Wouldn’t the paradoxes begin to show? Second thoughts (Eigen, 1996) and suicide are common after the operation. Would it be stretching much to make a comparison between going to a surgeon for help with gender problems with going to a dermatologist for help with problems of race (Shapiro, 1991)?

Marty also approached his treatment with questions about whether his wish to be a woman might mean he was gay. At times I longed to “help” him find that his “woman trapped in a man’s body” approach was just “a disguised form of homosexuality” (Shapiro, 1991, p. 252).

I wanted to say: You are gay, straight or “bi”; let’s figure out which and get over this societally-induced idea that being gay is shameful. But I could only take this stance with Marty if I assume that (i) gender identities have fixed predictable relationships to sexual preferences; (ii) that preference for same-sex or opposite-sex relationships is more important to defining a person’s identity than any other sexual preferences; and (iii) that sexual preference is a matter of finding one of two or three fixed niches to fit into (see Schwartz, 1995). Though I can’t assume these three positions comfortably, it’s also uncomfortable sitting with Marty’s shame. Caught between my discomfort and Marty’s, I want to rough ride over the meaning of his concerns, fears, conflicts and pain on the road to liberation. But somehow I know if I do this, I’d be like a frustrated Freud saying to a patient suffering from hysterical blindness: “Get off it, you can see!” So I don’t answer him when he asks me if he’s gay. Like a good psychoanalyst, I explore the conflict and move on.

Similar problems crop up when I take the postmodern approach. If I promote too assuredly a view of gender as “basically” flexible and ambiguous, it becomes difficult to explore the ways Marty and I (and all of us) enact gender as if it isn’t. If I imply that living gendered is as simple as “seeing” the emperor’s new clothes—I imply also that Marty and I are capable of interacting in some gender-free space where we both can “pass.” With my stance of knowing better than he that his feeling of being out of gender is a symptom of his inflexibly held gender ideology, I subtly request that he stop enacting his conflict about gender within the transference relationship and that he ignore my part in such enactments. I “dissociate what I know” and forget that my own conscious and unconscious gender configurations affect the treatment in ways in which I am and am not aware. I pretend that there is no intersubjective part for me to play in transference enactments of Marty’s concerns about gender. I forget the extent to which my own, more inflexible positionings as to gender are camouflaged from myself.

Bederman again:

The ideological process of gender—whether manhood or womanhood—works through a complex political technology, composed of a variety of institutions, ideas, and daily practices. Combined, these practices produce a set of truths about who an individual is

and what he or she can do based upon his or her body. Individuals are positioned through that process of gender, whether they choose to be or not. Although some individuals may reject certain aspects of their positioning, rare indeed is the person who considers “itself” neither man nor woman. And with that positioning as “man” or “woman” inevitably comes a host of other social meanings, expectations, and identities. Individuals have no choice but to act on these meanings—to accept or reject them, adopt or adapt them—in order to be able to live their lives in human society. [p. 7]

### *TED*

Though Ted didn’t present with concerns about gender, it eventually became clear that such concerns were a major reason he subjected himself to what was a difficult experience for him: analytic psychotherapy, three times a week. Ted didn’t have a sexual relationship or move out of his parent’s home until he was in his mid-thirties and had had only one sexual partner, his wife. Now in his forties, he spoke of missing the more active sexual relationship that they had had in the first few years of their marriage. He wanted sex more frequently than she did—this was becoming a problem. About six months into the treatment, Ted began to speak vaguely about fears that he was sexually attracted to men. Indirectly, he began relating these fears to parallel concerns about gender. My approach was to sidestep the gender issue altogether, exploring Ted’s pleas as interpersonal or intrapsychic problems in a way that said: gender is not the true problem here. I tended to focus on the rigidity evident in his thinking about gender and how this rigidity permeated his feelings and thoughts about everything, not just gender. My assumption was that the ability to move “between qualities of greater rigidity and greater fluidity” (Sweetman, 1996) with respect to gender is “healthier.”

However, as I avoided gender, Ted circled in on it. In one session, Ted talked about “categorizing” people by gender. He talked about men who are “car-oriented. That’s a masculine thing. Then there are ladies who like trucks. This gender demarcation thing gets to be very interesting because as I go through life I see people who don’t fit into categories.” He adds, “I can categorize a couple of females” and then describes women at work who exhibit what he considers to be mascu-

line behavior and dress. He expresses disapproval of a man at work who wears an earring, and then says: "I put people in these categories. Everyone has a place. Everyone has a category." In response, I ask him if he has tried to categorize me. At first he says no, that I'm an enigma like Mona Lisa. But then he says: "You want a reading? You want me to tell you what I think?" I reply affirmatively, and he says, "I don't want to be embarrassing." I respond by saying, "embarrassed for me or embarrassed for you?" He answers at length:

Me being embarrassed about how I see you. It might not be anything how you see yourself or how you really are . . . Let me see . . . Your hands. Well, you have a wedding ring on. You have rather large hands. You have a squarish face. You don't seem to be ultra feminine, but you're definitely a woman. I think you're very kind and sensitive to people's moods. That's why you do what you do. No jewelry. I don't think I've ever seen you wear earrings. No make-up. No lipstick. You don't fuss with your hair to any great degree. It's just there, which is fine. You're not beautiful, but you're not ugly either. You're fine and you seem to wear very dark clothes all the time. Today gray. Once in a while you touch it up with some red, but not too often. Always conservative shoes. No high heels. Maybe if you go to a party you look different, but meeting with me it's fine. It would be a distraction if you were different. I might even find you attractive, more than I do at the present time, and that could be a problem. I don't know. Does that make any sense?

I nod and he continues: "I don't know. I wonder if you wash your windows and if you vacuum your floors or if you have someone who does it. Who puts the light bulbs in? I don't think you climb way up there. You're wearing a wedding ring. Maybe your husband likes to vacuum." He talks about his fascination with television programs about cross-dressers and pushes me to tell him what this fascination means. He asks me to "rate" him like he "rated" me. He says, "Do you see me as masculine, feminine, somewhere in between? How far in one area and how far in another?" He then free associates about gender and sexuality and television talk shows about transsexuals until the time is up. He has left me no chance to answer and I feel relieved. But the relief is telling. Ted is asking me to use my own personal

gender rating system to rate him, and I want to keep this (very non-postmodern) part of myself hidden.

Ted did not let me hide. He was clear that there were two people in the room. In this case, two different sexes and the implication of multiply- or at least ambiguously-gendered selves. He made it clear that no matter what my theories about gender are, I carry unconscious and conscious gender processes, both rigid and fluid, that are reflected in my tone of voice, body language, clothing, language, affect, etc. It is understandable that Ted would “rate” me with respect to gender and to expect that I would “rate” him too. Within each moment we are each positioning ourselves with respect to gender. His experience of how I position myself at a particular moment might be different from another person’s or from my own “rating” of myself. Contradictions and ambiguities may clutter up these rating systems to the point where they make little sense, but to deny that each of us consciously and unconsciously rate ourselves and others with respect to gender, is to deny the obvious.

### **MARTY**

Just a few weeks into the treatment, Marty began discussing an experience he’d had the night before. A woman he had recently met offered to give him a massage for free. She was a licensed massage therapist, who “needed the practice.” As she was married and because she behaved “professionally” when she came to his house, Marty felt shame when he began to feel aroused during the massage. Since Marty knew I was taking a very low fee because I was in institute training and “needed the practice,” I wondered whether Marty was talking about shame he felt about sexual feelings he had in sessions with me. So I asked if he ever felt aroused during our sessions. Marty paused and then changed the subject, talking about his mistrust of a woman at work. When I connected this to his possible mistrust of me following the question that I had asked, he had what seemed to be a dissociative experience, and said he felt “almost” like he was “having an LSD trip.” When I asked him to say more he said, “My face feels large. There’s a feeling I would get when I was a child. There’s a similar, like a suffocating kind of large swollen feeling. Boy, I don’t know what that’s about.” In the next session he talked about leaving treatment. I asked why, and after a pause Marty wondered aloud about why I had

asked “that question” in the previous session. I told him some of my reasoning. Seemingly changing the subject, Marty then described a “dysfunctional” relationship he had had with a woman years before. She had loved him and would “do anything” for him. He had taken advantage of her and now felt ashamed about how he had treated her. Ignoring the sadistic aspect of this story, I focused on his fear of getting entangled in another “dysfunctional relationship” with me.

In the next session, Marty talked about a previous treatment in which the male therapist seemed to have difficulty maintaining boundaries. Later in the session, Marty told me a dream:

You and I were talking about friends being friends and it was warm, and nice. I kept waking up with a powerful erection and I don't get a lot of erections now. My libido is not that strong. For some reason I put the two together.

Later he said that the erection was actually “sparked” by another dream about a transsexual he had had the same night. Later he said that though the erection was “sparked” by the dream, the erection was the all-important thing. “not the dream.” Marty then talked about another long-past “dysfunctional” relationship with a woman and about a male friend who had recently betrayed a confidence related to Marty's cross dressing. Throughout the session, it was the erection that continued to preoccupy Marty and he eventually said: “My male performance is important to me because so many of my fantasies have involved being a woman.” In the next session he discussed a history of physical fights with his mother when he was an adolescent, including one in which he pushed her down and broke her shoulder. He spoke again about his mother's intrusive sexualized behavior with him as a child, and we explored the possibility that when I asked whether he felt aroused in sessions, this had reminded him of his mother's sexual intrusiveness.

A dream I had while working on this paper led to associations about my work with Marty:

I'm young in the dream, just out of college and at a new office job. I'm in the ladies room with another woman. We are each sitting in a stall and she is telling me about a game that is played every year at this office. Eventually I'm hanging out over the top of the stall talking to this woman from above (I must be standing on the toilet seat). Some time during this friendly, easy-going

chat, the woman opens her fly or lifts her dress and shows me that she has a penis. My first reaction is self-protective. A man is exposing himself to me in a ladies room and I don't want to be victimized or humiliated. How can I humiliate him instead? So I say, "It's not such a great penis. I don't see why you'd want to go showing it to people." Then I start to look anxiously at his face and figure out how I could have missed the fact that "she" was a he. Where did I go wrong? How was I fooled? There must have been some sign in "her" face that "she" was a man. And now I see it, yes, I see that she is a man. Her features are heavier than a woman's. Her hair is like straw. As "she" now begins to look more male, I feel more oriented, less anxious. Then the scene changes and I'm in the office playing the game she/he had told me about earlier. Anxious once again, I am sitting at a card table practicing with another woman. I play for a while and eventually it doesn't seem that hard. It's like Trivial Pursuit and I get some answers right. So again, I start to feel less anxious. I think: "This isn't so bad. I can play this." Then, as I sit there, I remember what has just happened in the ladies room. I realize that I may have misinterpreted the whole interchange. I realize that I may have felt vulnerable with the man in the ladies room because I saw the interchange as one between flasher and victim, but as I look back on it I see that the man was taking a risk in order to tell me something personal about himself. He was actually making himself vulnerable to me. So I start to feel guilty. I wish I could take back my hurtful words. I am going through this change of heart as fellow office workers begin to explain the game to me in detail. As I try with difficulty to pay attention, they tell me that I will have to make up questions for the game and that I'll be given two words that are related to each other in some analogous way—like a pun—and each must be in one part of a two-part question. This makes me nervous. This sounds hard, and I've always been somewhat befuddled by puns. Then someone hands me a piece of paper and tells me I've been assigned to a team. On the paper are two or three number/letter combinations (like L4 or H2) and I say, "Oh, I must be in the L4 team" and they say: "No, no, no. Teams do not have letter and number combinations!" But I'm still confused. I don't really get it. I look around for help and I notice something I hadn't noticed before: everyone in the room

is a woman. I'm about to comment on this when I remember that the man dressed as a woman is not a woman. So I hold back on saying anything about the gender of the people in the room. I consider the possibility that the man doesn't want anyone to know he's a man. Maybe he just told me. Maybe he wants to pass.

My associations to this dream included: memories of "take back the night" rallies in the seventies, when women would tell stories of successful attempts to turn the tables on flashers and subway gropers; memories of feeling frightened and angry as a young therapist when male patients would sexualize the therapeutic relationship; my guilt in response to Marty's dissociative experience when I asked him if he felt aroused in sessions; and the thinking and reading I had been doing about gender ambiguity. Marty had described his childhood relationship with his mother as one in which sexuality was used to dominate and humiliate. He described his adolescent relationship with her as stormy and violent, and adult sexual relationships with women in which he is dominating and self serving. Was I then, by sexualizing the therapeutic relationship with Marty first, beating him to it in order to protect myself from feeling defeated in a dangerous gender game with confusing and changing rules and roles? Was my too-early reference to a sexualized transference with Marty sparked by the same aggression and fear I experienced in the dream when my co-worker exposed him/herself to me in the ladies room? Did I have to buy the stereotype: "women typically violate boundaries less often than men" (Maroda, 1999, p. 80) in order to violate this particular boundary? Did a tendency of mine to expect men (and not women) to sexualize a relationship as a way of asserting control help me dissociate from what I knew—that women (and I) can do the same? Was it only by dissociating this aspect of myself from myself that I was able to construct, with Marty, a reenactment of particularly nasty aspects of his relationship with his mother? Is this an example of gender functioning as camouflage?

Women as subordinator (mother) of the vulnerable (child) must be a powerful internally gendered relationship for all of us. Do I dissociate from woman as sadist because it's too frightening to dwell too long on this particular dyad? Is it easier to associate masculinity with sadism and femininity with masochism and allow our opposite associations to be expressed in misogynist or feminist intellectual acting out that implies women are either inferior to men or superior, more victim or more victimizer, more nurturing or less rational, more relational or less aggressive?

Associations to my dream also included the word “fag,” which in England means cigarette and in this country is a pejorative term for gay men: two separate meanings made analogous by medieval witch burnings. (Gay men were said to have been used to feed the fires in which the witches were burned.) This association reflects power relationships in which gender is used to punish, and annihilate, but in ways both inside and outside the “woman as victim of male domination” stereotype. Women and men both, this association reminds me, made up the burners and the burned in medieval Europe. Gender relationships shift, according to historical circumstances, class and race relationships, who is involved in a given relationship, life circumstance, momentary shifts in mood or motive, or shifting identification. There is a moment in the dream when I almost understand this. It is the moment when I realize that the man in the ladies room was not necessarily a threat to be feared, but that his behavior was an attempt to reach out to me or make himself vulnerable to me. This is a familiar experience; a moment when I realize I have mistaken one kind of relationship for another; a moment when the transference is apparent, when I can see my tendency to assume a relationship to be binary (with room only for one-up and one-down). Suddenly there is room to consider more ambiguous configurations.

And yet, what does one do with all this room? Ambiguity is uncomfortable, disorienting, a little scary. Of course, pretending that reality is unambiguous—that I can clearly differentiate between myself and my patient, between one of my selves and another, between masculinity and femininity—that’s also pretty uncomfortable. But ambiguity is worse. Or is it? In the dream it is both differentiation and ambiguity that are uncomfortable. All the binaries are there: win/lose, correct/mistaken, virtuous/sinful, smart/dumb, ignorant/educated, male/female, victim/victimizer. I don’t want to be a victim or a loser. I want to be a winner. I want to understand the rules of the game like my office mates seem to. It’s not just that I want to feel smart and win. I also don’t want to feel so out of it and alone. But the rules, which seem so orderly, so differentiated one from the other to my office mates, in the end, don’t make any sense to me. I try to understand them, but I am befuddled by them. I feel vaguely dissociated: half in my memory of the incident in the ladies room, half in the game trying to concentrate so I can understand. In the end, all I have is guilt because I made a “mistake.” I am comfortable only at the beginning of the dream, when female is fe-

male. I'm beside (unable to see "her") or I'm on top (looking down on "her") and the game is outside.

Marty and Ted feel that they are trying to pass for something that they should be but are not. They feel vaguely out of gender (Dimen, 1991) and they feel alone. They have mixed feelings about asking me to categorize them as gay or transsexual because, on the one hand, there's hope that a category would help them feel less anxious, less confused about themselves and less alone; but on the other hand, they sense that categories carry with them stereotypes that are too confining and unambiguous to describe the way they really feel about themselves. Rather than sit in the ambiguity, however, Marty and Ted choose to hold onto the certainty that can be found in stereotypes. Though I claim to "know" how ambiguous gender "is," I also have difficulty sitting in the ambiguity I find. But I try to escape in a different direction. Rather than clinging to Marty and Ted's unambiguous reality of gender stereotypes, I try to escape to the unambiguous reality of "corrected, 'purified,' unbiased" (Grosz, 1995, p. 41) ungendered knowledge. That is a position as untenable as Marty's or Ted's. So this is how we get so stuck. Marty and I or Ted and I take on incompatible approaches to gender and sit on opposite sides, neither of us wanting to enter the space between. What we all fail to realize is that there is no escaping this space. Marty and Ted can pretend that if they try hard enough they can be masculine or feminine and not just pass or I can pretend that if I try hard enough, I can sit outside of gender and smugly feel "right," but in "reality" there is no doing either. That stuck feeling I get with these men, that discomfort, frustration and unease; that is gender. It is only by resisting the urge to escape the discomfort, by living through the stuck feeling and noticing how it feels, that we can explore what gender is and does to each of us. We are all passing. In that sense, Marty and Ted and I are not alone. We just don't "know" it yet.

## NOTES

1. Also see Breuer, J. & Freud, S (1895), Studies on hysteria. *Standard Edition* 2. London: Hogarth Press, 1955., and Freud, S. (1905), Fragment of an analysis of a case of hysteria. *Standard Edition*, 7:1-122. London: Hogarth Press, 1953.

2. See Freud, S. (1905), Three essays on the theory of sexuality. *Standard Edition*, 7:123-246. London: Hogarth Press, 1953.

3. See Kohlberg, L. (1966), A cognitive-developmental analysis of children's sex role concepts and attitudes. In *The Development of Sex Differences*, ed. E. Maccoby.

Stanford, CA: Stanford University Press, pp. 82-172, Maccoby, E. & Jacklin, C. (1974), *The Psychology of Sex Differences*. Stanford, CA: Stanford University Press, and de Marneffe, D. (1997), Bodies and Words: A study of young children's genital and gender knowledge. *Gender and Psychoanal.*, 2(1):3-33].

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# Gay or Straight? Why Do We Really Want to Know?

Linda I. Meyers, PsyD

**ABSTRACT.** Issues pertaining to sexual orientation, while always deeply personal, are most profoundly constructed along traditional lines by cultural factors. The dilemma—gay or straight—appears most frequently in treatment in its interrogative form: “Am I gay or am I straight?” The question is imbued with an urgency considered self-evident by the patient and the therapist. Why? Why do we really want to know? What can the answer mean for the patient? What does it mean to the therapist? What does the necessity of an answer illuminate about Western notions of sexuality? Inherent in this paper’s thesis is the supposition that we are unable to clinically comprehend what we do not culturally comprehend. The cultural, like the psychological, is rarely manifest; it must be made visible before it can become comprehensible. Three approaches come to mind: the first method, most familiar to psychoanalysts, is the analysis and deconstruction of language; the second, most familiar to anthropologists, is the contrast and comparison with other cultures; the third, an integration between the cultural and the psychological, can be seen within the developing metapsychology of psychoanalytic theory. The way we use the question of sexual orientation with patients beautifully illustrates the importance of an integrative comprehension. A case vignette is used to illustrate these points. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>>]*

**KEYWORDS.** Anthropology, countertransference, homosexuality, lesbianism, psychotherapy, psychoanalysis, transference

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Issues pertaining to sexual orientation, while always deeply personal, are most profoundly constructed along traditional lines by cultural factors. The dilemma—gay or straight—appears most frequently in treatment in its interrogative form: “Am I gay or am I straight?” The question is imbued with an urgency considered self-evident by the patient and the therapist. Why? Why do we really want to know? What can the answer mean for the patient? What does it mean to the therapist? What does the necessity of an answer illuminate about Western notions of sexuality?

### ***“THE QUESTION” IN CULTURE***

Inherent in this paper’s thesis is the supposition that we are unable to clinically comprehend what we do not culturally comprehend. The cultural, like the psychological, is rarely manifest; it must be made visible before it can become comprehensible. Three approaches come to mind: the first method, most familiar to psychoanalysts, is the analysis and deconstruction of language; the second, most familiar to anthropologists, is the contrast and comparison with other cultures; the third, an integration between the cultural and the psychological, can be seen within the developing metapsychology of psychoanalytic theory. The way we use the question of sexual orientation with patients beautifully illustrates the importance of an integrative comprehension.

Judith Butler (1991, p. 17), a queer theorist attentive to the importance of language, shows us how the ostensive polarity of the terms “straight” and “gay” dissolves upon closer inspection. She asks, “What do we use as the determinant of its [sexuality’s] meaning: the phantasy structure, the act, the orifice, the gender, the anatomy?” If a woman has sex with men, but achieves orgasm only through fantasies of other women, is she straight or is she gay? Or consider a male transvestite whose preferred sexual partner is a woman; sexually he functions like a man but he looks like a woman. If he were to feel like a woman, dress as a woman, yet choose sex with a woman, would he be a psychological lesbian?

The anxieties that are raised by Butler’s simple question are ameliorated by a belief in the existence of confined categories. The straight/

gay dichotomy is particularly seductive because it proffers stability; choose and the issue is closed. The psychological needs of the individual are supported by the misconceptions of the culture. We'd rather believe that if you're gay now, you were gay before and you'll be gay later. If you were gay before, but now you define yourself as straight, you're just "trying to pass"; and if you're gay now, but say you were straight before, you just weren't ready to accept the truth. The edict in our culture is "let's just decide and get it over with."

Ambivalence—an inevitable, normal human condition—is not well tolerated in Western, particularly American, culture. Ambivalence and anxiety nourish one another, creating the entropic, circular condition which language is meant to penetrate. The more ambivalent the issue, the greater the anxiety, and the greater the impetus to create and name binary categories, false or otherwise.

The term, *homosexual*, was first coined by the medical establishment in 1892; *heterosexual*, its presumed counterpart, was labeled eight years later. While the term *sodomite*, the homosexual's predecessor, had no female counterpart, the term *homosexual* required an opposite and the category *lesbian* was created (Halperin, as cited in Lesser, 1995). Obviously, *homosexual*, in its vagueness, induced an anxiety necessitating the relief of a new category. However, the desire and the behavior meant to inform these distinctions always existed; the labels and stigmatization are modern social inductions.

The more powerful the anxiety, the more tenaciously we cling to the category.

The history of psychoanalysis' nosology reflects the anxiety. Classical psychoanalysis, conceived in the Darwinian era, needed a strict and discerning taxonomy in order to be respected as science. Patients, of necessity, were *diagnosed*; that is, they were pathologized and categorized. Although Freud professed the existence of an inherent bisexuality, that did not mean he believed bisexuality was "normal." He believed that sexuality, and particularly homosexuality, needed to be sublimated for the benefit of society. The drive may be normal but the behavior was pathological. It wasn't until 1973, that attempts were made to remove homosexuality from the American Psychiatric Association's DSM-II manual. Psychoanalysts protested vociferously (Bayer, as cited in Drescher, 1995).<sup>1</sup> In the 1980s, an attempt was made to retain the perception of homosexuality as pathology but the burden was transferred from the psychoanalytic establishment to the pathology

of the patient; hence, the category of ego-dystonic homosexuality was created. We claimed to no longer think of homosexuality as pathology, but if patients did, we were completely understanding and willing to "cure" them.<sup>2</sup> By 1987, I suspect, more as a reaction to its untreatability than a true change in beliefs, homosexuality as pathology was finally removed from the nomenclature.

In our society we use specific categorical distinctions to ameliorate ambiguity and to allay anxiety. True androgyny is too uncomfortable. However, this anxiety is a cultural, not a biological manifestation and the categorical distinctions are cultural constructions. A meaningful presentation of cultural comparisons is beyond the scope of this paper. However, for illustrative purposes I will briefly mention the *hijra* of India and the *Sambia* of New Guinea. For a more comprehensive investigation, I point the reader to Gilbert Herdt's edited volume, *Third Sex Third Gender: Beyond Sexual Dimorphism in Culture and History* (1994).

The *hijra* are an Indian cult whose members are considered not men, not woman. They begin their lives as males, but claim power through emasculation. The surgical removal of all genitalia is generally self-performed and represents the final initiation into the cult. *Hijras* dress as women and demonstrate through their ritual dances and comportment the "hot, erotic, aspects of female sexuality that . . . transforms them into sacred, erotic, female, men" (Nanda, in Herdt, p. 375). In the Hindu view, the Supreme Being has male and female sex organs; hermaphroditism is idealized.

According to Kakar (cited in Nanda, 1995) the anxiety in the Indian culture is assuaged by a third sex. He offers a classical psychoanalytic interpretation. Mature Indian women eroticize their relationships with their sons because of the sexual deprivation they endure with their husbands. The sons distance the engulfing women and eventually become the sexually depriving husbands. The *hijra* help the men contain their anxiety by acting out the actual castration.

Similarly, the *Sambia* of New Guinea defend against castration anxiety by the institutionalization of "homosexuality." This is not a contradiction for the *Sambia*, nor is it necessarily "homosexuality," as we conceive of it. Male individuation, supremacy, and agency are achieved through dependence on semen and exclusive relationships with men. At initiation, boys are wrested away from women's life and their male identity is secured through the powerful initiation rituals.

First and second stage initiates are fellators. Third-stage pubescent boys are recipients of fellatio, inseminating prepubescent boys. Although there may be erotic attachment, after marriage eroticism transfers to the wives. It is interesting to note that the “stronger” idealized warriors are allowed to continue homoerotic practices even though they are married.

The Indian hijra and the Sambian men are presented as examples of non-dichotomous sexual categorization. In these cultures, sexuality is, as Schoenberg describes (1995) “a fluid, dynamic process which assumes different forms at different times” (p. 220).

### ***“THE QUESTION” IN PSYCHOANALYTIC THEORY***

I had mentioned earlier that the development in psychoanalytic theory also reflects changes in culture. These changes have had an impact upon our clinical approach and conception of sexuality. In contemporary, relational theory, the human need to develop and maintain relationships has replaced drives as the major motivation and cohesive force within the psyche. Therefore, the intersubjective world created by the patient/analyst relationship has become paramount to psychoanalytic theory and application.<sup>3</sup> This shift from the intrapsychic to the relational has profoundly effected the way analysts think and apply themselves in their work. The postmodern emphasis on subjectivity that has infiltrated anthropology, literary criticism, history, etc., has not neglected psychology. It is interesting to note that this movement, best represented within psychology by psychoanalysis, develops side-by-side with a burgeoning research in neuroanatomy and brain physiology.

One clear manifestation of the shift to the subjective can be seen in our new attitude towards countertransference. The so-called “neutral” analysts are out; not because they’re passé but because they never existed. Today, analysts are encouraged to explore and apply all of their feelings and reactions to their understanding of their patients. The term countertransference has expanded meaning. No longer limited to the analyst’s residual pathology, it is now meant to include the subjectivity the analyst brings to the treatment, the subjectivity stimulated by the treatment, and the subjectivity induced by the patient.<sup>4</sup>

How does this theoretical shift affect the gay or straight dichotomy? The current recognition and use of countertransference forces the

therapist to grapple with her own conflicts and anxieties about homosexuality. She can't simply retreat to the safety of cultural reductionism.

The recognition and utilization of countertransference is particularly salient when the patient is grappling with questions of sexual orientation. The following case is intended to elucidate the value of the theoretical shift. I have used the question "Am I straight or am I gay?" and its permutations to organize the case material and to highlight the underlying subjectivities. As you can see by now, I believe this question is artifice; a culturally constituted binary that falsely implies the existence of two discrete choices. As you will see, it was used by me to achieve distance from my patient. It allowed me to safely locate myself in the cultural mainstream, outside the anxiety and travails of my patient's exploration. The patient, Mary, through the question "Am I straight or am I gay?" identifies my perch and attempts to dislocate me from the security of the moral highground. She forces me out into the margins of our culture into the fray of her personal experience.

### ***"THE QUESTION" IN TREATMENT***

#### ***The Case***

*I ask myself, "Is Mary gay?"*

Mary, my analysand, first came to see me upon her return to college after a year off for a "breakdown." It was three years before I learned that her escape from school was precipitated by an attraction to a female classmate. Mary's reticence to reveal this pertinent piece of information was not particularly remarkable. She offered very little information about her past, frustrating me in my efforts to discern the etiology of her extreme anxiety and guardedness. Mistrust and caution were the key descriptors of our work. Nevertheless, she clearly wanted my help. She was in a great deal of psychic pain, but there was an unverballed, yet strong message to stay back. This "please help me but don't get too close" communication was familiar to my past experiences with trauma victims. I began to wonder, and then later in the treatment, seriously suspected, that Mary had been a victim of early sexual abuse. The most probable perpetrators were her mother and her maternal grandmother. While Mary had no definitive memories of her

own abuse, her mother knows that she, herself, was abused by Mary's grandmother, and while claiming no memories that she abused Mary, thinks it is quite possible that Mary may have been abused by her grandmother. The fact of this probability had complicated the transference, countertransference, and the issues around Mary's sexuality. Its importance was seductive and distracting.

Mary made it clear that she needed to control the sessions; she would decide when and what I should know. This was not done aggressively. Her eyes would look inward and she would hide behind a gauzy vagueness, or she would erect a smokescreen of obsessional concerns. My vision was obscured while hers was clear and focused. She watched me vigilantly, attending to every nuance of expression and gesture, calibrating every inflection of voice and semblance of mood. I could not escape Mary's scrutiny. Mary's mother's behaviors and moods were unpredictable. Mary must have learned to watch her very carefully. I was very uncomfortable. I felt as I imagined Mary's mother felt, and I also felt Mary's fear. Vigilance is exhausting. I wanted to push her away. I longed to put her on the couch but that was out of the question.

I contemplated whether to tell Mary that I was feeling under the microscope. Perhaps I should have but it felt important, at the time, to not seem intimidated. I did not want Mary to feel too powerful. I suspected it would have scared her and further intimidate me. I avoided the issue by trying to get her to do self-reflecting, history-seeking, analytic work. It was a theoretically-sanctioned effort to escape the present by attempting to get her to focus on her past. It didn't work. I was increasingly aware of wanting to leave the room. I felt like a butterfly in a net; would I be pinned to the wall or would I be admired? Either way I was captive. Mary had stripped me of my psychoanalytic *modus operandi*; with little else at hand, I was forced to contain my anxiety. I'd sit quietly, unnoticed, in my chair. I did not realize until later that I was anxious because I was being sexually aroused. I suppressed those feelings and occupied my thoughts with the most salient question, "Is Mary gay?" "Is she gay?" I kept wondering. The apparent sensibility of the question provided a cognitive puzzle and a rational distraction. It was calming. If I needed a cognitive focus, the more relevant question—it eluded me at the time—would have been, "Why am I aroused?" What does my arousal tell me about our relationship, about Mary, about myself?

*I ask myself, "Am I gay?"*

Mary, having mastered the art of hiding while appearing present, recognized it in me before I was aware of it in myself. It unnerved her. Mary believed many of the women she encountered were sexually aggressive and seductive. If they were conscious of their behavior, they were less dangerous to Mary than if they were unaware. She preferred the conscious to the unconscious manipulation but never doubted that attempts were being made to manipulate and use her. Her beliefs were not only a complex manifestation of projected desires and fear of victimization, but, also at times, intuitively astute and an accurate reading of the situation. My position was difficult, as I could not assess the accuracy of Mary's perception. I did not want to be another out-of-touch, inattentive, unprotective authority; nor did I want to validate misperceptions. As long as I remained hidden and disconnected from my own desires, my abilities to accurately intuit hers were dubious. Fortunately, Mary, like many of our patients, knew what she needed and knew how to get it from me (if I would not come out, then Mary would go in).

Mary became extremely confrontive. She was convinced that my touching my hand to my neck was an erotic gesture; that the crossing and uncrossing of my legs was evidence that I was getting "hot"; or that I had chosen my dress specifically with her in mind. The spotlight was on me. I tried to deflect it onto her. "What," I asked, "would it mean to her if I did desire her?" She was having none of that psychoanalytic evasion; she simply answered, "You do." There was no place to hide. I became increasingly self-conscious and annoyed. I wondered if I could scratch an itch without it being construed as seductive? Finally, my defenses began to waver; did I want to seduce Mary? I may be experiencing an induction of her childhood feelings, but what of my own feelings? What about my desire? There was no doubt I would have less difficulty with my erotic feelings if my patient were a gay man, or even a straight man. Unnerved by my obvious defensiveness, I tried to retreat. I began to ask myself, "Am I gay?" By a variation of the superstitious logic that regulates the binaric plucking of daisy petals, if the answer was "no" then my desire was negated. This was a distraction that allowed me to continue to disavow my wish for homosexual love.

When I finally began to imagine loving Mary, I conjured sexual scenes in which she was genitally dominant and I was the cared-for,

appreciative receptor. I could feel her strength and caring. My fantasies allowed me to experience her in the way she could—and eventually, I hoped—would someday, be sexually with the right partner. It was quite different from the actual, but minimal, experiences with she had had men, or from her probable childhood history with women. At this time, she was sexually inactive; she masturbated rarely and never achieved orgasm. My fantasies were gratifying scenarios because they provided a positive love map for Mary and, importantly, expanded the interrelational space. A secure place had evolved where the two of us could comfortably rest together. I now felt safe with Mary. In time, my fantasies shifted from genital sexuality to a different kind of intimacy: a deep, warm feeling of closeness; a shared knowledge that required few, if any, words to communicate; a longing for symbiosis that may not be possible in heterosexual love. I felt a pervasive sadness that I recognized as mourning. I was mourning the absence of homosexual love and felt envious. These fantasies and feelings were very different from those I had experienced with my male patients. Mary had helped me push through personal and cultural defenses and imagine a sexual world of positive homosexual love and desire.

*Mary asks me, “Are you gay?”*

It had been my resistance to my feelings, not the feelings themselves, from which Mary had protected herself when I was denying the erotic countertransference. I was unwittingly increasing her fears of being manipulated and misused. She could not risk closeness with a woman who was split off from herself. In a certain sense, Mary had succeeded in “outing” me, inducing a countertransference experience which Drescher (1996) parallels to the actual internal experience of people struggling with same-sex desire. Once this happened, the transference began to shift and we experienced the full force of Mary’s sexual desire. No longer was I the evil woman who wanted to misuse her, rather I had become the vulnerable loving object of her desires. Having been split off from my seductiveness, I began to worry if I had worked carefully enough with my countertransference. Perhaps I had just shifted the quality of the seduction from venal to loving? Anxious again, I reminded myself that I had tried to keep a delicate balance between being neither seductive nor rejecting. I’d let Mary know that I thought she would be a wonderful lover, but I periodically reiterated the boundaries implicit in our relationship. I tried to assuage her disap-

pointment by explaining how much more useful I was to her in this capacity than I would be as her lover. Once again, I was retreating behind normative, psychoanalytic interventions. Rational responses to a “hot” erotic transference can be like cold water on a severe burn—momentarily cooling, but not particularly curative. My words were useless. Mary, however, was tenacious. The erotic transference persisted. She did not doubt that with time and patience on her part we would eventually be “together.”

If my suspicions of early abuse were correct, then the erotization of the relationship was the only protection she had against abandonment. If I didn’t want her, then I didn’t love her, and, therefore she was of no use to me, and I would leave her. If, however, I wanted her then I wouldn’t leave her; as such, our relationship was obviously destined to be sexualized. I felt as trapped as Mary did. I was preoccupied in trying to discern how I could disentangle caring, erotic desire, acting out, and Mary’s fears of abandonment. The question of my sexual orientation had gradually lost its relevance for me but it remained paramount for Mary. She wanted to know, “Was I straight or was I gay?”

*Mary says, “You want me to be gay.”*

With my acceptance of my own and Mary’s sexual feelings, her concerns of abandonment abated but what remained of them she used in resisting her same-sex desire and in the service of her own culturally supported homophobia. Mary’s erotic desires were no longer dictated by her fear of women. She spoke frequently of her romantic interests in women. When I reflected and supported her feelings, she accused me of pushing her into society’s margins: “How could you care about me and want me to be gay?” Mary was trying to extricate herself from her own homophobia by giving it to me. Crespi (1995) speaks of the need to mourn lost heterosexuality. This was work needing to be done. As McWilliams (1996) notes, it is difficult terrain. The temptation is to mitigate the issue by dissolving sexuality into the totality of the person, which can be interpreted as an attempt to deny the uniqueness of the patient, and negate the importance of affiliation. Mary needed to mourn the loss of her heterosexual ideal, but she also needed to locate herself. She needed a reference group and self-objects that reflected an image she could embrace. She needed to negotiate her own balance between self and culture. Defining herself as homosexual exacerbated

the conflict. Feeling herself a victim in her childhood, forced into a precocious autonomy, she consciously identified with and tried to glamorize the hard working gas station attendant or the waitress who was on her feet all day. These were the people that carried society, but were unappreciated and exploited by the upper classes. In moments of disappointment and despair, she shamefully admitted that her ivy league education and superior intellect entitled her to more. No one was going to keep her down. She would not be a lackey her whole life. She equated the gay life with an underclass and she projected that prejudice on to me. To Mary, embracing homosexuality was forfeiting her rights to my lifestyle. She wanted the nice house and the husband and children. She'd decided that I wasn't gay and my support of her homosexuality amounted to a rejection and subjugation; she wasn't good enough to be part of the mainstream.

The working through of Mary's homophobia signaled an end to this phase of the treatment. She became aware and appreciative of the heterogeneity in homosexual culture and began to imagine affiliation without having to sacrifice her hard-fought individuality. The "question" was no longer needed by either of us and was no longer asked. Mary had begun to date and experiment sexually. I realized that I was only hearing of her relationships indirectly, in an off-handed way. When I confronted her, she admitted she was afraid I'd be jealous of her new woman, her youth, and her sexuality. I knew then that our dynamic had moved into oedipal territory.

### ***SUMMARY***

The question, "Am I straight or am I gay?" functions as a lightning rod that attracts individual and cultural anxieties. It is a question that galvanizes the attention of the patient and the therapist, refracting and filtering their associations and seemingly less significant conflicts, through its culturally constructed lens. Caught up in the clinical moment, we accept the apparent validity of this question without attempting to fully deconstruct its meaning. We sit with our patients and labor this issue, wishing to make the quintessential interpretation as if it could reveal some essential truth about their nature. In fact, this question and its permutations, are intended not to reveal but to obscure. It masquerades as a "natural," "human" need for identity and connection while it subtly seduces us from the more difficult, insightful, and

substantive emotions at the heart of human relationships. As I hope Mary's case illuminated, if we focus on this question, we end up perpetuating anxiety and unwittingly playing out the heterosexual bias of contemporary Western culture. Our psyches have incorporated the misuse of the gay/straight dichotomy. Of course, psychoanalysis cannot stand outside of culture. However, the emphasis in contemporary theory on the subjectivity of the therapist, paradoxically provides us with a greater observing ego. Today we are better able to confront anxiety, tolerate ambiguity and shed the cultural defenses our discipline has helped to construct.

## NOTES

1. See Bayer, R. (1981), *Homosexuality and American Psychiatry; The Politics of Diagnosis*. New York: Basic Books.

2. This was concretized in the DSM-III as the diagnosis of ego-dystonic homosexuality. For the history of these diagnostic changes, see Krajeski, J. (1996), Homosexuality and the Mental Health Professions. In: *Textbook of Homosexuality and Mental Health*. ed. R. Cabaj & T. Stein. Washington, DC: American Psychiatric Press, pp. 17-31.

3. See Mitchell, S. A. (1988), *Relational Concepts in Psychoanalysis: An Integration*. Cambridge, MA: Harvard University Press.

4. See (i) Racker, H. (1968), *Transference and Countertransference*. Madison, CT: International Universities Press, (ii) Levenson, E. (1983), *The Ambiguity of Change*. New York: Basic Books, (iii) Hoffman, I. (1983), The patient as interpreter of the analyst's experience. *Contemp. Psychoanal.*, 19:389-422. Reprinted in *Relational Psychoanalysis: The Emergence of a Tradition*, ed. Mitchell, S. A. and Aron, L. Hillsdale, NJ: The Analytic Press, 1999, pp. 40-72, and (iv) Stern, D.B. (1997), *Unformulated Experience: From Dissociation to Imagination in Psychoanalysis*. Hillsdale, NJ: The Analytic Press.

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# On Homoeroticism, Erotic Countertransference, and the Postmodern View of Life: A Commentary on Papers by Rosiello, Tholfsen, and Meyers

Karen J. Maroda, PhD

**ABSTRACT.** This is a discussion of three papers: Florence Rosiello's "On Lust and Loathing: Erotic Transference/Countertransference Between a Female Analyst and Female Patients," Barbara Tholfsen's "Cross Gendered Longings and the Demand for Categorization: Enacting Gender Within the Transference-Countertransference Relationship," and Linda Meyers' "Gay or Straight? Why Do We Really Want to Know."

The author agrees with Rosiello's point that the erotic countertransference often hinders the treatment, due to the therapist's discomfort or shame over having sexual feelings toward a patient. However, this raises the dilemma of how to interact with the patient about the erotic aspects of the relationship without being seductive or blurring the boundaries. Rosiello is criticized for both her seductiveness with her patients and for creating a highly-charged sexual atmosphere in an analytic session where the patient is encouraged to describe the intimate details of her sex life. The author wonders how much of what transpired between analyst and patient was actually countertransference dominance rather than a flowering of the erotic transference.

The author believes that Tholfsen's paper raises many questions. Among these are how much do we accept about who we are and how

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much can we change, both internally and externally? How do we determine what transformations are possible versus what must be grieved as unattainable? When patients are ardently seeking feedback during treatment, perhaps therapists fall into their own postmodern trap when they refuse to respond honestly. There is a difference between callously hanging a label on a troubled patient that will only arm him with a new insult versus compassionately helping him draw a portrait of himself that is real and that he may one day accept.

The author agrees with Meyers' contention that being "gay or straight" is a cultural construction. However she counters that what is not socially constructed is whether a person prefers to have sex with the opposite sex, same sex, both, or neither. It is one thing to accept that sexuality, along with gender identification, runs along a continuum, and another to deny that most people ultimately fall into one of two categories when it comes to sexual preference. To postulate two general categories, each containing a broad and diverse array of personalities, styles, and modes of sexual expression, is not nearly as restrictive and de-personalizing as many postmodern theorists would have one believe. What makes being gay oppressive is not the expectation that one is sexually attracted to the same sex, and rarely intensely attracted to the opposite sex. What makes being gay oppressive is what society says about the meaning of being gay. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>>]

**KEYWORDS.** Countertransference, erotic transference, homosexuality, lesbianism, postmodernism, psychoanalysis, psychotherapy

Dr. Florence Rosiello's paper, "On Lust and Loathing: Erotic Transference/Countertransference Between a Female Analyst and Female Patients," was not only the longest of the three papers to be discussed, but certainly the most intellectually and sexually provocative. I was impressed with her powers of observation, especially her frank self-observations, yet equally amazed at the small impact these insights seemed to have on her overall approach to her patients. Dr. Rosiello's main point is that the erotic countertransference often hinders the treatment, due to the therapist's discomfort or shame over having sexual feelings toward a patient. She points out that denial of erotic countertransference has the effect of subduing or even eliminating the erotic transference. I quite agree with her statements on this point, as well as her contention that a relational perspective implicitly calls for more admission of participation on the therapist's part, even when it occurs

in the area of eroticism. The dilemma we face is how to interact with the patient about the erotic aspects of the relationship without being seductive or blurring the boundaries.

Clearly speaking as one who is quite comfortable with her sexual feelings, she asks, "Why is the erotic countertransference so difficult to work with, especially with same-sex female patients?" My own opinion on the difficulty in handling erotic transferences, be they heterosexual or homosexual, is the fear/wish that they will be acted on (Maroda, 1997, 1999a, 1999b). This can be especially true regarding disclosure of the erotic countertransference. Many analysts fear that once a disclosure of erotic countertransference has been made, the likelihood becomes greater that some type of sexual acting out will occur, although I have tried to illustrate that this fear is not substantiated by the details of patient sexual abuse documented by Gabbard (1996). The point I have made repeatedly is the critical importance of whether or not the patient was *seeking* the information from the analyst, and whether or not the analyst restricted him or herself to precisely what the patient wanted to know (Maroda, 1994, 1999a).

So even though I agree with much of what Dr. Rosiello says regarding the necessity of acknowledging, and even, at times, revealing the erotic countertransference, I was quite taken aback by some of the things she actually said and did. For example, in her discussion of her patient Pauline. Rosiello describes Pauline's mother as unresponsive and rejecting, often foreclosing any conversation at all by simply telling her to be quiet. Rosiello is far more active with the withdrawn and socially isolated Pauline, presumably to avoid repeating the sins of her mother. When Pauline says she has no sex life, Rosiello asks if she masturbates. And I have no problem with this question. However, when Pauline answers that masturbation is too much work and she quits before reaching orgasm, Rosiello responds with, "Don't you use a vibrator?" Not surprisingly, Pauline becomes quite sexually stimulated by this question and immediately runs out and buys a dildo, which she uses before the next session. My question when reading this material was, "Does Dr. Rosiello realize that she has just planted a fantasy in Pauline's mind of her analyst masturbating with a vibrator?" If this was done deliberately, then to what end? Certainly this goes far beyond affirming Pauline's need to have sex and, in fact, encourages her to think about sex with her analyst.

Rosiello goes on to describe the other signs of Pauline's subsequent

overstimulation, including her relentless pursuit of details of her analyst's private life, sexual and otherwise. Pauline is also now openly flirtatious. Rosiello does not say how she herself responded to all these questions and flirtations, but this is a regrettable omission. Did she continue to sexually stimulate her patient, or did she hold more closely to the boundaries of the professional relationship? Having titillated her patient, did Rosiello provide even more stimulating personal information or did she refrain from further blurring of the boundaries between a personal and professional relationship? I fear that she did continue to reveal intimate details of her life to Pauline, because Pauline upped the ante by then bringing small presents to her analyst, suggestive of more stimulation and a continuing courtship.

In the ongoing juxtaposition of what Dr. Rosiello seems to know about herself, and what she does with that knowledge, she says, "I have slowly come to the realization that I speak a very passionate language. Words that to me feel warm and intimate, are sometimes experienced as seductive, enticing, and alluring to others." Good, I say to myself. She knows she can be very seductive, even if she is not aware of it at the time. And I congratulate her on her willingness to see this about herself. Yet I am frankly amazed at how little impact this self-awareness seems to have had on her decisions with regard to Pauline. Does she or doesn't she realize that her seduction of Pauline began with the question about using a vibrator? Or does she realize it, and feel that this is a legitimate opening up of the sexual feelings between them? I would like to know more about what happened between Rosiello and Pauline. Rosiello describes their relationship as warm and very intimate, but it is hard to imagine that the stormy periods of frustrated sexual desire would not also be present.

I would be reluctant to make strong statements regarding Rosiello's seductiveness if it were not for her own admission of it, and the evidence presented not only in the case of Pauline, but in the subsequent case history of Simone. In describing Simone's affair with her boss, Tony, Rosiello says, "It often felt like we were mutually visualizing porno flicks as she narrated weekly events with her boss. We were both becoming sexually aroused by her stories." Implied in this is a significant amount of graphic detail, which I think is gratuitous in any treatment situation. This behavior is rationalized by a quote from Benjamin regarding the need for "recognition of desire."<sup>1</sup> Although I am in agreement with both Benjamin and Rosiello that desire must be

recognized and affirmed, this is very different from creating a highly-charged sexual atmosphere in an analytic session where the patient is encouraged to describe the intimate details of her sex life. Affirmation and voyeurism are not the same thing.

Rosiello also mentions that her own style of dress, use of language and personal manner have a sexual edge. What does this mean exactly? Is her style of dress overtly sexually revealing or provocative, or does she merely dress stylishly? Is she openly flirtatious or merely emotionally available and engaging? Does she typically have very intense sexual transferences and countertransferences with her patients, or are the three cases she reports atypical?

In her continued discussion of Simone, Rosiello asks all the right questions and is dead-on in her observations. She says she knows she is involved in an enactment with Simone, knows that Simone was imagining having sex with her, and then proceeds to declare that they were, in fact, having a type of sex. She says, "For me, it was sex between Simone and me and it is my interpretation that for Simone it was sex for her, too. We created these sexual feelings together, and maybe I started them." To me, this was an astounding admission. Rosiello said everything I was thinking about her relationship with Simone and assumed she was denying. But this therapist doesn't appear to be denying anything that is going on between her and her patients, save the potential destructive consequences of her actions. Just when I thought the whole sexualized relationship with Simone had reached outrageous proportions, Rosiello reports that Simone has a baby, which she nurses in her sessions for the next year.

Next comes her discussion of the sexually aggressive June, who calls her a "fucking cunt" with abandon. When the sex talk between them abates and June becomes obsessively boring, Rosiello lets her have it, again demonstrating her self-awareness by admitting that she had underestimated the effect this would have on June. She says she should have been kinder. I found myself wondering if the only thing that keeps Rosiello's attention for very long is graphic sex talk or some other form of seduction. She concludes her paper quite abruptly, failing to provide any overarching view of what she saw as effective, desirable, therapeutic or dangerous in her three cases. Her last words are a quote from June referring to her amazement that she keeps on coming, week after week. Is this meant as some affirmation of the treatment? Are we to assume that what goes on between them must be

therapeutic if June keeps on coming? Or is Rosiello equally amazed that June continues to come?

I am sorry that I do not know more about how Rosiello thinks that these sexual enactments with her patients are therapeutic. As I said previously, I agree with many of her basic notions about the need for handling erotic transferences, and countertransferences, better than we do. I agree that most therapists, including myself, could be much more comfortable with these situations than we are. But Rosiello's blatant sexual play and seduction of her patients goes way beyond anything that I can condone in the name of allowing room for the erotic transference to emerge and be worked through. I cannot imagine that her admitted form of having sex with her patients would ultimately be therapeutic. How long does the "sex" go on, and how does she manage to move out of this form of relating to explore other important topics in the treatment? What keeps her patients from expecting that actual sex will eventually replace the virtual sex they are having, especially since the boundaries have become so blurred? Do many of them respond like spurned lovers and leave in a rage? Or do they never terminate and stay for the sex with her? Do they stalk her outside of the sessions? These all seem like potential consequences of her behavior.

I try to keep an open mind regarding creative options for engaging patients, particularly those who are difficult to engage, and am happy to consider anything within reason that has some therapeutic potential. But patients baring their breasts in sessions, having unending periods of graphic sex talk, and being openly seduced by their therapist constitute a level of sexualization that I cannot condone and feel is inappropriate. It also concerns me that so many of the provocative exchanges between Rosiello and her patients were initiated by her, rather than by the patient. It makes me wonder how much of what transpired between analyst and patient was actually countertransference dominance rather than a flowering of the erotic transference.

Given my strong statements, I hope that some type of future commentary can take place within the *Journal of Gay & Lesbian Psychotherapy*, allowing Dr. Rosiello the opportunity to respond to my concerns and continue the dialogue on these issues.

Barbara Tholfsen, in "Cross-Gendered Longings and the Demand for Categorization: Enacting Gender Within the Transference-Countertransference Relationship," addresses an issue that remains controversial for the very reasons that she presents in her paper. On one

hand, if we can name something it becomes more real. It provides form and definition. On the other hand, once something has been named it begins a move toward reification, toward rigidity. I find it interesting that both Marty and Ted practically beg their therapist to name what they feel is wrong with them. Tholfsen is understandably reticent to do this. First of all, how can she know for sure? Second, even if she felt confident about some conclusion regarding these men, would it really be helpful to label them? She is understandably reluctant to label them as freakish or abnormal. She talks about the bind she is in when they desperately want to know what she really thinks and she wants them to give up the notion of diagnosing themselves, in favor of accepting and exploring who they are.

I am sympathetic to Tholfsen's concerns. She knows what her patients may not appreciate—that we know precious little about how our sexual identities, sexual preferences, and gender identities are formed. When our patients ask us for explanations, we are truly at a loss much of the time to provide them with any certainty. What we mostly know is that these things rarely change. Marty is not likely to lose his interest in women's clothing or his fantasies of becoming a woman, no matter what treatment he undergoes. Tholfsen is reluctant to encourage his thoughts of sex change, given what she knows about the depression and suicide rates following reassignment surgery. She wonders if seeking surgery for gender dysphoria might be akin to seeking out a dermatologist for race dysphoria (shades of Michael Jackson). This analogy can be extended further to include longings to be beautiful, taller, shorter, smarter, or richer. How much do we encourage our patients to take any action in their lives, especially if it includes major surgeries? How much do we accept about who we are and how much can we change, both internally and externally? And what are the potential consequences? How do we determine what transformations are possible versus what must be grieved as unattainable? Perhaps the vivid imagination of the transvestite should remain just that, a capacity for fantasy and fantasy-based play that can only be fulfilling if left to the world of fantasy. When it comes to gender-changing, it may be a case of being careful what one wishes for.

Tholfsen makes another important point when she talks about Marty's shame. In part, he wants to know what she really sees when she looks at him because he fears that she shares his feelings of loathing and disgust. And this is what needs to be discussed in depth,

rather than Marty's gender or sexual identity. However, it may be true that both Marty and Ted need to have their therapist admit that they are not normal, meaning not like most other men, even if the therapist herself is uncomfortable with this, simply because they know this to be true. Part of the reason they are obsessed with what is male and what is female, what is heterosexual and what is homosexual, is because they are conflicted in these areas. Most people take their sexuality and their gender for granted. Marty, Ted, and many others do not. So in an odd way, both these men may be seeking a form of empathy and understanding from Tholfsen when they insist on some definitive feedback from her. They need to know that they have real problems, that they are not just being silly or being sissies. They are in real conflict and in real pain over their identities. And they know that most men do not suffer the way they do.

Ted wants Tholfsen to "rate" him on his gender, and she admits that we all do this. We size each other up on any number of variables, including our femininity or masculinity. Tholfsen says Ted is rigid on the issue of gender, yet he perseverates on it because he has unanswered questions. Not fitting the masculine stereotype, he worries about how people see him and asks Tholfsen to give him a reading, presumably because he trusts that she will be honest. Who else can he ask? Who else can he admit these things to? Perhaps a description of what she sees when she looks at Ted would help him in his quest to define himself. Perhaps then he could settle in to a reality-based vision of himself and get relief from his fears of how he is seen by others. Tholfsen says that our postmodern version of reality may be too ambiguous to bear. I might add that it is too ambiguous to be helpful.

When patients like Mary and Ted are ardently seeking feedback, perhaps we fall into our own postmodern trap when we refuse to respond honestly. There is a difference between callously hanging a label on a troubled patient that will only arm him with a new insult versus compassionately helping him draw a portrait of himself that is real and that he may one day accept.

Linda Meyers says early in her paper, "Gay or Straight? Why Do We Really Want to Know," that being "gay or straight" is a cultural construction. If we are speaking purely about language, about the use of labels, then I would have to agree. What is not socially constructed is whether a person prefers to have sex with the opposite sex, same sex, both, or neither. She says, ". . . implicit in the binary is society's

belief in sexual stability; choose and the issue is closed.” It has always struck me as odd that heterosexuals, for the most part, are quite comfortable with their label, and also with their sexual stability. Why is it that gays often take such offense to being labeled as gay, when straights do not? Doesn’t it have more to do with the fact that for many people, gay and straight, gay is a dirty word? And if we who *are* gay, regardless of our sometime attraction to members of the opposite sex, refute this naming of our preference, aren’t we implicitly stating that we share the view that there is something wrong with being gay?

I have argued elsewhere (Maroda, 1997) that it is one thing to accept that sexuality, along with gender identification, runs along a continuum, and another to deny that most people ultimately fall into one of two categories when it comes to sexual preference. To postulate two general categories, each containing a broad and diverse array of personalities, styles, and modes of sexual expression, is not nearly as restrictive and de-personalizing as many postmodern theorists would have us believe. Again, do heterosexuals feel pigeonholed by their designation? They do to the extent that we all feel the societal pressure to behave in certain ways (which I do not deny can be oppressive). So I am not saying that societal expectations cannot be oppressive. I just do not agree that the designation of “gay or straight” is as oppressive as it is made out to be. What makes being gay oppressive is not the expectation that we are sexually attracted to the same sex, and rarely intensely attracted to the opposite sex. What makes being gay oppressive is the what society says about the meaning of being gay. Society says we are immoral, we are sinful, we are degenerate. Straight people should hide their children from us. Now *that’s* oppressive.

Meyers presents her patient, Mary, who is intent on finding out whether or not Meyers is “straight or gay.” True to her theoretical and clinical position, Meyers does not answer Mary. But she ponders the question “Is Mary gay?” and then asks the same about herself. I couldn’t help but wonder how she could disavow these categorizations and then use them when trying to understand Mary and herself. But she does effectively explore her erotic countertransference to Mary, showing us how her initial discomfort with Mary gave way to her realization that she was sexually aroused in response to her.

Meyers’ astutely concludes that what Mary is really seeking is for Meyers to be comfortable and honest with herself and her feelings. She says, “When I was denying the erotic countertransference, I was

unwittingly increasing her fears of being manipulated and misused.” I couldn’t agree more. Mary simply wanted to know that Meyers wasn’t afraid of what she might feel for Mary, so then Mary could trust her and feel free to express and explore her own feelings. I also agree with Meyers that the question of “Am I straight or am I gay?” can serve to hide an underlying and more important question, but this can be true of any question. That is why we typically discuss such a question and its meaning before deciding to answer or not. Yet I believe that the underlying meaning when a patient asks the analyst, “Are you straight or are you gay?” often involves wanting to know that we have the courage to admit who we are and how we feel, whether society approves or not. And this can pave the way for our patients to do the same.

#### NOTE

1. See Benjamin, J. (1988), *The Bonds of Love: Psychoanalysis, Feminism, and The Problem of Domination*. New York: Pantheon Books.

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# The Analyst's Erotic Subjectivity: A Reply to Karen Maroda's "On Homoeroticism, Erotic Countertransference, and the Postmodern View of Life"

Florence Rosiello, PhD

**ABSTRACT.** This paper is a response to Karen Maroda's "On Homoeroticism, Erotic Countertransference, and the Postmodern View of Life." One of the paradigmatic changes that has developed, particularly in contemporary psychoanalytic theory, is the use of the analyst's countertransference in treatment. Countertransference or the analyst's subjectivity is used to inform an interpretation or an insightful response to the patient. Contemporary psychoanalytic literature is currently focusing on the advantages and disadvantages of self-disclosing with many authors determining that some analysts are better able to work with self-disclosure than others. The question of why erotic transference/countertransference develops between a patient and an analyst, and why they don't, is of particular theoretical interest. The development of a patient's transference cannot be separated from the development of the therapist's countertransference—both are mutually constructed by patient and analyst. Transference and countertransference are not linear. They develop together and are indistinguishable from the whole. The author goes on to further present clinical material of her work with three women patients. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>>]*

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**KEYWORDS.** Countertransference, erotic transference, intersubjectivity, mutuality, psychotherapy, relational psychoanalysis, sexuality

In Chapter 1 of Maroda's book, *Seduction, Surrender, and Transformation* (1999) she says, "Our reluctance to admit what we actually do and say when we are working with our patients remains the norm. Worse than that, however, is the tendency to *omit* the mention of interventions that might be controversial. That is, even when clinicians are talking about what they actually do, they frequently fail to include a behavior that they fear being censored for, such as, taking a patient's hand, or disclosing their feelings. The absence of honest discussions of technique has naturally created a most unfertile ground for innovations" (p. 11). Maroda adds that even with the excitement over new developments in the two-person psychology of the Relational Theory, analysts are "still reluctant to talk about technique, and there is a regrettable resistance to changing what we do to accommodate our new paradigm . . . if reconceptualizing the analytic relationship doesn't translate into technical changes, how important can these theoretical changes be?" (p. 12).

### SYNTHESIS

One of the paradigmatic changes that has developed, particularly in contemporary theory, is the use of the analyst's countertransference in treatment. Most frequently, countertransference or the analyst's subjectivity is used to inform an interpretation or an insightful response to the patient. Self-disclosure of countertransference is most commonly not provided, although the analyst may decide it is indeed useful and disclose it to the patient. Contemporary psychoanalytic literature is currently focusing on the advantages and disadvantages of self-disclosing with many authors determining that some analysts are better able to work with self-disclosure than others.

One of the reasons I wrote "On Lust and Loathing" was to openly disclose homoerotic countertransference. In the third paragraph I said, "The focus of this paper . . . will be on the erotic countertransference since it is in the erotic countertransference arena that the erotic transference often gets bogged down or eliminated." I meant to provide my insights to my own interventions and interpretations to three female

patients who had developed erotic transference. Only a few of my patients have developed erotic transference and when I write I usually refer to these few. Most of my patients do not have erotic transference feelings. The question of why erotic transference/countertransference develops between a patient and an analyst, and why they don't, is of particular theoretical interest to me.

In wondering and writing about development of erotic transference/countertransference, we have to question 'who did what first,' according to Maroda. She makes a good point when she asks if my treatment of these three female patients were influenced by "countertransference dominance" and not "a flowering of the erotic transference." To my way of thinking, I cannot really separate the development of my patient's transference from my countertransference—both are mutually constructed by patient and analyst. I don't have to make sure that an erotic transference developed first in my patient, because I don't believe it could possibly just originate in the patient—I'm involved even when I don't know it. Similarly, my countertransference or my subjectivity is also created within the relational mix with ingredients from my patient's transference/subjectivity. Transference and countertransference are not linear. They develop together and are indistinguishable from the whole.

Aron (1996) states, "the term countertransference obscures the recognition that the analyst is often the initiator of the interactional sequences, and therefore the term countertransference minimizes the impact of the analyst's behavior on the transference" (p. 77). Aron continues saying "The relational-perspectivist approach I am advocating views the patient-analyst relationship as continually being established and reestablished through ongoing mutual influence in which both patient and analyst systematically affect, and are affected by, each other. A communication process is established between patient and analyst in which influence flows in both directions. This implies a 'two-person psychology' " (p. 77).

The essential notion of a two-person psychology is that we make meaningful intersubjective spaces that cannot be broken down into a linear model where one thing causes another. For practical purposes, the analyst may have to think who started it, but still thinking about who started it is a question of perspective. Psychoanalysis is something that is lived forward and understood backward. Similarly, the

erotic transference is something lived forward and understood backward, and how we understand it is determined by perspective.

Winnicott (1960) said, “there is no such thing as an infant” (p. 39) and by that he meant there was mutual influence between mother and infant even in the womb. I would say there is no such thing as just transference or just countertransference, they are mutually constructed and both are so thick that the analyst can’t sit around and wonder “Is it the patient’s or is it mine?” Countertransference dominance is subsumed under mutual construction—if it is not, where are we in the development of a two-person psychology?

### ***THE ANALYTIC FRAME AND BOUNDARIES***

Maroda repeatedly appreciates my insights but bemoans that they have no impact on my behavior. Part of her contention is that I blur the boundaries of the analytic frame. Maroda writes that I have selective insight and selective self-awareness and my understanding of internal dynamics doesn’t extend to my patients. This seems a rather limited interpretation of my treatments on Maroda’s part and not very realistic.

My insights and awareness, whether about myself or about my patients, originate from a different subjectivity than Maroda’s. Each analyst can only bring their own subjectivity to bear on the clinical situation—these differ, one from another, particularly in terms of what each analyst feels to be primary. We are all influenced by who we are in how we organize our analytic frame. For instance, lesbian and gay analysts have a different frame than I do, given their own experiences with homophobia. Analysts of color have a different theoretical frame, given their experiences with racism. I try to keep my own and these other analysts’ theoretical paradigms, both traditional and contemporary in mind when I work with patients. Likewise, I hope that other analysts will consider a relational, mutually constructed, theoretical frame influenced by sexuality in their own work, as well.

Would a theoretical frame influenced by sexuality just blur the boundaries of treatment as Maroda suggests? Just what are those boundaries? Who set them? Have they changed since the beginning of psychoanalysis? Are they different for analysts who are of different theories, of different generations? Are they different for analysts who live in different cultures, or different than analysts who live in cities than in the country? Are boundaries fluid, elastic, rigid, changing?

Who tells us what they are? Our institute instructors, our supervisors, our analysts? I think we can all agree that we don't agree on analytic boundaries, some people may have similar analytic boundaries, but I bet they disagree somewhere along the line.

### *CLINICAL ILLUSTRATIONS*

I mentioned earlier that I discussed three female patients in “On Lust and Loathing,” Pauline who identified as bisexual, Simone who identified as heterosexual, and June who identified as lesbian. In addition to my essay serving as a clinical illustration of erotic countertransference, it also contains lengthy, clinical examples of three different patients. Clinical illustrations are more the exception than the rule in contemporary psychoanalytic literature which tends to focus on theory, as any new approach would. Essays include vignettes of patient experiences or analyst subjectivity, but rarely include clinical illustration—Dimen (1997) and Pizer (1998) being exceptions who do present both analyst and patient clinical illustrations. “On Lust and Loathing” is a clinical, relational-perspective essay that focuses on erotic countertransference supported by interactions with three female patients who developed erotic transference dynamics. Maroda criticized my treatment of these patients saying that I “created a highly-charged sexual atmosphere in an analytic session where the patient is encouraged to describe the intimate details of her sex life. Affirmation and voyeurism are not the same thing.” Affirmation and voyeurism are not the same thing since it is the voyeur who watches another from a secret position. The restrained analyst does the same thing and keeps mum about it. I addressed sexuality with Pauline, Simone and June, I have not been mum—to the contrary, I have written my experience with these patients. So, I will now present my patients in more detail since Maroda focused on them in her criticism.

### *PAULINE*

Pauline has been in treatment for three years at a frequency of four times a week. She began her analysis sitting up, but after a few months I asked her to move to the couch. When Pauline sat in the chair, from the first session on, she slithered over the cushions, the armrests,

fondled the carpet by her feet, slid her hands up from her shoes to her shoulders in what felt like constant movement over her body. She spoke to me with her head tilted, her eyes never looking at anything but me. Before leaving every session, she would stand in the doorway, put on her coat, walk back and forth between the chair and the door (I open the door at the end of all sessions) and would finally exit. She would then turn around at the threshold for one last long look before she left. If a patient acts in such a manner from the first session onward, does that mean she started it? Does it mean that I did because I already existed in the room? I don't much care who started it, and that's why I said, "maybe I did" because mutual construction of emotions and influence eliminates countertransference dominance or transference dominance.

Within a few weeks of treatment, I asked Pauline to begin using the couch for my own relief as well as an attempt to get her to concentrate on her analysis. Now, on the couch, she still slithers and wears short cropped shirts that rise well above her waist when she stretches her arms above her head. Although Pauline was sensual when I first began treating her, she was not sexually active. She identified as bisexual although she had never slept with a woman. While she had sex with men, she never experienced an orgasm. She rarely dated men and those she did date were eliminated after a few meetings. She did maintain erotic crushes on unattainable, heterosexual women. My question about her sexual life or lack thereof, and why didn't she use a vibrator when she was vibrating visibly in her sessions, seemed natural. Perhaps Pauline was stimulated by this question, but, what did it matter given the state of her already existing stimulation? Maroda then questions whether or not I knew I "*planted* [*italics mine*] a fantasy in Pauline's mind of her analyst masturbating with a vibrator?" Sure I knew that, but, to my way of thinking, the purpose of treatment is to create fantasy–fantasy bridges experience, real or dissociated. Fantasy links the multiple layers of the self. In this case, sex for Pauline was dissociated and my comment about the vibrator addressed a movement of experience, a communication along a network of dissociated islands, dissociated aspects of the self. Pauline didn't know she was advertising sex—my question opened up this discussion, it helped her become more creative in talking about it, in conceptualizing it within herself, as a part of herself, about herself as a sexual being.

In the time we've been working together, Pauline has "come out," a long, complicated, painful experience, and now identifies as lesbian. She has begun dating available women who also identify as lesbian and she climaxes during sex with them. She has also been promoted at work and is earning close to six figures. She is finally attending a much-desired, though enormously feared film course. She is attempting a more realistic relationship with her parents. And, recently told me she thinks I'm straight and likes me anyway.

### *SIMONE*

Maroda was right that Simone's treatment was full of graphic details of her boss's sexual interest in her. Was it gratuitous and destructive as Maroda judged it to be? It was graphic data from my perspective, not just detail, and more importantly, it was resistance. I don't think it was sinful as Maroda infers. Sinful would be destructive and what developed between Simone and me was not sinful, unless talking about sex is considered so. For Simone, sex got a little dirty with her boss—but, I don't think that's a sin either and discussing it with one's analyst is expected when it is within an analytic frame and boundaries that include sexuality. So, in Simone's treatment, did she start the sexual feelings between us when she spoke about her boss's transgressions? Or, did I start the sexual feelings between us because I let her talk about her boss's transgressions?

Again, to my way of thinking, Simone's erotic transference and my erotic countertransference were mutually constructed—not linear, not cause and effect. In "On Lust and Loathing" I said "We created these sexual feelings together, and maybe I started them," but how would anyone know who truly starts any dynamic first? Certainly, I did not suggest that Simone breast-feed her baby in our session, she just did it; and I realized I had seen her breast after she did it and of course we discussed it. But, I remember during our discussion that this experience of a 'naked breast feeding' was nothing compared to Bollas' (1994) essay about a male patient who sexually aroused himself on Bollas' couch and climaxed during the session.

Simone left treatment when she became pregnant with her second child and after she and her husband bought a house in another state. I hear from her by phone on rare occasions and she sends me pictures of her children at Christmas. She says she is happy with her life and her

marriage and remembers her affair with her boss as a last hurrah before motherhood. At the time our “sex talk,” according to Maroda, communicated Simone’s dissociated fears about not being sexual, about becoming a non-sexual mother, like her own mother. This was interpreted to Simone. Her sexual fantasy toward me and my acknowledgement of mine toward her, meant to her, an acceptance and recognition of being a sexual subject concurrent with being a mother who still had sexual desires. Our mutually developed fantasies united aspects of her self to other aspects of her self—a creative dynamic that helped Simone eventually bridge two desires—sexuality and motherhood.

### JUNE

Maroda wonders if only “graphic sex talk or some other form of seduction” keeps my attention and she asks the question “Are we to assume that what goes on between [June and myself] . . . must be therapeutic if June keeps on *coming*?” [italics mine]. Certainly, in June’s treatment, her loathing of me when I could not tolerate her emotional emptiness led to her talking about her desire to become more intimate. But, I surmise her emotional emptiness and her resulting verbal aggression were a resistance against her erotic desires to begin with. From the beginning of June’s treatment, she spoke about her attraction to me. While I did not feel a mutual attraction, I have always felt very emotionally related to June, as though I have always known her. Perhaps that feeling is erotic, or perhaps the feeling of having always known her is better defined as loving June.

I have used June as a clinical example in quite a few essays on erotic transference/countertransference, perhaps four or five essays all told. Her treatment and her development over the years are chronicled in these essays (Rosiello, 2000). June has recently gotten promoted in an office job she took a few years ago. A year ago she began a relationship with a woman with whom she seems to have fallen deeply in love. They are discussing living arrangements and long term commitment. This is June’s first serious relationship in seven years, outside our treatment relationship.

I would credit June most for helping me struggle with my idea that the purpose of treatment is to create fantasy. I recently wrote a paper dealing specifically with how fantasy bridges experience, particularly dissociated experience. The paper begins with June discussing her

fetish toward amputees and her pigeon phobia. Our use of fantasy had allowed her to admit her fetish (we were four years into treatment) and to elaborate on her phobia (which I had known about from the get go). In my opinion, dissociated fantasy, sexual or otherwise, fuels creativity and bridges isolated aspects of the self with other self aspects, allowing an inner communication to move along a network linking isolated islands of the self.

Now, in June's treatment, as she discusses her relationship with her lover, which I also understand as an expression of transference developments, she has been attempting to define what love means to her. This from a patient who used to curl up under the kitchen sink and cry for hours when she first began treatment. Who couldn't imagine being more than a waitress, and of only being sexual in a ménage à trois because she needed the buffer of another individual. I will cite what she has written because I think it shows her inner growth from dissociated affect to acceptance of her own desires within her self:

Love is the mutual enjoyment of one another, and an awareness of that mutuality, an awareness of the awareness. It's an 'I know you know that I know, and we both know' situation. Love provides a context for parts of the self . . . In thinking about love, I keep returning to the importance of mutuality, and the awareness of that mutuality. Mutuality in love engenders trust; trust engenders love. As trust grows our capacity to take love expands, and our desire to give love also increases.

Recently, an editor at a publishing house read a few excerpts of June's other notes to me that I've quoted in other essays. The editor was impressed with June's writing ability and thought she was quite talented and should write more and publish. I related this to June who has always harbored a wish to become a writer. When June first started writing notes to me, she only used lower case, no capitalization of any kind, and no punctuation, and no paragraphs, and no signature. A disjointed self at odds. Now, she writes in full sentences, her ideas are thought through, she is more creative, more daring in what she risks saying to me, and through me.

I like what Maroda says about mutuality (1999) and I think it applies to my work with June, Simone, and Pauline, "The essence of mutuality lies in the analyst's co-participation and emotional honesty

. . . I find it unfortunate that so many people have interpreted mutuality primarily in terms of positive emotions, giving short shrift to the primitive and aggressive impulses” (p. 29).

I assume these primitive impulses includes sexuality.

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# Boyhood Gender Nonconformity: Reported Parental Behavior and the Development of Narcissistic Issues

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**ABSTRACT.** Reported childhood gender nonconformity, parental behavior, and measures of narcissistic symptomatology were examined in a sample of 109 gay and bisexual men. Childhood gender nonconformity was not related to narcissistic personality but was related to feelings of impostorhood and self-esteem, two possible symptoms of narcissistic damage. This association was partially mediated by parental variables, especially reports of an accepting and supportive father. Psychoanalytic theory suggests that both homosexuality and narcissism stem from early family dynamics. These results provide support for an alternative theory which, recognizing that childhood gender nonconformity and same-sex adult sexual orientation are linked, posits that narcissism results from parental reactions to childhood gender nonconformity. Implications for clinical interventions are discussed. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.HaworthPress.com>]*

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**KEYWORDS.** Gender nonconformity, gender identity, homosexuality, psychotherapy, psychoanalysis, narcissism, developmental theory

Despite extensive examination of a wide array of childhood variables, only gender nonconforming behavior is consistently associated with adult sexual orientation (Bell, Weinberg, and Hammersmith, 1981; Harry, 1982). In a recent meta-analysis of 41 studies, Bailey and Zucker (1995) noted that this effect was unusually strong. Between 65% and 90% of gay and bisexual men reported significant amounts of gender nonconforming behavior during childhood and 89% of gay and bisexual men reported more boyhood gender nonconformity than the mean level reported by heterosexual men.

Beyond its association with adult sexual orientation, however, several studies have found boyhood gender nonconformity (BGNC) to be correlated with other adult outcomes, including lower self esteem (Harry, 1983a), higher rates of depression and anxiety (Weinrich, Atkinson, Grant, and HNRC Group, 1992), and higher rates of suicidality (Harry, 1983b). Other researchers have noted that BGNC is also associated with poorer family relations including poorer relationships with fathers (Green, 1987), increased likelihood of physical abuse from parents (Harry, 1989), and fewer feelings of closeness with parents (Harry, 1989).

Another adult outcome that might be related to BGNC, at least from a psychodynamic perspective, is narcissism. Broadly defined as a tendency to be self-absorbed, failing to appreciate the needs or experiences of others, and relating to others through a carefully constructed and protected facade, narcissism has long been linked with homosexuality in psychoanalytic theory as well as in popular culture. Psychodynamic theories of narcissism and its development are quite complex and by no means unitary but generally presume that early experience (i.e., infantile or early childhood experiences within the family of origin) can thwart the child's development of a positive or unitary sense of self. Because of this fragmentary, negative, or unstable sense of self, the child becomes unable to relate to those around him or her in adaptive, healthy ways or, in psychodynamic terms, has a limited capacity for object relations.

The classic psychoanalytic perspective on narcissism, which originated with Freud (1914) and was later elaborated upon by Kernberg (1975, 1986), holds that these narcissistic traits stem from an unstable

sense of self that swings from grandiosity to devaluation, undermining the ability to maintain a cohesive sense of others and interfering with relating to others as complete, complex entities who exist apart from the self. These disturbances constitute a narcissistic personality structure which, in its extreme form, is the basis for the Narcissistic Personality Disorder as defined by the *DSM-IV* (American Psychiatric Association, 1994). By contrast, more recent theorists suggest that as parents reject their child's expressions or fail to recognize, accept, and mirror back their child's feelings and experiences to them, they narcissistically damage the child, causing him or her to chronically devalue the self and resulting in an exaggerated need for admiration, validation, or reflection from others. In this view, espoused by Kohut (1971) and later elaborated by Miller (1981), narcissistic damage results from a tendency to be overly focused on others at the expense of awareness of the self, and need not be manifest as narcissistic personality structure, though many of the same symptoms may be present (a tendency to alternatively devalue self and others, emphasis on achievement and talent, a need to be "special," etc.).

Although empirical evidence is lacking, narcissistic personality structure and homosexuality have been linked in the psychodynamic literature since Freud (1914, 1922; for a review see Beard and Glickauf-Hughes, 1994). Like narcissism, homosexuality is presumed to be the result of some sort of disturbance in development (Isay, 1989). Traditional psychoanalytic thinking holds that homosexuality is either the result of narcissistic direction of the libido (libidinal energy being directed towards the self rather than towards others, with resultant sexuality being directed at objects that are like the self and can therefore be viewed by the individual as extensions of him or herself) or a failure to separate and individuate from the infant/mother bond.

It is important to reiterate that there is little empirical support for the psychodynamic theories of homosexuality outlined above and to point out that many writers have criticized them on a number of grounds (see Isay, 1989). Despite this criticism and the fact that the American Psychiatric Association declassified homosexuality as a psychological disorder over twenty five years ago, theories asserting a de facto link between homosexuality and narcissism continue to influence psychodynamic theory and clinical intervention (see Socarides, 1988, and Lax, 1997, as examples), contributing to a pathological view of same-sex attraction. Theories linking homosexuality with psychopathology

also become highly politicized and are sometimes used to support discrimination or disparagement of gay people. Because they remain influential and even potentially harmful, these theories warrant the empirical investigation that has largely been lacking in the literature.

Similarly, it is important to understand that childhood gender nonconformity is also a highly political and often emotional issue. Many parents are quite disturbed by this behavior in their children and many attempt in various ways to alter it. Psychological treatment for these children, which will be discussed later in greater detail, is typically aimed at eliminating nonconforming behavior and thus at reducing the rejection and social stigma that accompanies it. These treatments have received more attention as the link between BGNC and adult same-sex attraction has been researched and publicized, and a subtext of these interventions seems to be an aim towards preventing an adult homosexual orientation. Others reject the idea of intervening in this way and increasingly there are calls for tolerance and support for childhood gender differences rather than attempts to change it (Sedgwick, 1991). These issues remain highly controversial and emotionally charged.

The authors posit a different model of the development of narcissistic issues in gay and bisexual men that emphasizes the negative consequences of rejecting and stigmatizing gender nonconformity in children. This model rests on the observation that the dynamics assumed to lead to narcissism are likely to be evidenced in the social environment of boys who differ in terms of gender norms, many of whom will become homosexual or bisexual (Beard and Glickauf-Hughes, 1994). In other words, boys who exhibit gender nonconforming behavior are likely to experience the rejection and lack of support for self-expression that is presumed to cause narcissism. Indeed, the family dynamics and parental rejection noted by Green (1987) in his longitudinal study would support this link.

It seems possible, then, that rather than homosexuality and narcissism both stemming from early family dynamics, gay men are more likely to have been gender nonconforming as boys, which would make it more likely that they would experience rejection or lack of acceptance from their parents. This behavior from parents would, in turn, make the development of narcissistic personality and narcissistic damage more likely. Therefore, rather than narcissism being an intrinsic part of homosexuality as posited by traditional psychoanalytic theory, homosexuality is a normal, non-pathological human difference that, if re-

lated to narcissism at all, is only associated with it through the indirect link of an association between narcissism and the social stigma that accompanies boyhood gender nonconformity.

The present study attempted to examine this model. Specifically, it examined the relationship between boyhood gender nonconformity, reported parental behavior, and narcissistic symptomatology in adulthood. Three hypotheses were investigated:

1. Adult gay and bisexual males who reported gender nonconformity in childhood would be more likely to report narcissistic symptomatology than adult gay and bisexual males who did not report such boyhood behaviors.
2. Gay and bisexual males who reported boyhood gender nonconformity would report experiencing their parents as more rejecting and less accepting than gay and bisexual males who did not report such childhood behavior.
3. Reported parental behavior would serve as a mediating variable of any apparent association between BGNC and adult narcissistic symptomatology. In other words, it was hypothesized that BGNC would not lead directly to narcissistic symptomatology; rather, gay and bisexual males who reported boyhood gender nonconformity were likely to report narcissistic symptomatology to the extent they reported experiencing their parents as more rejecting and less accepting during their childhood.

## ***METHOD***

### ***Sample and Procedures***

All participants were recruited in a large city in the southeastern United States with a large gay and bisexual male population. Only males were sampled because most of the research in this area, including that on childhood gender nonconformity, has been conducted with male subjects and the majority of the theory has been constructed around male sexuality. Female sexuality appears to differ from male sexuality in important ways (Freud, 1922; Huston, 1983; Lips, 1988) and associations between gender identity, sexual orientation, and sex role behavior differ from those found in males (Grellert, Newcomb,

and Bentler, 1982; Lips, 1988). For ethical reasons participants were at least 18 years of age. Age was not otherwise restricted because previous studies have not found cohort effects when studying childhood gender nonconformity (Bailey and Zucker, 1995). Gay and bisexual men were sampled because they report greater variability and higher amount of boyhood gender nonconforming behavior than heterosexual men (Bailey and Zucker, 1995; Sandberg, Meyer-Behlberg, Ehrhardt, and Yager, 1993).

Sampling "hidden" populations is never easy, leading Harry (1986), among others, to recommend multiple recruitment methods when sampling gay male populations. Like Peterson et al. (1992), the present study used three different strategies: Potential participants were approached at meetings of gay organizations, at gay bars, and through advertising in local gay and lesbian publications. Seven bars and seven organizations were identified and gave permission to have materials distributed. Organizations and bars with significant persons of color participation were solicited first and twice as many packets were distributed at these sites in order to recruit a more diverse subject pool. Men who agreed to participate were provided a packet of materials that included a consent form and a cover letter explaining the general nature of the study, which they were asked to return in a stamped, self-addressed envelope.

Overall, 112 of 256 packets were returned. However, three were unusable because directions were not followed or major portions were incomplete, leaving 109 (an additional 2 omitted questions about their father so  $N = 107$  for some analyses). Of the 115 packets distributed to organizations, the 96 distributed at bars, and the 47 sent in response to advertisements (and ignoring the three unusable packets), return rates were 41%, 31%, and 68%, respectively. Thus, 47, 30, and 32 completed questionnaires resulted from appeals through organizations, bars, and advertisements, respectively.

### *Measures*

Boyhood gender nonconformity was measured using the Boyhood Gender Conformity Scale (BGCS) developed by Hockenberry and Billingham (1987) with the four additional items recommended by Phillips and Over (1992). These items (participation in "rough and tumble" play, being a leader in boys' games and activities, a wish to be a girl, and early sexual fantasies about other boys) are often more

highly correlated with adult sexual orientation than most of the items on the original BGCS (Roberts, Green, Williams, and Goodman, 1987). Thus the scale consisted of 12 conforming and 12 nonconforming seven-point items (0 = never or almost never true, 6 = always or almost always true). We reverse scored the conforming items before summing, thereby creating scores that could vary from 0 to 144 with higher scores indicating greater BGNC.

Narcissistic personality characteristics were measured using the Narcissistic Personality Inventory (NPI), which was developed by Raskin and Hall (1979, 1988) to measure narcissistic personality traits as defined by Kernberg (1975, 1986) and as reflected in the DSM-IV criteria for Narcissistic Personality Disorder (American Psychiatric Association, 1994). Only the general summary score for the NPI was utilized. Raskin and Hall (1979) reported an alpha of .72 for this scale and Raskin and Novacek (1989) report significant correlation with MMPI profiles of narcissistic personality disorder, Millon's Narcissistic Personality Scale, narcissism scales of the California Psychological Inventory, and clinical assessments.

The O'Brien Multiphasic Narcissism Inventory (OMNI; O'Brien, 1987, 1988) was administered to assess the added dimension of narcissistic damage. O'Brien, using factor analysis, identified three scales. The first, labeled the Narcissistic Personality Dimension, reflects Kernberg's (1975, 1986) description of the narcissistic personality and the DSM-IV (APA, 1994) criterion for Narcissistic Personality Disorder and correlated .38 with the NPI (O'Brien, 1987). The second, labeled the Poisonous Pedagogy Dimension, reflects Miller's (1981) concept of "poisonous pedagogy" and Kohut's (1971) concept of "narcissistic object cathexis." The third, labeled the Narcissistically Abused Personality Dimension, reflects Miller's (1981) conceptualization of this personality type. The three scales consist of 16, 15, and 10 yes/no items and O'Brien (1988) reported alphas of .84, .82, and .76, respectively.

Two additional instruments were used to examine other factors thought to result from narcissistic damage as outlined by Miller (1981) and which were not assessed by either of the above measures. These two factors are feelings of impostorhood (i.e., feeling unsure and anxious about one's own success, like a "phony") and self esteem. Although either or both may be present in the absence of narcissistic damage and are often associated with a variety of other factors, they

are nonetheless central components of the cluster of symptoms that characterize the narcissistically damaged individual, and for that reason were assessed here. Feelings of impostorhood were measured using the Impostor Phenomenon Scale (IP Scale) developed by Clance (1985;  $\alpha = .96$  reported by Holmes, Kertay, Adamson, Holland, and Clance, 1995) and self esteem was measured using the Rosenberg Self Esteem Inventory (RSI) developed by Rosenberg (1965; as one example, Silber and Tippett, 1965, reported  $\alpha = .85$ ).

Participants' reports of their parents' behavior towards them during childhood were elicited using the 117-item Parent Behavior Form (PBF; Worrell and Worrell, 1974). Thirteen scores were computed for each parent (Acceptance, Active Involvement, Equalitarianism, Cognitive Independence, Curiosity, Cognitive Competence, Lax Control, Conformity, Achievement, Strict Control, Punitive Control, Hostile Control, and Rejection) as recommended by Schwartz and Mearns (1989), who reported alphas from .49 to .89.

## RESULTS

Descriptive statistics for the participants are shown in Table 1. Eighty-one (74%) were European American, 20 (18%) were African American, 4 were Latino, and 4 fell in other categories; 29% were in their 20s, 46% in their 30s, and the remaining 25% in their 40s or 50s; 44% had a college degree. The mean BGNC score (without the four additional items) was within a half standard deviation of that reported by Hockenberry and Billingham (1987) and Bailey and Zucker (1995) for other samples of gay men. Similarly, the mean impostorhood, self esteem, and narcissistic personality scores were within a half standard deviation of scores reported earlier for general samples (see Holmes et al., 1995; Rosenberg, 1965; and Raskin & Hall, 1988; respectively). With respect to the NPI, only 8% of the present sample scored 25 or higher, the usual threshold for narcissistic personality disorder. Internal consistency for these four scales was quite acceptable, ranging from .83 to .90.

The three OMNI scales, however, evidenced low internal consistency, ranging from .46 to .60, much lower than the alphas reported by O'Brien (1987, 1988). This led us to factor analyze the 41 items. O'Brien (1987) reported a factor analysis of 75 initial items administered to 230 graduate students, with 41 items loading .30 or higher

TABLE 1. Descriptive Statistics for Demographic, Boyhood Gender Nonconformity, and Narcissistic Symptomatology Variables

Variable	Mean	(SD)	Range	$\alpha$
Age	34.2	(8.39)	18-58	$\square$
Education	3.76	(0.99)	2-5	$\square$
BGNC	75.7	(20.9)	29-119	.87
OMNI Scale 1	5.11	(2.65)	1-13	.60
OMNI Scale 2	6.43	(2.50)	1-14	.53
OMNI Scale 3	3.80	(1.92)	0-8	.46
Impostorhood	59.7	(14.8)	27-91	.90
Self Esteem	31.8	(5.24)	19-40	.88
Narcissistic Personality	13.9	(6.71)	1-33	.83

Note.  $N = 109$ . Education was coded 1 through 5 for grade school, high school, trade or technical school, college degree, and graduate or professional degree, respectively.

forming the three factors described earlier and accounting for 79% of the variance. O'Brien (1988) then reported a factor analysis of the 41 items administered to 256 patients, which yielded an essentially identical factor structure with the three factors accounting for 85% of the variance. Following O'Brien's procedures (principal axis factoring, varimax rotation), a scree test suggested eight factors, accounting for only 47% of the variance (and 15 factors had eigenvalues greater than 1); moreover the Kaiser-Meyer-Olkin measure of sampling adequacy was only .56 whereas values of .60 and above are recommended for good factor analysis (Tabachnick and Fidell, 1989). Additionally, the OMNI Scale 1 (Narcissistic Personality Dimension) correlated .19 with the NPI, which is not quite significant and less than the .38 reported by O'Brien (1987). We concluded that the OMNI scales did not evidence sufficient reliability and validity in our sample to warrant their further analysis.

We derived four scores from the Parent Behavior Form (PBF): a positive (i.e., accepting and supporting) father and mother score and a negative (i.e., controlling and rejecting) father and mother score. The derivation was guided by factor analysis and motivated first by a desire for simplicity and second by reliability and validity criticisms of

the PBF (Olejnik, 1992; Carlson, 1992). Paternal and maternal scales were factor analyzed separately (maximum likelihood factoring, oblique rotation). Two strong factors were identified accounting for 70% and 69% of the paternal and maternal variance, respectively. For both fathers and mothers, the six generally positive attributes (acceptance, active involvement, equalitarianism, cognitive independence, curiosity, cognitive competence) had loadings on the first factor greater than .50. Similarly, the six generally negative attributes (conformity, achievement, strict control, punitive control, hostile control, and rejection) had loadings on the second factor greater than .50 (with the exception of maternal rejection whose loading was .46). Lax control, however, had loadings of less than .50 for both factors. Accordingly we formed the four variables by averaging the standardized scores for the appropriate six variables.

Correlations between demographic, boyhood gender nonconformity, parental, and narcissistic symptomatology variables are shown in Table 2. In general, age and education were not associated with other variables. Higher reports of boyhood gender nonconformity were associated weakly ( $r = .10-.30$ ; Cohen, 1977) with lower positive father, higher negative mother, higher feeling of impostorhood, and lower self esteem. Not surprisingly, positive father and mother were moderately ( $r = .30-.50$ ) associated and negative father and mother strongly ( $r > .50$ ) associated, whereas associations between positive and negative father and positive and negative mother were correlated negatively. Feeling of impostorhood and self esteem were weakly or moderately associated with BGNC and the parental variables. These two variables were themselves strongly and negatively correlated, thus it is not surprising that their associations with other variables were similar (adjusting for direction). Narcissistic personality, however, correlated weakly with only one variable, positive father.

In general, except for age and negative father, the variables shown in Table 2 did not vary by either sampling site or ethnicity. Non-European American participants (African American, Hispanic, other) were younger than European American participants (30.3 vs. 35.6,  $p < .01$ ); participants recruited from organizations were older than those recruited from either ads or bars (36.9 vs. 32.0 and 32.3,  $p < .05$ ); and participants recruited from ads reported higher negative father scores than those recruited from either bars or organizations.

TABLE 2. Correlations Between Demographic, Boyhood Gender Nonconformity, Parental, and Narcissistic Symptomatology Variables

Variable	Variable									
	Age	Educa- tion	BGNC	Positive Father	Positive Mother	Negative Father	Negative Mother	Impos- torhood	Self Esteem	
Education	.22*	□								
BGNC	.02	.02	□							
Positive Father	□.14	.11	□.20*	□						
Positive Mother	□.06	□.04	□.14	.30**	□					
Negative Father	□.04	□.01	.11	□.21*	□.03	□				
Negative Mother	□.05	□.04	.24*	□.11	□.30**	.52**	□			
Impos- torhood	□.16	.03	.25**	□.39**	□.26*	.29**	.28**	□		
Self Esteem	.14	.08	□.27**	.40**	.33**	□.35**	.33**	□.66**	□	
Narcissistic Personality	□.07	.05	.02	.20*	.12	□.05	□.01	□.12	.18	

Note.  $N = 108$  for Positive and Negative Father, 109 otherwise.

\*  $p < .05$

\*\*  $p < .01$

Multiple regression statistics, regressing impostorhood, self esteem, and narcissistic personality first on boyhood gender nonconformity and then on the parental variables, are shown in Table 3. BGNC accounted for significant proportions of impostorhood and self esteem variance (6% and 7%, respectively), and adding parental variables increased that amount considerably (by 19% and 24%, respectively). Moreover, once parental variables were taken into account, the direct effect of BGNC on impostorhood and self esteem weakened (the step 2 regression coefficients for BGNC were beyond a SE of the step 1 coefficients), suggesting that the effect of BGNC on these two outcome variables was at least partially mediated by the parental variables (Baron and Kenny, 1986). Taking other variables into account, the strongest predictor of impostorhood and self esteem was positive father (decreases in impostorhood and increases in self esteem were

TABLE 3. Predicting Narcissistic Symptomatology Variables: Hierarchic Regression Statistics

Variable or Statistic	Impostorhood		Self Esteem		Narcissistic Personality	
	Step 1, BGNC	Step 2, parental	Step 1, BGNC	Step 2, parental	Step 1, BGNC	Step 2, parental
BGNC	.25**	.13	□.27**	□.14	.02	.06
Positive Father		□.28**		.25**		.18
Positive Mother		□.12		.20*		.08
Negative Father		.16		□.22*		□.03
Negative Mother		.10		□.10		.03
$R^2$	.06**	.25**	.07**	.31**	.00	.05
$\Delta R^2$	□	.19**	□	.24**	□	.05

Note. Variable scores are standardized partial regression coefficients ( $\beta$ 's) after steps 1 and 2.

\* $p < .05$

\*\* $p < .01$

associated with increases in positive father scores). Additionally, increases in self esteem were associated with increases in positive mother and decreases in negative father scores (Table 3). In contrast, BGNC accounted for essentially none of the variance for narcissistic personality and adding parental variables improved variance accounting a statistically insignificant 5%.

## DISCUSSION

Limitations of this study include the low response rate and the retrospective design. First, the low response rate (42%) from men approached to participate in this study suggests problems in terms of generalizability of its findings. It is unknown to what extent the majority of participants who did not return the questionnaires would have responded differently than the 42% who did and it is possible that this minority shares traits or personality characteristics that might constitute a

sampling bias. Thus, the results of this study should be generalized to the general population of gay and bisexual men only with caution.

With that in mind, in regard to our measures of narcissistic symptomatology, this sample of gay and bisexual men showed no more pathology than the general non-clinical population. The present sample was no more narcissistic and had no lower self esteem or higher feelings of impostorhood than is typical. Thus, the links postulated in the psychoanalytic literature between homosexuality and narcissism received no support here.

However, the hypothesized link between boyhood gender nonconformity and narcissistic symptomatology (hypothesis 1) was partially supported. Reported boyhood gender nonconformity was not associated with narcissistic personality but was, at least indirectly, with narcissistic damage as evidenced by lower self esteem and increased feelings of impostorhood among participants who scored higher on BGNC. Still, because the OMNI was excluded from analysis because of its low reliability and validity, we were left without a direct measure of narcissistic damage.

Moreover, this association was at least partially mediated by reports of parents' behavior towards the participants in boyhood, with the strongest predictor of both higher self esteem and less feeling of impostorhood being positive (accepting, supportive) behavior from the father. Reports of more positive (accepting, supportive) behavior from the mother and less negative (controlling, rejecting) behavior from the father were also associated with higher self esteem.

These findings support the model of the development narcissistic issues suggested by Beard and Glickauf-Hughes (1994). Specifically, a small number of boys begin early in their lives to exhibit behaviors that differ from cultural norms regarding how boys "should" behave. As these boys develop, their fathers tend to respond to their gender nonconformity with less acceptance and support than would be accorded to a more gender conforming boy and mothers may tend to display more rejection and control. Perhaps both parents directly or indirectly communicate to these boys that their behavior is somehow bad or even shameful. As a result, these boys may learn to view themselves, at least in part, as shameful or unworthy of love. This may engender in them low self esteem, a sense of emotional inauthenticity, and a tendency to move through the world feeling like impostors who, if found out, would be rejected by those who profess to care about

them. In other words, they would be narcissistically damaged, as we found.

This model has important implications for clinical intervention with gender nonconforming boys or with adult males who were gender nonconforming as boys. Treatment for such boys has to date consisted of interventions, largely behavioral in nature, aimed at eliminating gender nonconforming behavior (e.g., Rekers, Kilgus, and Rosen, 1990; Zucker and Green, 1992). This treatment employs removal of any positive reinforcement (often the attention or the approval of the parents) and, in some cases, the application of punishment, sometimes physical, in response to BGNC and the use of positive reinforcement when the gender nonconforming behavior ceases or when “appropriate” gender behavior is demonstrated.

Clinicians using treatment methods such as these claim a measure of success in eliminating gender nonconforming behavior, with the ostensible goal of eliminating the rejection that accompanies it. However, as Zucker and Green (1992) note, it seems likely that such approaches may contribute to the development of personality problems. Well meaning as they may be, these interventions may also end up reinforcing a sense of shame, a negative sense of self, and the development of a “false self” in an attempt to gain approval. The findings of the present study indicate that lack of acceptance and increased rejection from parents mediates the development of low self esteem and feelings of impostorhood. As suggested by Zucker and Green (1993), a more helpful and less harmful therapeutic approach would aim to decrease the rejection that such boys face and increase sources of support and approval for them. Perhaps the most effective way to do this would be to intervene with the parents, and particularly with the fathers, rather than with the children, helping parents to challenge their own negative feelings around gender nonconformity and teaching ways to minimize the rejection and to increase the accepting, supportive behavior they express towards their sons. In short, the results of this study support assertions made by Isay (1989) and others that decreasing the “sissyphobia” that surrounds these boys is likely to be the most helpful way to intervene in their lives and to support their healthy development.

There are also implications for clinical intervention with adult gay or bisexual men who were gender nonconforming as boys. Therapists are advised to be sensitive to the probability that these men had to

contend with less acceptance and more rejection from those around them than might otherwise be expected. Therapists should thus be alert to the ways in which such treatment might have had an impact on the client's sense of self and aware of the ways in which this might contribute to the client's presenting problems and might affect rapport building and the establishment of trust in the therapeutic relationship (see Beard and Glickauf-Hughes, 1994).

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## BOOK REVIEW

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BETRAYED AS BOYS: PSYCHODYNAMIC TREATMENT OF SEXUALLY ABUSED MEN. Richard B. Gartner, PhD. *New York: The Guilford Press, 1999, 356 pages, ISBN 1572304677.*

The subject of boys betrayed by supposedly benevolent and benign adults is a tough one for psychiatrists—straight, gay or in-between, female or male, Freudian or otherwise. The sodomizing of boys operates in a zone where childism reigns, where children are thought to be born in sin and indiscriminate lust and where adults are justified in doing whatever occurs to them in relating closely and intimately with children. The sociocultural milieu of child molestation is flagrantly anti-child. The adult is always right and to be obeyed, that is according to patriarchal religion, Freudism, and the ethnological followers of Konrad Lorenz (1966). Childism is institutionalized violence in and out of the academy. Richard B. Gartner makes a substantial contribution to a different world-view regarding children with this book about what happens to sexually abused children when they have become grown men.

Pervaded by the ideology of childism, many adults assert that a boy child is incapable of being sexually abused. He is only initiated into sexual activity under the tutelage of an adult and under whose influence the child finds himself. By this logic, the boy who is masturbated, fellated and bugged earlier is only luckier than most. Imbued with childism, adults get primitivized in their repertoire of defenses and coping mechanisms: denial of reality, lying, projective identification, identification with the aggressor, victim-blaming, rationalization, displacement, dissociation, role reversal, narcissistic identification, pro-

moting one's false self, and others. These defenses are of no help to the betrayed and victimized child whose sanity needs the helping empathy of adults. The children consequently grow up to distort and deny reality, which only makes the children more wicked in the eyes of the adults. The children are told that they are the wicked perpetrators of "childhood sexual crimes." This, as Gartner explains, is made more confusing when the molester has also done some helpful things for the abused child.

Gartner is an exceptional psychoanalyst who truly thinks independently. His book is an exceptionally good one. Whereas some psychoanalysts prefer to dismiss memories of childhood sexual abuse as fantasy fabrications, Gartner listens in sensitive empathy because he believes the erstwhile child, traumatized into a near-stupor, near-trance, dissociating and faltering while he tells the story of his coercion and seduction by dad, uncle, grandpa, mom, baby-sitter, scout leader, priest, teacher, coach, or counselor. To see seduction as a betrayal of trust is to return to a Ferenczian psychodynamism that highlights the trauma in a child's betrayal. That is a pathway rarely followed by many psychoanalysts.

Sandor Ferenczi (1933) was not operating from the perspective of a complex of sibling rivalry or Oedipal strivings when he wrote of the confusion that arises when a child speaks love and tenderness only to be heard by the adult as uttering lust and longing in order to garner the adult's erotic stimulation and to provide the adult with orgasm. Ferenczi was just being a splendid clinician, one may say, who adhered to the truth even when such a truth was heretical. In my own analysis with a Sullivanian<sup>1</sup> analyst, I tried to tell my secret of how, as a five-year-old, I sought love from a 15-16 year old male, but instead was sexually misused and then had to escape from the adolescent male's attempt to kill me. When that was bungled, the adolescent male made a threat to kill for real if I ever told anyone. My narration of those events in my personal analysis was diverted from such reflection and revelation with a comment, approximately exact, from the analyst: "I suppose he was just using you as a substitute for a girl." It was a chic and fast summation for a reality that, multilayered and indistinct as it was, had traumatized me, interfered with my interactions with my mother and siblings, made me precocious in solving problems for the adults in my world, and had given difficulties to my loving and lustful attachments to all others.

Fortunately, Gartner, himself from a Sullivanian lineage, has done

better about betrayed boys than the analyst with whom I labored over forty years ago. The views of “interpersonal and relational psychoanalysis” are sounder than ever today. Our indebtedness to Sullivan is enormous. It is the Sullivanian spirit that infuses Gartner’s excellent psychotherapy with men who were betrayed as boys, including his use of analysis, not enactment, of the transferences and countertransferences in the here and now, and his patience, compassion, candor, and helping empathy.

Harry Stack Sullivan (1956, pp. 266-268) wrote that as he grew more experienced in his work with mentally ill people, he realized that when they said their parents and family members were malevolent toward them as children, we had better believe and not doubt them, and then go to work to help them. When Gartner goes to work, great healing is aborning. Gartner, like Jung and Sullivan, sees dissociation as adaptive and protective and much more common in our lives than has been acknowledged by the other schools of psychoanalysis. So he is not buffaloes by trance, or split, or zone-out. He does not talk of “objects,” “object relations,” and “mental representations,” but uses terms such as “intimate relatedness.” Gartner perceives the patient/therapist dyad as a co-construction that advances the work of demystification and allows both analyst and patient to see through some of the gross fictions typifying their culture and their familial upbringing. This permits an “encoding” of abuse within the dyadic relational context, as Gartner sees things, and it has a healing effect. This is not a power-hungry manipulative psychotherapy.

Gartner is also a family and group therapist, and these allied therapy skills influence his writing about dyadic interpersonal psychotherapy. He is, I gather, a multimodal psychotherapist, but a psychotherapist whose work is not blessed, it appears, by any of psychiatry’s great psychopharmacological wonders. That is refreshment that today can be found only in books by our non-medical therapist colleagues.

This book’s content is divided into 11 chapters covering 38 of the author’s cases. Interwoven throughout is Gartner’s discussion of several vital themes for psychotherapists: notably, issues of boundaries and their violations (Chapters 6 and 7); the familial context of abuse (in Chapter 5); worries about masculinity, machismo, heterosexism and homophobia (Chapters 3 and 4); and the after-effects of abuse as seen in precarious self-esteem, selfhood and intimate relatedness, difficulties which can last a lifetime if not treated. Gartner knows well

how girls are often incestuously abused within the ordinary authoritarian family. He shows how boys, as well, may be brainwashed, physically and emotionally abused, and subjected to boundary distortions, in such families. But boys' sexual abuse, more than girls', is often from extrafamilial figures even when they live in a sexual hothouse for a family. Families of betrayed boys, he finds, cover a wide spectrum in terms of how they handle dispensing sex information. They may be nurturing, withholding, "permissive," sex-positive or negative, and even give warnings about seductive moves from others. To his credit, Gartner sees the complexity but writes of it candidly and simply.

The two socially critical themes that infuse the book, which I have not found written about elsewhere, are of the compulsion within the boy growing up to disclaim ever having been a victim, as though the boy must be in complicity with his sodomizer, and the boy's intricate and daunting struggle with machismo and rigid heterosexism. Again, Dr. Gartner demonstrates that not every adult male who molests a little boy is either gay or straight or in between. Childism is more universal than rigid sexual orientation.

The true problem in the ground substance of sexual betrayal of boys comes from patriarchy's pervading our awareness and colonizing our brains with its machismo, violence, heterosexism, childism, misogyny, and stereotyped sexual role ascriptions. Gender bending in the mildest of forms cannot occur in such a societal dispensation. For a male to demasculinize himself is thought unconscionable. Our unconscious is masculinized too. We survivors see ourselves as sissies because we do not respond every time according to the rough and tumble patriarchal typecasting. Sexual abuse of boys is socially constructed as not really being harmful and is scripted to give praise to, and augment the power of, violent patriarchy. Force lies barely below the surface with patriarchy. Brute force.

But brute force has made us into a horde of killers, rapists and attackers. The twentieth century saw rapid development of violence as both a means and an end, a panacea for all problems and also a way of life. The twentieth is the most brutally violent, per thousand of population, of all centuries of recorded human history. We can claim no longer that our enemies are violent people who must be curbed—for violence itself is our enemy now.

## NOTE

1. Contemporary psychoanalysts whose clinical approach is based upon the original contributions of Harry Stack Sullivan (1892-1949) today refer to themselves as Interpersonal, rather than Sullivanian psychoanalysts. Readers who are interested in learning more about the life of Sullivan should refer to Helen Swick Perry's biography, *Psychiatrist of America: The Life of Harry Stack Sullivan* (Harvard, 1982). Those interested in learning more about the theory and practice of Interpersonal psychoanalysis should refer to the *Handbook of Interpersonal Psychoanalysis*, by Lionells, Fiscalini, Mann and Stern (The Analytic Press, 1995). For those interested in learning the distinctions between classical Freudian and Interpersonal theory, refer to *Object Relations in Psychoanalytic Theory* by Greenberg and Mitchell (Harvard, 1983).

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