SEX IN PSYCHOTHERAPY

SEXUALITY, PASSION, LOVE, AND DESIRE IN THE THERAPEUTIC ENCOUNTER
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You are about to enter the private sex lives of a number of psychotherapists and their clients as known in the workspace of the psychotherapeutic consulting room. While Freud (1912a, 1912b, 1915) acknowledged that loving and even sexual feelings toward patients on the part of the therapist are an inevitable part of psychotherapy, he prescribed only consultation and more personal analysis for the therapist. For this reason, it was not until the 1950s in London that countertransference—feelings of the therapist toward the client—begin to be seriously studied as a vital source of information about what is going on in the therapeutic relationship.

The reports of sexualized therapeutic encounters that follow are organized into my four developmentally based relatedness listening perspectives, which were briefly described in Chapter 1. Each of the four listening perspectives is introduced here with a repeat of the brief paragraph describing the kinds of relatedness that are attended to in this perspective followed by a listing of the listening parameters involved. As mentioned, my listening perspectives are explicitly constructed and ordered according to developmental metaphors of increasing relatedness complexity.

Internalized relatedness patterns from the lived past of each participant, as well as novel configurations emerging from the interpersonal engagement of therapy (the “third”), are an expectable focus of discussion as the therapeutic relationship unfolds (Hedges, 2005). Emotional honesty about and limited disclosure of affective experience on the part of the analyst is an expectable part of the emerging therapeutic relationship (Maroda, 1999). The development of a personal creative style of relating that, like postmodern art, integrates a variety of ideas and interventions into the specific
therapeutic exchange is another expectable aspect of the emergent dialogue (Johnson, 1991). A multiplicity of ways of viewing and working together with the internalized patterns of both people, along with the emerging configurations of interaction characteristic of the couple, are also expected (Stark, 1994, 1997).

The four relatedness listening perspectives that follow are based on developmental metaphors of how a growing child potentially engages and is engaged by others in interpersonal interactions that build internal habits, structures, or patterns of relational expectation during different age periods. Differential framing secures for psychotherapeutic study the structures, patterns, configurations, or modes of internalized interpersonal interaction that have characterized the past interactions of both participants and that are transferred into and resisted conscious awareness and expression in the current mutually developing therapeutic relationship. Relatedness listening perspectives thus formed do not represent a developmental schema per se but rather serve to identify a general array of relatedness possibilities lived out each day in various ways by all people.

Relational psychotherapists rightly or wrongly have been repeatedly criticized on the basis that there is little systematic attention to transference, resistance, and countertransference in relational work. In contrast, the relatedness listening perspectives have been explicitly defined for the purposes of bringing out the unconscious transference/resistance and countertransference/counterresistance relatedness dimensions perennially at play in the therapeutic relationship.

The relatedness listening perspectives approach considers psychotherapeutic concepts valuable and viable only insofar as they are formulated specifically within a human listening (relational) context. Psychotherapeutic knowledge cannot be about a thing, the human mind, but rather exists as a body of thought about how people are able to achieve mutually enlivening, consciousness-raising experiences in an emotionally alive and emotionally stressful therapeutic relationship (Friedman, 1988).

In recent years, there has been considerable discussion regarding so-called countertransference disclosure. The field of psychotherapy inherited from Freud the “blank screen” model that effectively foreclosed any personal emotional involvement or disclosure on the part of
the therapist. Recent analysis showed that what was foreclosed was in fact the therapist acknowledging, or perhaps even knowing about, his or her necessarily participatory role in the process. The point has been repeatedly made that in fact therapists are emotional participants, and that their clients know a great deal about them that can be effectively made use of as therapeutic grist for the mill. The question remains what kinds of disclosure are therapeutically appropriate under what circumstances (Aron, 1996; Hedges, 1996; Maroda, 1993)?

The following vignettes illustrate some points of view on therapist disclosure of sexual responsiveness. This issue is revisited in the final case study of Charles in Part 3 of this book.

Some Relational Countertransference Issues

Maroda: On Speaking Erotic Feelings

Psychoanalyst Karen Maroda considers the question of whether it is ever appropriate for the therapist to speak to a patient of the therapist’s erotic feelings toward the patient (1994). Gorkin (1985, 1987) notes that the sexualized countertransference is a seriously neglected topic. Maroda agrees with Gorkin and further endorses his position that disclosure of erotic feelings is not generally a good idea because of the high level of anxiety that it usually provokes in the patient. But, she holds that there are exceptions to everything.

Maroda (1994) cites as an example a case with an impasse reported by Atwood, Stolorow, and Trop (1989). The patient, Alice, was a 36-year-old Asian woman who had been ignored by her father because he had wanted a boy. She developed an erotic attachment to her therapist and demanded that he acknowledge that he found her attractive and sexually exciting.

Her demands for a concrete affirmation of her sexual self became increasingly strident. The therapist, feeling enormous pressure, finally did acknowledge that she was an attractive woman whom many men would find appealing. The patient became furious at what she felt was a lukewarm response. She continued to demand that he simply acknowledge that he felt sexually excited by her. She reiterated her awareness that they would actually never do anything sexually, but she still wanted...
him to demonstrate that he was interested and excited. In reaction to her increasing demand, the therapist became more emotionally disengaged and adopted a more intellectual stance, inquiring into why she was feeling so needy at this time. The patient became even more incensed and felt that he was abandoning her and that she should leave him. It was at this point that the therapist sought consultation in an attempt to understand what had happened between them. (p. 562)

Maroda (1994) believes that the situation described is a classic impasse, and that it calls for an effective response from the therapist.

Alice is focusing on her therapist’s sexual interest in her, with the importance of her attractiveness being over-determined by her history. Her conviction that her therapist is sexually attracted to her is rooted in reality, since Alice is not psychotic. … Alice is very probably correct in her belief that her therapist is sexually attracted to her and she is telling him in no uncertain terms that she needs confirmation. … [It] is impossible from the information given to ascertain whether Alice’s fixation on obtaining the admission of sexual arousal from her therapist is based solely on her need for affirmation of her female sexuality or whether it also represents a displacement of some other emotional response that she believes her therapist has withheld. … When a patient is as frustrated and as focused on erotic aspects of the therapy relationship as Alice was, I would certainly want to consider seriously that there were underlying contributing factors and that the erotic attachment might well be serving as a defense against hostility or other repressed material. [But] regardless of what underlies it, once a crisis and impasse of this intensity exists, the patient needs a personal and emotional response to it. Before disclosing something as potentially anxiety-producing as sexual arousal, I would definitely discuss the impasse with the patient and attempt to discover any and all meanings that it has. … Telling the patient that you know the situation is critical and he obviously needs something from you that he is not getting, responds to the patient’s needs and feelings, and begins transforming the impasse into a joint effort at resolution. (p. 136)

But, Maroda (1994) feels that even discussing the impasse may not respond to the patient’s needs, that the patient will feel falsely placated and become angry again, thus reinstating the impasse.
With Alice, the therapist was distant and defensive at first, but after consultation he could discuss the impasse with her by stating his desire to be emotionally responsive in the face of his not being professionally comfortable answering her questions. Alice’s acceptance of the therapist’s professional stance was her contribution to resolving the impasse. Says Maroda:

But as I read the case I wondered how long her acceptance would last. Would Alice really be able to accede to her therapist’s refusal to answer her questions or would the impasse take hold again later? If Alice renewed her demands for her therapist to admit his sexual interest in her, I believe he would have had no choice but to do so. Alice had already stated that she knew that their professional relationship did not allow any acting out of sexual feelings and that she had, in fact, accepted this limitation. She simply wanted him to admit what he felt anyway. Undoubtedly such a disclosure from her therapist could be highly sexually stimulating to Alice, but I believe this would pass if the therapist was not being seductive. Furthermore, the problem of sexually stimulating the patient is less severe than frustrating her to the point of dealing with a lengthy impasse or, worse still, a premature termination. (p. 137)

Maroda (1994) believes that Alice may have been one of those rare exceptions—someone who actually needed her therapist to acknowledge that he found her sexually attractive. Maroda advises caution and recommends careful exploration and consultation regarding the meanings of such requests, in tandem with making clear that acting on erotic feelings is never appropriate. “When a patient repeatedly demands to know the truth regarding the therapist’s feelings, no matter what the truth is, I think he has a right to be treated respectfully and given an answer” (p. 138). Maroda’s stance marks a courageous approach to dealing with the inevitable sexual feelings that arise from time to time on the part of the therapist.

_Davies: Love in the Afternoon_

I am here reminded of the wonderful case study contributed by Jody Messler Davies, “Love in the Afternoon” (1994). Her client had
an intense dread of sexual stimulation in himself, but especially of perceiving arousal in others. At a decisive moment, Davies stood against the character scenario of his childhood by telling him that she indeed had sexual fantasies about him. This precipitated a storm of indignant outrage reminiscent of the frequent storms of outrage that the client’s mother had frequently directed at him. The client had often recalled how as a boy, following delicious afternoons in mother’s bed snuggled up against her body with her reading exciting stories to him, mother would realize that he was in a pleasurable ecstasy, intensely enjoying his time with her, and then become outraged. Dynamically, mother would seduce the boy with delicious incestuous relating, and then when she sensed he was enjoying and feeling aroused by the relating, she would become indignant and angrily push him away. Little wonder that he had been totally unable to sustain sexual relationships as an adult. Davies’s client had continued to regale her with tantalizing sexual imagery for some time, which she had been deflecting. But, as her analytic curiosity allowed her to consider what this was all about for him, she found herself having sexual fantasies—and at a critical juncture told him so. His sudden indignant outrage served momentarily to frighten and shame her, replicating how cruelly his mother had raged at and shamed him—and perhaps also signaling his realization that the delicious but perverse scenario with his therapist was crumbling, slowly coming to an end.

In my view, her intervention was directly to the point and did serve to bring a long-festering internalized erotic scenario directly under analytic scrutiny. She dared to stand against the scenario by declaring that all of his sexual talk and imagery was indeed having an erotic impact on her, whether he wanted to think so or not. Although his instantaneous rage and outrage were momentarily intimidating to Davies, in the confrontation she spoke what the boy’s child-self could not speak: that he was stimulating her, and that it was both titillating and invasive. And that in raging and shaming her, he was attempting to blame her for a mutually stimulating situation that he was deliberately instigating and in which she was participating. In role reversal, he had given her in the countertransference the untenable position that he had been victim to in childhood. Her speaking up for herself, and therefore against what was happening, gave voice to the client’s child-self and unmasked the perversity of it all.
Aron: Dominance and Submission

Lewis Aron (1996) describes a man who had for some time been associating about sadomasochistic interactions, sexual fantasies of anal penetration, and feelings of abuse, dominance, and submission. Aron interpreted his client’s idea that he (the therapist) was dominating him, controlling him, and expecting him to submit. The client then expressed his belief that Aron did want him to submit, that this is what he always felt his therapist wanted from him. Aron replied, in a way he hoped conveyed an attitude of musing or thinking aloud, “The entire psychoanalytic therapy is a sexual conquest for me, in which I become excited by your submissions” (p. 178). He left it ambiguous regarding whether it was the client’s belief or the therapist’s experience, both in an attempt to avoid dismissing the client’s thoughts as projections and simultaneously to open himself up for possible countertransference interpretations. He may have learned something about himself and about the analytic interaction that he had not known before.

As I tell the client that I derive sexual excitement from dominating him, I may recognize some excitement in my tone of voice, excitement that I perhaps had not been aware of. Or I may realize that my interpretation has a more aggressive or penetrating quality than I previously realized. … It is not that I expect that my client will regularly interpret something dramatically new to me. After all, if I had no idea that I was susceptive to issues of dominance and control, I believe it would be quite unlikely that I could hear my client’s associations as interpretations and make good use of them. What occurs more commonly is that the client will cue me in to some conflictual area that I do know about but was not sufficiently aware of at the moment, in the present analytic context. The client serves as my therapist by helping me to work through a conflict that was previously worked on in my own personal psychoanalytic therapy. There are risks and complications in this approach but the fact that thinking in terms of mutuality is complicated and hazardous does not mean that it is to be avoided. (pp. 178–179)

These three clinical examples of Maroda, Davies, and Aron serve to alert us to the importance at times of openly acknowledging the presence of sexual feelings in the consulting room. They further illustrate
how seasoned therapists can move forward in this work in the most thoughtful and professional manner possible.

Developmental Listening

Psychotherapists have had a keen interest in developmental theories since Abraham (1924) defined the psychosexual stages, Erikson (1959) set up the stages of ego development, and Mahler (1968) put forth her separation-individuation theory of development. The assumption of these early attempts at developmental listening was that symptoms and transferences in adult psychotherapy could be traced back to the individual’s developmental experiences in infancy and childhood. Jacobson (1954, 1964) shifted the paradigm from considering individual growth experiences to looking at the ways children in their early years come to internally represent their worlds of self and other and how those internal representations serve as silent guides in subsequent relational experiences. Following in her footsteps, Kernberg (1976, 1984) saw the building blocks of personality as (a) a representation of self, (b) a representation of other, and (c) an affect state linking them.

I located four main watersheds of self and other experience that have emerged from a century of psychoanalytic listening and theorizing. But, following contemporary philosophers of the mind such as Ryle (1949), Wittgenstein (1953), Searle (1992, 2004), and Rorty (1979, 1989), I have taken the position that theorizing about the nature of the unitary mind only serves to reify and personify processes that are always ongoing, fluid, and interpersonal. Abandoning scientific objectivity in favor of systematic subjectivity and intersubjectivity, I have taken the position that the only theories that are valuable to therapists are those about how to listen to and to be emotionally present with the narratives put forward by people who choose to talk with us about their lives (Hedges 1983/2003, 1992, 1996, 2005).

Thus, the four relatedness listening perspectives are derived from self and other developmental considerations and define an array of relatedness possibilities from the least complex (I) search for connections, to (II) the establishment of reliable channels of mutual attunement, through separation and individuation to (III) the
firming up of a cohesive sense of self, to (IV) the highly complex capacity for fully ambivalent triangulated experiences of self and other. The liberating twist of the listening perspective approach is not to be found simply in the overall reorganization of familiar clinical concepts; rather, a profound shift of mental organization on the part of the therapeutic listener is required—a mental shift from looking for what is “really there” in the speaker to experiencing what is happening in the intersubjective field of mutual and reciprocal influencing. The sexual vignettes in Part II are ordered along this axis of self and other experiencing.