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PSYCHOANALYSIS AND SEXUAL ISSUES

Abstract. Psychoanalysts were once thought to be experts on sexual issues, but that is less true today. The rift between psychoanalysis and scientific sexology that occurred in the mid-20th century may be partly responsible. In this article, I suggest ways this situation can be remedied. Psychoanalysts can best become more literate about variant forms of sexuality by reading first-person accounts and by garnering information from empirical research and Internet sites for specific forms of sexuality. In addition, psychoanalysts need to examine their own attitudes to different forms of sexuality, make sure they learn a patient's goals in treatment, be honest and open about whether they can help achieve those goals, and pay attention to the difference between psychopathology and societal pathology. In addition, the analyst needs to be aware of how sexual excitement can unconsciously bind erotic experience with other complex emotions and motivations. A case of coercive voyeurism is presented to illustrate these principles.

Keywords: sex, psychoanalysis, perversion, voyeurism, sado-masochism, clitoris

It used to be thought that psychoanalysts were experts about sex. Freud theorized that the sexual drive was centrally involved in most psychology, and he developed sophisticated models of the sexual drive, separating aim and object. A patient with a sexual problem once expected expert treatment from a psychoanalyst (Berry, 2013).

Today, most psychoanalysts know relatively little about sex. In 2009, a startling survey by Shalev and Yerushalmi was published that showed how sex-ignorant and sex-phobic psychoanalytic practitioners can be. They found that many analysts did not want to hear about their patients' sexual experiences. Some felt the sexual experiences per se were not

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critical but masked underlying relational issues. When the therapists were put off or disgusted by their patient's sexual practices, they often presumed that the patient was trying to attack them or shock them, rather than considering the limitations of their own experience, knowledge, and tolerance. How did the field of psychoanalysis reach this alarming situation with respect to sexuality?

One basic problem is a simple lack of knowledge. Most psychiatric, psychological, and psychoanalytic training programs do not address sexual problems adequately, if at all. Few psychoanalysts today have learned about how to work psychologically with people who like to cross-dress, have sex with animals, enact different or multiple genders, or other unusual patterns of sexual experience. Few have a clinical understanding of urolagnia, voyeurism, exhibitionism, and dyspareunia. I lecture often on the subject of psychoanalysis and sexual issues and usually ask my audience about whether they learned about these subjects in graduate school or medical school, internship, residency, or psychoanalytic institute. After years of asking this question, only one person has reported comprehensive training in these subjects; she was trained at a university in Puerto Rico.

This article will outline how psychoanalysts can broaden their knowledge about psychological approaches to sexual issues. Most of what I learned about psychoanalysis and sexual issues was not in my formal training—not in graduate school and not in psychoanalytic training—but was acquired through independent study, academically and from clinical work. My knowledge and interest in varied forms of sexuality probably started with the fact that I am a gay man. That is not such a major revelation in our current world, but in 1971, when I took my first psychoanalytic course in college, homosexuality was considered a deal-breaker when it came to psychoanalytic training and being accepted into the psychoanalytic community. At that time, it was the norm for psychoanalysts and psychiatrists to consider homosexuality to be a pathology that needed fixing, and many people worked toward that goal.

For decades, several psychoanalysts have tried to rectify some of the misconceptions in the psychoanalytic world about homosexuality (e.g., Blechner, 1993; Corbett, 1993; Isay, 1996; Phillips, 2003; Schaffner, 1995). The psychoanalytic field has come a long way on the topic of homosexuality, and now it is time to expand our knowledge of many other patterns of sexuality and gender identification, and establish guidelines for what can and should happen clinically in such cases.

The cause of psychoanalytic ignorance about sex may be dated to the mid-20th century, when psychoanalysis effectively broke relations with scientific sexology. In Freud's day, psychoanalysts tried to be knowledgeable about sex, and they were in regular communication with sexologists. These sexologists included:

1. Richard von Krafft-Ebing, who wrote *Psychopathia Sexualis* in 1886, the single most authoritative treatise on variant forms of sexuality (and who supported Freud's appointment as a university professor, even though they disagreed about many issues);
2. Iwan Bloch, known as the first sexologist, who in 1906 wrote *The Sexual Life of Our Time*, an encyclopedia of the sexual sciences in their relation to civilization;
3. Albert Moll (1908/1912), whose research on childhood sexuality and whose book *The Sexual Life of the Child* had a major impact on psychoanalysis;
4. Magnus Hirschfeld (1914/2000), founder of gay liberation in Germany 60 years before it took off in the United States, and also a scholar of "intermediate sexual conditions" like intersex and cross-dressing;
5. Havelock Ellis, who published his series of *Studies in the Psychology of Sex*, starting in 1897, in which he wrote humanely and with great accuracy about unusual sexual behaviors.

Freud developed his ideas in interaction with these researchers, and they studied the ideas and findings of psychoanalysts.[1]

This pattern changed: The turning point was in 1948, when Kinsey published his first scientific study of human sexuality. He was viciously attacked by psychoanalysts for his empirical data showing that approximately 37% of adult American males had engaged in at least one sexual experience with a same-sex partner. From then on, there was a major rift between psychoanalysis and sexology. Edmund Bergler's arrogant 1948 paper: "The Myth of a New National Disease: Homosexuality and the Kinsey Report," which appeared in *Psychiatric Quarterly*, showed a trend; psychoanalysts felt they could ignore and be contemptuous

[1] Familiarity with sexological findings did not necessarily prevent psychoanalysts of the time from being judgmental and pathologizing, but it tended at least to make them more knowledgeable and inquisitive about the details of their patients' sexual experiences.

of scientific studies of sex. Others who attacked Kinsey included Karl Menninger (Bowman et al., 1956) and Arno Karlen (1971). A rift appeared and expanded between scientific studies of sex and psychoanalysis.

For evidence of this disjuncture, consider one of the best-known articles about psychoanalysis and sex: André Green's (1995) article, "Has Sexuality Anything to Do with Psychoanalysis?" Green writes: "If any one of us breathes the air and is alive, it is as a consequence, happily or unhappily, of a primal scene, in other words, to be fully explicit, of a sexual relationship, happy or unhappy, between two sexually different parents, whether we like it or not" (p. 880). In 1995, when this was written, it was already false; a single woman could receive artificial insemination. Today, it is false in many more ways; modern reproductive technologies, such as in vitro fertilization, make it possible for a child to be conceived and born in many ways without any actual sexual relationship between two sexually different parents.

It is in the nature of science to disprove earlier beliefs; psychoanalysts working as practicing clinicians must keep abreast of new research findings and not rely only on theory and the data emerging in their consulting rooms.

One of the effects of my being known as an openly gay psychoanalyst was that I received many referrals of people with unusual sexual predilections, such as practitioners of ritualized sado-masochism, male heterosexual voyeurs, a man who liked to urinate in his pants while being hugged by his lover, and many others. I was puzzled at first why I was receiving these referrals, because I knew almost nothing about these sexual practices. The referring doctors may have presumed that I, being gay, knew a lot about seemingly strange forms of sexuality. This was wrong at first, but eventually it became true as I struggled to find my way with these patients. In time, I evolved a way of informing myself about their sexual desires, experimenting with the theories that I read about, and ultimately forming a kind of general strategy for treatment. Understanding alternative sexual patterns makes the clinician more sensitive and skilled in understanding the sexuality of all patients. Once immersed in working with patients with atypical sexual patterns, the clinician becomes sensitized to the specific and subtle ways that each of us develops a unique and private pattern of sexuality and tries to live with it.

When I was first referred some patients with sexual patterns that were strange to me, my first strategy was to read all I could. A female sado-masochist triggered my search through psychoanalytic journals and

books. Although the theories were compelling, they were not really helping me in my office with this patient. At one point, she referred me to the book, *The Story of O* (Réage, 1954/1973), which is the classic novel about female masochism. This book taught me more than all the psychoanalytic treatises.[2] First-person accounts, by people with various sexual desires, are the best way to learn what that sexual pattern feels like from the inside.

Today, the Internet has changed everything; it has made sexual knowledge much easier to acquire. One can Google anything and find extensive material on almost any sexual predilection, both narrative descriptions and empirical research. There will probably also be a website where people with the same desires share facts and experiences, and that is the best source of information. One can find out what their sexual experience is like, how it interacts with their lives in general, and their experiences in working with psychotherapists and psychiatrists—what helped and what did not help, what was constructive and what was harmful.

Some postmodern psychoanalysts may bristle at the implied empiricism of the words "fact" and "data." Nevertheless, it is my view that data are necessary to test our psychoanalytic hypotheses. I am concerned that the field of psychoanalysis has used postmodern arguments as a way of evading the difficult task of obtaining facts through research. To be sure, facts can be wrong; Bieber et al. (1962), for example, believed the "fact" that homosexuality was caused by a distant father and an overly close mother. They did not consider the alternative—that this pattern of parenting is influenced by the child's homosexuality (Blechner, 1995b; Goldsmith, 2001; Isay, 1989). But although facts can be wrong or questionable, and need to be considered critically, it is still better to know the data than to dismiss them out of hand. Also, facts of first-hand sexual experience, reported by those with shared sexual patterns, are often more reliable than facts put forth by the clinicians and theoreticians who study them.

Consider the extensive literature on the distinction between clitoral and vaginal orgasms. Freud (1905/1953, 1908/1959, 1925/1961) posited that

[2] For example, I learned that there are masochists who seek to inflict pain, but there are also masochists who seek only domination, without sensory pain. The desire to have physical pain inflicted is sometimes called "algolagnia" and is distinguished from masochism in general. Some masochists seek no physical pain, only dominance, a relinquishment of their own will. The analyst may presume that such a position is in itself a humiliation, but that may not be universally so.

in normal development, the girl transfers the center of sexual excitement from clitoris to vagina. Yet, recent studies of anatomy (O'Connell, Eizenberg, Rahman, & Cleeve, 2008; O'Connell, Sanjeevan, & Hutson, 2005), using advanced imaging techniques, have discovered that the clitoris is much larger than the part that is visible in the external vulva. The clitoris in its entirety is approximately four inches long; it has "legs," the crura, erectile tissues that extend downward internally and surround the vagina. Thus, it is an anatomical fact that vaginal stimulation can mean clitoral stimulation.

In actuality, O'Connell's discovery was a rediscovery; a German anatomist, Georg Ludwig Kobelt, studied female anatomy and came to the same conclusions. Kobelt's hand-drawings are not as vivid as O'Connell's images, but the basic details are there (Kobelt, 1844, 1978). It is surprising that these anatomical findings about the clitoris were forgotten or suppressed over time, rediscovered, and then forgotten again, a fact that in and of itself has significant psychological implications (Blechner, 2013, in press; Moore & Clarke, 1995). None of Freud's writing about female sexuality refers to the anatomical discoveries or shows an awareness of them. The psychoanalyst Marie Bonaparte, had she known more about clitoral/vaginal anatomy, might not have subjected herself to surgeries to relocate her clitoral glans in a failed attempt to improve her sexual responsiveness (Bertin, 1982). The crura of the clitoris were extensively discussed in the psychoanalytic literature by Sherfey (1966), but subsequently received little attention from psychoanalysts. Without knowledge of the "facts" of clitoral anatomy, it is not possible to adequately assess or revise Freud's theory of female development or to apply those theories in clinical practice.

Clinicians who do not learn the latest facts about sex and sexuality will likely rely on the "common sense approach to sexuality." Common sense is a fine thing, but it is no substitute for knowledge. Common sense has led to all sorts of misconceptions about sex. Psychoanalysts are excellent at coming up with meanings of symptoms that sound plausible, but may not be valid. We do not adequately test the truth of our explanations. This is a central part of the crisis in psychoanalysis: We rarely collect empirical, relatively objective data, and so our work is marginalized or ignored by other fields. In fact, as stated above, the turn to hermeneutics in psychoanalysis may be a *consequence* of our simply not having enough facts, so we say that it is all in the interpretation of meaning.

Empirical researchers can err, as well; influential thinkers can at times assert, without sufficient proof, that their hypotheses are true, with disastrous results for patients. One of the most serious examples of this is the case of David Reimer. Reimer was the victim of a botched circumcision that destroyed much of his penis. His parents consulted with the famous sexologist, John Money, about what to do. Money believed that nurture during the first two years of life could determine the gender of the child; he recommended that the penis be removed, the child given female hormones, and be renamed Brenda. Money reported that the treatment was successful:

> Although this girl is not yet a woman, her record to date offers convincing evidence that the gender identity gate is open at birth for a normal child no less than for one born with unfinished sex organs or one who was prenatally over-or underexposed to androgen, and that it stays open at least for something over a year after birth. (Money & Tucker, 1975, p. 98)

This resulted in the widespread assumption that gender could be assigned during the first two years of life, regardless of genetic endowment, and shaped medical practice (Diamond & Sigmundson, 1997). In fact, however, Reimer never felt like a girl. Despite all the efforts of his family and of John Money, Reimer rejected his assigned female identity at age 14. He committed suicide at age of 38 (Colapinto, 2001).

In retrospect, it appears that Money reported clinical success that would prove his theory, but the clinical success was a falsehood. As Charcot said, "Theory is good, but it does not prevent things from existing" (Freud, 1893/1962, p. 13). Thus, it is important for psychoanalytic clinicians to know and report the latest facts, beware of shaping facts to fit theories, and be constantly ready to rethink psychological principles that need revision in the light of new knowledge.

Besides learning as much as possible about sexual experiences, the clinician needs to think through a basic approach when beginning a psychotherapy. The psychiatrist William Alanson White said we should always address a fundamental question: "What is the patient trying to do?" (Sullivan, 1924, p. 8). We should then determine whether we can and should help him or her to do it. These are fundamental questions for any treatment. In the case of someone with unusual sexual proclivities, we can ask: What does the patient want to be the outcome of psychotherapy in relation to the sexual pattern? In many cases, the clinician can make

assumptions about what the patient ought to aim for and then head for that aim, not necessarily with the patient's agreement or cooperation (Blechner, 2007).[3]

How much does the analyst ask and pay serious attention to a patient's stated aims and wishes? How straightforward is the analyst about whether he or she is willing and able to work toward the patient's stated goals? How clearly have psychoanalysts staked out what is possible and desirable clinically in such cases? What are the data about outcome with respect to sexual issues? How aware is the psychoanalyst of the question of psychopathology versus societal pathology: namely, whether the unusual sexuality is intrinsically problematic for the person or problematic because society condemns that sexuality? And finally, how do the analyst's own life experiences and biases shape his or her clinical work? Our perception of other people's sexuality is shaped by our own sexual experiences, as well as what we have learned we should think and feel. Judgments about sex are subjective. For example, it has been said that a promiscuous person is someone who is having sex with more people than I am.

The same logic could be applied to most of the other old judgmental terms about sex. The pervert is someone who does things that I would never do. The person who is inhibited and constricted about sex is someone who never does what I would readily do. The undersexed person wants to have sex less often than I would. The oversexed person is someone who wants to have sex more often than I do. In the film *Annie Hall*, Diane Keaton complains to her therapist, "He wants to have sex all the time, maybe three times a week!" and Woody Allen complains to his therapist, "We hardly ever have sex, maybe three times a week!"

Although psychoanalysis started as a radical reenvisioning of the role of sexuality in human experience and behavior, it evolved more-often-than-not into an upholder of conservative values and Old Testament notions of normality. Thus, for many psychoanalysts, the guidelines of what is "pathological" sexuality are strongly influenced, often unconsciously, by the Judeo-Christian guidelines of what is sinful. In fact, the

[3] Sometimes, as treatment progresses, patients change their minds about their goals, but these remain the patients' goals. As a general rule, the psychoanalyst should avoid as much as possible imposing personal beliefs about what is the right kind of sexuality on the patient.

word "perversion" has its roots in religion. The definition of "perversion" in the *Oxford English Dictionary* is "turning the wrong way; corruption, distortion; specifically, change to error in religious belief."

There is therefore a basic problem with the concept of perversion: in orthodox religion, there is a right way to do things, and if one does things differently, even if it makes one happy and one does not harm anyone, one is still wrong, perverted, and sinful. Many clinicians have bought into such a translation from sin to psychopathology, even if the connection between pathology and sin is not fully conscious. That has caused a lot of clinical mischief and a good deal of suffering for patients.[4] Indeed, Freud (1905/1953, p. 150) defined perversion as any sexual act that did not lead to genital intercourse: "Perversions are sexual activities which either (a) extend, in an anatomical sense, beyond the regions of the body that are designed for sexual union, or (b) linger over the intermediate relations to the sexual object which should normally be traversed rapidly on the path towards the final sexual aim." Thus, oral sex was considered a perversion if it led to orgasm, but not if it was preparatory to penis-in-vagina intercourse. It may be that if one thinks perversion, one is also implicitly thinking, "I know the right way to behave." Not just the right way for me to behave, but *the* right way to behave (Dimen, 2001). Or, as one colleague put it, "I may not know the right way to behave, but I do know the *wrong* way to behave."

Saketopoulou (2014a, 2014b) has attempted to salvage the term "perversion" as a sexual experience that is overwhelming, without retaining its pathologizing connotations. She writes: "Anal sexuality, for example; penis-in-vagina sex; acrobatic sex while suspended from the ceiling are all equally viable candidates for perversion as long as they are subjectively experienced as overwhelming" (Saketopoulou, 2014a, p. 287). Her definition of perversion comes close to (some might say is synonymous with) "great sex," which is overwhelming, destabilizing to the ego, and often mixes pleasure with disgust, danger, and taboo (Blechner, 2005). Indeed, Saketopoulou's (2014a) primary clinical example in her paper on

[4] Janine Chasseguet-Smirgel (1985) vilified homosexuality as a denial of difference. Yet Chasseguet-Smirgel, a female French-speaking Jewish psychoanalyst, married Béla Grunberger, her male French-speaking Jewish psychoanalyst. Was that a denial of difference? And should such difference deniers be cured? Is sameness of gender in a relationship problematic, but is sameness of nationality, religion, and profession not problematic? This is an example of what I call the "gender fetish" (Blechner, 1995b)—disproportionate attention to gender over other significant dimensions of human identity.

perversion is of a gay man who goes with his husband to a bathhouse and has very exciting sex with a physically repulsive stranger.[5]

Harry Stack Sullivan gave us an important alternative to the pathologizing inherent in the psychoanalytic view of perversion. Sullivan tried to formulate a view of sexuality that would evade old religious formulas and would instead define sexual health in practical terms. He argued that there are many sexual practices and preferences, and what is most important for psychoanalysis about these practices is how much they allow for pleasure and intimacy. One example was mutual oral sex, which Sullivan (1972) called "synstomixis." Freud considered mutual oral sex leading to orgasm a perversion, but Sullivan saw it as a good path toward intimate and mutual satisfaction.

Sullivan tried to establish a way of looking at sexual practices without being limited by religious and cultural taboos. In Sullivan's own words, in the *Interpersonal Theory of Psychiatry* (1953, p. 294): "In this culture the ultimate test of whether you can get on or not is whether you can do something satisfactory with your genitals or somebody else's genitals without undue anxiety and loss of self-esteem."

I call this Sullivan's postulate on sexual functioning (Blechner, 2005). If one really takes this postulate seriously, one may have to reconsider many judgments of sexual health and pathology. Sullivan does away with the religious idea that healthy sexuality must culminate in at least the potential for pregnancy, as well as the psychoanalytic derivative of this, so-called "mature genitality." Sullivan does not judge whether any sexual desire is in itself healthy or pathological; instead, he focuses on how feasible it is to realize any particular sexual desire, without excessive

[5] This highlights the issues of values in psychotherapy. Among gay men in New York today, it is common for gay male couples in marriages and other long-term relationships not to take monogamy for granted, but to negotiate whether to be monogamous (Mitchell et al., 2016), and their choices often evoke pathologizing judgments among couples therapists (Shernoff, 2006). Although many gay couples choose monogamy, it is not as much of a cultural given as it is, at least officially, among heterosexual married couples (Blumstein & Schwartz, 1983). The data seem to vary widely with time and method of sampling. McWhirter and Mattison (1984) claimed that all gay male couples, after five years of being together, had some provision for sexual activity outside the relationship, what Morin (1999) calls "modified monogamy." A more recent study (Spears & Lowen, 2010) of 556 male couples found that approximately 50% had sex outside their relationships, whereas Campbell (2000) found that 70% of his sampled gay couples were monogamous. Parsons, Starks, DuBois, Grov, and Golub (2013) found 58% monogamous, 22% had "open relationships," and 20% had "monogamish" relationships (Savage, 2012) in which sex with other men occurred only when the other partner was present (which seems to have been so in Saketopoulou's case).

anxiety or danger. Odd forms of sexuality are not a problem if one can find a way to satisfy one's desire without danger to oneself or someone else. We should uphold the right of every person to experience pleasure, as long as it is consensual and no one is damaged. If a psychoanalyst insists on pathologizing and trying to change another person's nonharmful sexuality, especially when that person has no desire to change that sexuality, the psychoanalyst is committing a crime against that person. Sexuality is too important an aspect of life to yield to another person's arbitrary sense of right and wrong.

Sullivan's postulate needs some revision, because it implies that anxiety is the enemy of sexual excitement. Yet for some people most of the time, and for most people some of the time, a certain amount of anxiety or other "unpleasant" affect can heighten sexual excitement.[6] It is one of the great paradoxes of sexuality that any emotion that inhibits arousal—including anxiety, guilt, shame, fear, disgust, humiliation—can, under different circumstances, intensify arousal (Blechner, 2016; Morin, 1995). Can we develop an affective neuroscience of sexuality? Can we specify which affects, with what intensity, and under which circumstances, enhance or diminish excitement? These are the affective dimensions of the "sexprint" (Person, 1980) or "lovemap" (Money, 1986), the personal pattern of sexual excitement and satisfaction. Is the relationship of negative affect and sexual desire unique for each person, or can we spell out any general laws or principles about the relationship of multiple affects and sexual excitement? And to what degree, if at all, can the sexprint be modified by psychotherapy or by experience?

Within Sullivan's postulate, are any forms of sexuality inherently problematic? Anything that is nonconsensual or coercive or seriously damaging another person remains problematic, such as coercive voyeurism (see case example, below). In addition, one must pay attention to Sullivan's phrase: "In this culture the ultimate test of whether you can get on or not is whether you can do something satisfactory with your genitals or somebody else's genitals *without undue anxiety and loss of self-esteem"* (emphasis added). "Without undue anxiety and loss of self-esteem"—

[6] "Barbara's Song" from *Die Dreigroschen Oper* (The Threepenny Opera) by Bertolt Brecht and Kurt Weill (1928) captures this fact. A man who is wealthy, kind, clean, and knows how to treat a woman comes along, and she says "No!" to him. Then a man with no money, is not kind or clean, and who doesn't know how to treat a woman comes along, and she is smitten.

these are large caveats. Psychoanalysts must attend to the level of the patient's anxiety and loss of self-esteem when it comes to sexual experience. Is the sexual experience followed by affects such as shame, regret, abjection, and hatred (Dimen, 2005; Stein, 2005a, 2005b)? When that is the case, an analysis of unconscious aspects of the sexual experience may reveal the sexual pattern as an attempt to master anxieties and other unpleasant affects.

Nevertheless, the clinician must also be careful not to confuse his or her own anxiety with the patient's. It is an easy pitfall to assume that if the clinician feels disgust and anxiety about a patient's sexual experience, the patient feels those same affects or *intends* to evoke those affects in the clinician.[7] Such distinctions are not always easy to make. In Shalev and Yerushalmi (2009), a therapist who is disgusted by her patient's sexual exploits identifies (rather unconvincingly, to this reader, at least) the arousal of her disgust as his intent. A more nuanced separation of intent and effect can be found in De Peyer's (2002) self-study of her work with a man whose primary sexual fantasy is to inflict pain on another person, leading to their castration and murder. He had not enacted the entire fantasy, but he had once beaten another man to the point that he feared (incorrectly) he had killed him. His fantasy bound sexual feeling to self-disgust, rage, and alienation. De Peyer found herself with a mixture of fascinated excitement and fear for her own safety, and struggled admirably to maintain a centered presence with this man, while helping him to discover the unconscious psychodynamics of his fantasies.

A patient who engaged in masochistic rituals that she called "the game" came to me for treatment when she found herself avenging herself on her lover with enormous rage and violence (Blechner, 1995a). As a child, she was frequently frightened by her father, who said terrifying things in a joking manner. For example, when she was on her first cruise on an ocean liner, he told her, laughing, about the *Titanic*. Her masochistic rituals were attempts to bind the conflicting love of her father with the terror and suffering he induced in her. Like De Peyer, I was made uneasy by her destructiveness, but struggled not to be paralyzed or obsessed by it. In the treatment, the patient eventually played a practical joke on me that her father had played on his friends. I was harshly humiliated by the

[7] It is worthwhile to do a self-study of personal reactions to nonnormative sexual practices, to learn one's personal boundaries, and perhaps expand them, such as by watching a film like *Beyond Vanilla* (Lilja, 2001).

joke. Observing the pain engendered in me by the experience, she was able to understand, through experience rather than by interpretation, her own conflict about being the victim of sadism disguised as humor, and find ways to master it without resorting to a cycle of masochism and revenge (Benjamin, 1988). The case highlighted the distinction between hearing an accurate interpretation, which can launch clinical curiosity, and experiencing one's conflict in vivo in the transference, which is more likely to lead to substantial change. This illustrates a basic principle of psychotherapy with sexual issues: A well-formulated interpretation that is true can intrigue a patient, as it did when I told this woman that her father's comment about the *Titanic* seemed cruel and must have terrified her, yet his laughing demeanor must have made it seem important to hide her anxiety and act cheerful. Yet profound change only occurred when the patient lived out the conflict of laughing cruelty with me. She could watch me experiencing the fundamental questions posed by Ghent (1990), which she herself had tried to answer: "What happened? How did it happen? A loved one could not have done that to me! That is inconceivable. Then how did it happen? He did it! . . . but somehow I cannot 'take it in.' It just cannot be . . . . Oh, I see! So that's what father was up to when he did such and such!" (pp. 127, 130).[8]

The "Basic Psychoanalytic Premise"

Many psychoanalysts have a vague notion of normalcy, and they have a basic approach to working with people with unusual sexual predilections that don't conform to the analyst's notions of normalcy, which is to seek out the roots of the predilection in the early relationship with the parents, with the aim of "understanding" the sexuality and perhaps changing it. Psychoanalysts are expert at coming up with plausible accounts of anything based on early parental relations, and at that they rarely fail, but unfortunately, these accounts too often make little difference in the patient's sexual pattern and experience.

This is what I call "the basic psychoanalytic premise": if we can understand the role of a symptom in someone's life as well as its function in the patient's history, we can thereby help the person to get over the

[8] See Blechner (1994) for a related example of the enactment of sado-masochism in psychoanalytic treatment.

symptom. When applied to sexual behavior, the same premise is often applied: exploring the developmental history of the patient will clarify the psychodynamics that caused the sexual pattern, and such analysis will lead the patient to understand his or her sexuality and no longer need the familiar "pathological" sexuality, or—failing that—at least be able to foster a normal sexual life in addition to the patient's nonnormative sexuality. Plausible as this sounds, it is often false. But because there is so little empirical outcome research in psychoanalysis, practitioners continue to proceed as if this approach will work more often than it does. The fact is that some nonnormative sexual patterns have almost never disappeared because of psychotherapy. It is probably unethical to hold out the hope for such change to someone who may desire it.

The Example of Male Cross-Dressing: Facts and Values

Our judgments about sexual experience and behavior can be subjective and often need to be corrected by empirical facts. For example, with male cross-dressers, there is a disjunction between commonly held beliefs and the facts. Despite the popular image of the gay drag-queen who dresses up as Barbra Streisand, the fact is that the majority of men who want to dress up as women are not gay; most are heterosexual. The desire to cross-dress is more common than usually thought, because most cross-dressers have been secretive about it, although that may be changing. In 2003, the British potter, Grayson Perry, won the prestigious Turner Prize (Jones, 2006). Perry attended the award ceremony, accompanied by his wife and daughter, dressed in a purple silk frilly dress that cost $10,000. He said, "Well, it's about time a transvestite potter won the Turner Prize."

The difference, between common-sense presumptions about cross-dressing and facts was clearly illustrated when the journal *Studies in Gender and Sexuality* published a clinical paper by Irwin Hirsch (2007). Hirsch described a case of a male cross-dresser, Z., who had a girlfriend. Hirsch tried to influence him away from cross-dressing, even though the patient never expressed a wish to stop the practice. He wrote,

> I believed that Z. would have a good life with this girlfriend, and thought that she would help him settle into the hard work of his demanding profession, and as well, help him actualize what I felt would be his considerable potential as a loving father to his yet unborn children . . . . In my misguided zeal to help Z. actualize his career and to solidify his relationship with his

> girlfriend, my interpretive schema accented the immaturity of his sexual interests, maintaining his archaic girly-boy identification with his mother and avoiding the "stronger" and more masculine emphasis on career and commitment to this, in my mind, wonderfully flexible young woman. Even if I had been largely on target with my insight in linking history to present, the more salient message this sensitive man heard from me was to control his cross-dressing distractions and to settle down to a promising career, and a monogamous relationship with this girlfriend with whom I was so taken. In his charming and seductive way Z. quit therapy for "practical" reasons, never challenging me for my egregiously unwarranted impositions on elements of a life that he desired.

This is the "common-sense" approach to psychotherapy with its flaws exposed. Hirsch applied the basic psychoanalytic premise; he identified aspects of the patient's relationship with his mother that he proposed were causative of his wish to cross-dress. Hirsch thought he knew what would be good for his patient, he thought he knew how to change his patient, and he never really found out what his patient wanted. In fact, websites for heterosexual cross-dressers reveal that no crossdresser reports any luck at getting rid of his desire through psychotherapy. Instead, the consensus about therapy with heterosexual cross-dressing seems to be quite similar to therapies that claim to change homosexuals to heterosexuals. They are costly in terms of time and money, they are distressful for the patient, and they do not work in the long run. For many a male heterosexual cross-dresser, what he most wants is not to lose his desire to cross-dress; instead, what he most wants is to be able to dress up in women's clothes and be accepted by his wife or girlfriend, or better yet, have her help him put together his outfits, and often to make love to her while he is dressed in women's lingerie, as was the case with Hirsch's patient, Z.

It is interesting to note that our culture is quite skewed when it comes to pathologizing cross-dressing. Heterosexual cross-dressing is seen in our culture as much more of a problem for men than for women. If a woman wears her husband's shirt to bed, it is not considered a perversion; it is usually considered normal, even sexy. But if a man wears his wife's negligée to bed, he is considered abnormal. Marlene Dietrich in a tuxedo was considered sexy; Jack Lemmon or Rudy Giuliani in a dress were considered comic. Our society still seems to value masculinity above femininity. It is considered much more problematic for a man to act female than for a woman to act male.

And why should male heterosexual cross-dressing be a problem? After all, does it hurt anyone if a man wears a dress? Does it hurt anyone more than if a woman wears pants (a practice that was once considered unwomanly, but not any longer)? Maybe it is not that heterosexual cross-dressing patients need to stop putting on dresses; maybe society needs to change, to allow them to do so without censure or punishment. The question moves from one of psychopathology to societal pathology.

It might be best to conceptualize cross-dressers as "bigendered" (Blechner, 2015); that is, they want to experience themselves, at different times, as either a man or a woman. They have two gender-identities, and they want to keep both gender identities. In that sense, we should distinguish bigenderism from a bisexual sexual orientation. In current usage, bisexuality can refer to having *sexual attractions* to men and women. Bigendered people have a mixture of two *gender identities*, male and female. In psychoanalysis and in "common-sense" beliefs about sexuality, for a man to identify as a woman was seen as indicative of homosexuality, but we know today that sexual attraction and gender identity are by no means identical (Stoller, 1968; Money & Ehrhardt, 1972; Shively & DeCecco, 1977). The men who want to dress up as women and make love to their wives are not gay men. One could say that as men they are heterosexual, and in their feminine identity they are lesbians (Novic, 2005).[9]

How Do We Work With Sexual Issues? An Informal Study

After publishing my book *Sex Changes* (Blechner, 2009), several fellow clinicians contacted me to tell me that they felt that learning how to work with sexual issues in psychotherapy had been mostly absent from their training. As a result, a year later, I began teaching a private seminar on sexual issues in psychoanalysis. My original plan was to teach a 10-week course, but the students asked to continue, and we continued for three years, covering topics such as:[10] the psychological factors in sexual excitement; nontraditional patterns of sexual expression, including zoophilia (Earls & Lalumière, 2009), transvestism (Blechner, 2007; Hirsch, 2007; Person & Ovesey, 1978), voyeurism, exhibitionism

[9] Harris (1991) noted how a putative homosexual sexual orientation may mask an alternative gender identity and therefore a psychically heterosexual relationship.

[10] The references here are representative readings; the actual reading list was more extensive, but cannot be presented here in its entirety.

(Hinderliter, 2010), sado-masochism (Ghent, 1990; Réage, 1965/1973), urolagnia (Grosskurth, 1980), gerontophilia, ephebophilia, pedophilia, prostitute usage, homosexuality in men (Blechner, 2009; Drescher, 1998) and women (Newman, 1999; Slater, 1999; Vaughan, 1998; Young-Bruehl, 2000), heterosexuality (Blank, 2012; Chodorow, 1992; Katz, 2007), bisexuality and bigenderism, and asexuality; masturbation; sexual fantasy; gender identity (Fausto-Sterling, 2000; Nestle, Howell, & Wilchins, 2002), intersex, and transgenderism (Hansbury, 2005); the involvement of penis, vagina, anus, mouth, breasts, and other body parts in sexual practices; kinds of sexual excitement and orgasm in men and women (Horney, 1933; Komisaruk, Beyer-Flores & Whipple, 2006); couples therapy, with both opposite-sex (Goldklank, 2009) and same-sex couples (Greenan & Tunnell, 2003; Iasenza, 2004): sexual dysfunctions, including inhibited sexual desire, impotence, anorgasmia, premature ejaculation, delayed ejaculation, and dyspareunia (Binik et al., 2002; Kingsberg, 2002; Kolod, 2009; Masters & Johnson, 1966); fidelity and infidelity, monogamy and nonmonogamy (Kernberg, 1980; Oppenheimer, 2011); and the theory of different kinds of love (Sternberg, 1986). The group studied sex-therapy techniques to treat sexual dysfunctions, and how to integrate sex therapy and psychodynamic psychotherapy, especially in the work of Helen Singer Kaplan (1975, 1979), David Schnarch (1997), and Esther Perel (2007). We reconsidered questionable psychoanalytic formulations about sex, sexuality, and gender identity, including penis envy, mature genitality, and perversion (Dimen, 2001; Horney, 1933; Iasenza, 2010; Schafer, 1995; Thompson, 1943).

We read widely in the literature of psychoanalysis, sexology, and sex therapy. We also read many first person accounts of people with unusual presentations of sex and gender, and of their experiences, good and bad, in clinical treatment. For example, we read the autobiographies of Renée Richards (1983, 2007), well-known as a transgender ophthalmologist and tennis professional, who, although still a man named Richard Raskind, was in a classical analysis with Dr. Robert Bak, then the director of the NY Psychoanalytic.[11] Bak interpreted to Richard that his wishes to become a woman were an illusion. He said that Richard's attempts to hide and mutilate his genitals covered up a wish to keep his genitals

[11] Bak (1968, case 5) also wrote about Richards, so one can compare the accounts of analyst and patient.

intact. After the self-abuse, he said, Richard was unconsciously relieved that his penis was still there, and he had not been castrated. Richard considered the interpretation to be clever, but it made no difference in his wish to become a woman. He had sex reassignment surgery after ending psychoanalysis with Dr. Bak.

The Richards case shows that a psychoanalyst can make interpretations that are plausible, even clever, but not necessarily true; even if they are true, they do not necessarily have any impact on the patient's experience or wishes. By the end of the analysis, Dr. Bak started yelling at Richard and issuing ultimatums and warnings, such as that if he went through with a sex-change operation, he would become psychotic. Psychoanalysts must attend to unconscious fantasies, but it is essential to base the exploration of unconscious fantasies solidly in the facts of the patient's life and the first-hand experience in the transference–countertransference matrix, and not resort to formulas, the analyst's own or those that can be found for many sexual experiences in textbooks like that of Fenichel (1945).

The format of the seminar was such that in each class, there was also one clinical case presentation. We considered each case according to understanding the patient's clinical aims, the analyst's attitudes, the relevant literature, and the transference and countertransference. It allowed us to study, first-hand, some patterns in how contemporary psychoanalysts approach sexual issues. In this way, our findings comprise a supplement to the data of Shalev and Yerushalmi (2009). Our sample, however, was a group of clinicians who specifically sought supplementary training about sexual issues. Thus, members of the group were open to questioning their common-sense presumptions. They learned *not* to presume that their individual negative reactions, of confusion, anxiety, or disgust were necessarily reflective of their patient's intentions.

The members of the seminar were all highly experienced and talented clinicians. Two were over 75 years old and had more than 50 years of experience doing clinical psychotherapy. All were practicing psychotherapists, and most had graduated from psychoanalytic training programs, as well as other postgraduate kinds of training. Granted, this is not a random sample and not a balanced way of collecting objective data; nevertheless, it allowed us to make in-depth observations that might not have been possible with other methods, and that may show some significant trends, especially concerning objective knowledge, countertransference, and counterresistance.

The first fact is something already discussed in this article—that all the students had little or no formal training in working with sexual issues in their graduate or postgraduate education. Many did not know the meaning of many practices and syndromes—urolagnia, zoophilia, BIID, dyspareunia[12]—and had not been trained on how to address such issues when they come up in psychotherapy.

There was a question about lack of knowledge; there was also the question of their personal comfort or discomfort with different sexual issues. Most of the participants in the seminar felt they were comfortable talking about sexual issues with their patients, but they changed their minds as the course progressed. Certain trends in their work that showed anxiety and avoidance emerged during the seminar, such as:

1. *Rush to interpretation*: If the clinician feels uncomfortable with the specifics of a sexual practice, a good defense is to formulate the interpersonal dynamics and developmental experiences related to the sexual practice. Interpretations then tend to reframe sexual issues into interpersonal and relational meaning, and to account for the sexual issue by reference to early experience. Unfortunately, the rush to interpretation can get in the way of the therapist really finding out what the patient is talking about. For example, one woman talked about a patient with a rape fantasy, and she explored the psychodynamics of that fantasy. But at a certain point I asked, "What exactly happens in his rape fantasy?" The therapist said she assumed that it was the usual—man forces a woman to have intercourse against her will. But when the therapist inquired, she discovered that the fantasy involved a woman in an elaborate, balloon-like dress that made genital penetration impossible—so that the fantasy involved attempts at overpowering the woman, but without genital penetration.[13]

[12] Urolagnia is the presence of sexual excitement at the thought or perception of urine or urination. Zoophilia is a sexual attraction to and love of animals (Earles & Lalumière, 2009). BIID is Body Integrity Identity Disorder, in which one feels that part of a limb does not belong to one's body and wishes to have that part of the limb amputated. Dyspareunia is pain experienced during sexual intercourse.

[13] One could see this interaction as an enactment. The patient's fantasy may express his fear of penetrating a woman, being penetrated himself, and wishing to control a woman, and this is enacted by the therapist's reluctance to penetrate further into his fantasy.

2. *Avoidance of detailed inquiry*: Another sign of counterresistance towards sexual issues is when the clinician avoids inquiring into the details of the patient's experience. An analyst who was a heterosexual married woman presented her work with a single gay man, with whom she had already worked for 10 years. In one session, the man told her that he had met someone new, and together, in his words, "we did all my favorite sexual things."
   I asked her, "What are his favorite sexual things?"
   She replied, "I don't know. Do you think I should ask him?"
   "Why not?" I asked.
   "Well," she replied, "it seems to me that might be prurient."

I said to her, "If a heterosexual married woman told you that she did all her favorite sexual things, would you consider it prurient to ask what those things were?"

She said, "No, *that* would be interesting." I suggested to her that what she called prurient interest might be a by-product of her discomfort with hearing from the gay man what his favorite things were, plus a sense that she would not be able to understand what he was saying and integrate it into her total sense of him, although with the heterosexual woman, she would feel less anxiety and more likelihood that she could identify with and understand her sexual proclivities.

The thinking of this therapist is rather similar to the thinking of the therapist called Dahlia by Shalev and Yerushalmi (2009):

> From the beginning of the therapy, it was clear to Dahlia that the patient was suffering from a problem related to sexual fantasies. Recently, the patient had begun alluding to them. Dahlia knew that the fantasies were causing the patient a great deal of suffering. The patient felt "devastated" and "dirty," experienced "shame" and "loss of self-esteem," and devoted "all of her days . . . to trying to eliminate these fantasies." However, Dahlia knew nothing about the content of the fantasies and was content with filling the gaps in her knowledge with speculation. "I am guessing [the contents of the fantasies] from what she says and from what I know. My feeling is that they are not so wild . . . . But I don't know what the content of the fantasies is." (p. 354)

It is problematic when a therapist is clear that the patient's central problem relates to sexual fantasies, yet never seeks to find out what those fantasies are.

3. *Reliance on early history as explanatory*: One clinician with extensive training in developmental psychology was able to quickly identify possible early experiences that might lead to a current sexual pattern. Although these formulations were often fascinating, they could also be problematic. If a pattern was plausible, did it actually happen in the patient's experience? How reliable was it that the early experience *caused* the adult sexual pattern? And finally, even if it did, how much could it be expected that identifying the causation would lead to any modification in the current experience?

Unconscious Fantasies and Lovemaps

This is not to say that psychoanalysis can have no impact on someone's sexuality. In my clinical work, there have been cases in which the treatment did have a significant impact on the patient's sexual experience. To the best of my knowledge, what happened was that with each patient, we lived out their personality pattern together, and in doing so, we came to understand their sexuality in a vivid way (see case example, below, of a male heterosexual voyeur).

In clinical work, the discovery of the patient's unconscious fantasies and anxieties is important (Person, 1995), but it needs to be in balance with a full knowledge of the patient's conscious experience. As the novelist Margaret Millar (1985, p. 216) wrote: "Some people become so expert at reading between the lines they don't read the lines." Clinical cases like those described by Bak (1968), Hirsch (2007), and others show how a psychoanalyst may describe an unconscious fantasy that plausibly accounts for a patient's experience, yet the fantasy may be the analyst's, and the clinical effect not helpful. The title of Bak's (1968) article, "The Phallic Woman: The Ubiquitous Fantasy in Perversions" captures the problem; the search for unconscious fantasy should not be along the lines of "one size fits all"; instead, the identification of unconscious fantasy, anxiety, and other emotions must be as specific as possible to the patient and ideally should emerge from expressions and enactments in the transference.

Psychoanalysts also need to recognize the unconscious significance of their attempts to steer a patient away from a sexuality that may seem repugnant. As Joyce McDougall (1986, p. 19–20) has written: "The analysands themselves rarely wish to lose their erotic solutions. A

number of patients, under the impact of the analytic adventure, frequently develop richer sexual and love relations, but should this not occur, then to lose the only system of sexual survival they have been able to devise would be the equivalent of castration."

The psychoanalyst faces the difficult task of analyzing his or her own unconscious fantasies and motivations in relation to the patient's sexuality and lovemap. McDougall (1993) gave a brilliant example of this: analyzing her own dreams in tandem with her patient's dream, McDougall worked through her resistance to her erotic tie to her own mother, which was interfering with recognizing her patient's erotic maternal transference to her.

The term "lovemap" is important (Money, 1986). It means a particular pattern of sexual arousal, excitement, and satisfaction—a story-line and emotional pattern—that is unique to each person. Sexual desire is entangled with other emotions—anxiety, shame, triumph, taboo, and terror, among others (Kernberg, 2001; Laplanche, 1992; Morin, 1995). Our lovemaps often involve a complex script for using sexuality in the service of mastering difficult emotions or resolving bodily traumas (Shapiro, 1996). Sexual excitement can be energized by the tension between pleasure and a fundamental anxiety. Solving a fundamental anxiety can be pleasurable in itself, and can fuel or shape sexual desire.

It is an open question how much our lovemap can change during our lifetimes, and whether it should change. If there are changes to the lovemap, they usually are small changes, although a very small change can restructure a whole system (Harris, 2009) and make a very big difference in someone's life. A good psychoanalyst should help his or her patients learn about their lovemaps and learn how best to realize that lovemap. The nature of the lovemap may seem apparent to others, yet most people are unconscious about some or many facets of their own lovemap. The lovemap and the unconscious fantasy reflect and intersect one another; the mixture of sexual pleasure and other complex affects, some of them unpleasant or frightening on their own, leads to rich and complex variations in the experiences we group under the phrase "sexual excitement."

When considering a romantic couple, one has to take into account two lovemaps and how those lovemaps work together. It would ideal if the two lovemaps are at least compatible, or better yet, synergistic, so that the couple's love life is exciting. Nevertheless, a certain degree of mismatch, tension, or unavailability may lead to greater sexual excitement

and longevity of a sexual relationship. Too easy access and too much comfort and safety can lead, paradoxically, to diminished sexual interest, although the value of safety may change in subcultures where life is more perilous (Goldner, 2006). Morin (1995) produced the formula "Attraction + Obstacles = Excitement" (see also Blechner, 2006; Mitchell, 2002; Perel, 2007). Morin (1999, p. 12) writes: "The naturally shifting rhythms of contact and withdrawal, ambivalence and pursuit, help keep us slightly off balance, and thus erotically alert. The ideals of safety and security to which many couples aspire can either foster good sex or throw a cold blanket on it, or a combination of the two."

Some couples run into sexual difficulties because their lovemaps are incompatible, or at least seem incompatible. There are couples who have also been together for decades. Although their relationship began with intense sexuality, there were signs right from the beginning that their primary sexual fantasies were incompatible. Each of them had a lovemap that made the other's fantasies noxious. As each tried to realize his or her lovemap, the partner became alienated. They eventually stopped having sex altogether, although they felt they still loved one another and stayed together, sometimes for their entire lifetimes. In some cases, they each decide to pursue their particular sexual lovemap with someone outside the relationship. These extramarital relations can show remarkable staying power, and allow them to have relatively happy and stable lives. Although one might judge the cost to be high in terms of unrealized or diverted passion, it is important for psychoanalysts to respect those people who have arrived at such a life solution and do not wish to change it.

Sometimes incompatibility is not the problem. Instead, one member of the couple has particular fantasies or desires that he or she considers shameful or perverse and therefore keeps secret from the partner. These can include wanting to enact scripts like bondage and domination scenarios, practices like oral and anal intercourse, special erotic attention to a less-than-usual body part, wearing of particular kinds of clothes, and numerous other possibilities. A psychoanalyst who considers any of these manifestations to be perversions may try to cure the patient of such a desire, usually with little success. An alternative is for the person to overcome shameful feelings and share the proclivity with the partner or to find a partner with compatible desires. If this is done early enough in the relationship, there is a good chance that the partners may be interested in exploring their individual lovemaps together. However, if shame and

secrecy prevail for a long time, the eventual frustration and a pattern of sexual avoidance may be hard or impossible to undo.

Consider the case of the sexologist Havelock Ellis. He liked to watch and hear women urinate (known as urolagnia or undinism), and that was the only way he could become sexually aroused. His first wife, Edith Lees, thought that his wish to watch her urinate was disgusting and she would not do it with him, and they ended up with a sexless marriage. After his wife's death, Ellis met a French woman, Françoise Lafitte, who found his excitement about her urination charming and harmless. She gratified his wish, and they were able to have a good sex life.

Imagine Havelock Ellis comes to your office. He has urolagnia, a desire to watch and hear women urinate, and cannot have an erection without it. What is your way of thinking about this issue and what is your clinical approach? Do you consider his urolagnia a perversion that needs analysis, with the aim of having Ellis no longer need to watch and hear women urinate in order to be sexually excited? Or do you consider it an alternative kind of sexuality, and help him find a woman who can either tolerate or actually enjoy urinating for him as part of a sexual scenario? Or, as Shalev and Yerushalmi (2009) tell us is common, do you send him to a sex therapist? That is probably not going to work; most sex therapists are no better trained to work with urolagnia than psychoanalysts.

The Example of Voyeurism

An enlightened view of sexuality would support any sexual activity that would satisfy desire, without coercing or damaging oneself or someone else. Within this view, one form of sexuality that remains problematic is what I call "coercive voyeurism."[14]

Over the years, I have been referred a number of male heterosexual voyeurs. At first, I knew relatively little about voyeurism. I did know firsthand about typical psychoanalytic attitudes towards so-called perversions and the attempts to fix them, and that experience was helpful. It made me cautious about being judgmental and self-righteous about most forms of sexual expression, even if they were unappealing to me. It also made

[14] Karpman (1954) defined voyeurism as a "pathological indulgence in looking at some form of nudity as a source of gratification in place of the normal sex act." I have coined the term "coercive voyeurism" to distinguish those who enjoy seeing nudity from those whose main pleasure is seeing someone's nudity against her will.

me curious about how a particular form of sexuality was pleasurable for someone else, even if it had little or no appeal to me. I took an anthropologist's attitude towards my patients, trying to really understand how things worked for them, erotically and otherwise, and to avoid, as much as possible, making presumptions based on my own experience.

The Case of Jim

In order to illustrate the clinical application of the principles described in this article, I would like to describe in some detail my work with one voyeur—a man whom I will call Jim.

Jim came to see me at the age of 33. His complaint was that he was a compulsive voyeur. He was tall and his masculine build contrasted sharply with his boyish appearance. He dressed usually in a T-shirt, with either gaudy colors or a cartoon picture on it, such as of Mickey Mouse. His hair was long, which at the time was not in fashion, and he was usually unshaven. His appearance was sure to draw attention for being so incongruous. His speech was also unusual: a mix of proper English with sophisticated vocabulary, and poor grammar combined with slang and vulgarity. He shifted haphazardly between these, and he seemed to raise his voice and smile when he said things like, "Yous don't hafta ansa," (in a mock lower-class Brooklyn accent).

Jim had previously been in a four-times-a-week analysis for four years, but he felt it had little impact. When he came for his first consultation with me, his wife had discovered that she was pregnant for the first time. Although Jim loved his voyeuristic activities, he feared the effect of his voyeurism on his soon-to-be-born child, and that was why he sought treatment once again.

In addition, his mother had died a few months before. Jim seemed to have unsettled emotion about her death; in her last days, she confessed to Jim's mother-in-law that she had been having an affair for 30 years with Sam, a waiter in a resort town. Jim had suspected this in the past, but when he had asked his mother about it, she had completely denied it. Now, her deathbed revelation made things clearer for Jim, but it also enraged him about the years of confusion and deception that he had experienced.

I told Jim that I did not know whether we could do anything to change his voyeurism. We might be able to find out more about why he enjoyed it so much and why he shied away from other forms of sexual involvement.

I said we might understand how the voyeurism functioned in his life, and maybe find a better way to manage it. I told him that I thought he had other problems in his life, such as how he dealt with the world in general, especially in connection with his career, and that I could help him with that. I also said that he seemed to have a lot of feeling about what he had found out about his mother, and that maybe I could help him make more sense of it. He told me that he wanted to work with me. He and his wife had been planning to move to another city to raise their child, so he did not know how long we would get to work together, but he wanted to give it a try.

At the time, I did not know much about voyeurism, so a library search of the literature seemed to offer hope of enlightenment. There was a debate among psychoanalysts about voyeurism. Bergler (1957) had argued that voyeurism is an "original drive" whereas "exhibitionism is but a defense mechanism installed after the child's early voyeuristic wishes are severely inhibited" (pp. 214–215).

Kohut said the opposite was true. In *The Analysis of the Self*, Kohut (1971) wrote that voyeurism was a displacement of thwarted exhibitionism: "The voyeuristic symptom of Mr. E. had first appeared in his later childhood when his mother had not been able to respond appropriately to the boy's exhibitionistic wishes" (p. 315).[15] Which was true? Jim's first memory of peeping at someone was as follows: He was performing on the guitar at the window, hoping to impress the neighbor across the street. She, however, shut her window. He felt mortified by the rejection, and immediately tried to look at her. So Kohut's theory of frustrated exhibitionism seemed plausible.

I was not sure what would be helpful to Jim, but it became apparent what would not be helpful. Jim's previous analyst regularly referred to his voyeurism as "being disgusting," which may have sabotaged the treatment. Even if the patient claims to be unhappy about his sexuality, the clinician still needs to find out: What *does* he or she like about the sexuality? What is pleasurable about it? The clinician must keep that in mind and respect it. To have pleasurable sexual experience is important in anyone's life. Even when people say they would rather do something else, they probably will not for very long, unless the alternative is also

[15] Freud (1905/1953) also suggested that exhibitionist impulses precede voyeuristic impulses.

pleasurable. It is important to remember how precious it is to each of us to have a route for sexual passion, even if someone else disapproves of it.

When I started work with Jim, I assumed that male heterosexual voyeurs like to look at naked women. So I asked Jim the naïve question, "Why don't you just go to a strip bar?" As it turned out, this was of no interest to him, nor was it to most of the coercive voyeurs I have worked with since. The thrill for Jim was seeing a woman naked *against her will*; if she was willing, there was no thrill.[16] There was an erotization of power and coercion. The woman who is being watched must not know about it; or if she does know about it, she must not wish it. That is even more exciting. It is a kind of ocular rape.

In its coercive aspects, voyeurism is connected with exhibitionism. Most exhibitionists also want to expose themselves to women against their will. If the man opens his raincoat, and the woman licks her lips and says, "Nice!" and approaches, it will ruin his fun. He does not want to turn a woman on; he wants to scare her (Chan, 2007).

It is not clear whether there are any coercive female voyeurs; if there are, they are much more rare than coercive male voyeurs. To be sure, there are women who derive erotic pleasure from looking (Fenichel, 1945; Rehor, 2015). But it is important to make the distinction between general scoptophilic interest (pleasure in looking) and coercive voyeurism.

Perhaps the lack of female coercive voyeurs is related to the power relations between men and women in our society and the greater fear in women of male aggression than vice versa. If a female voyeur tried to see a man naked and were discovered, there is a much greater likelihood that the man would invite her to sexual activity or that he might endanger her physically.[17]

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[16] This was noted by Yalom (1960) in a landmark study of eight voyeurs, most of whom had been incarcerated. One man said, "Looking at a nude girl friend wouldn't be as exciting as seeing her the sneaky way. It's not just the nude body but the sneaking out and seeing what you're not supposed to see. The risk of getting caught makes it exciting. "Another said, "It must be clandestine, she must be a stranger and she mustn't see me watching."

[17] Yalom (1960) states that all coercive voyeurs are male heterosexuals, and that there are no reports of either female or homosexual voyeurs. There are dangers in asserting, however, that something does not exist. It was once presumed that men found it exciting to watch pornography of two women interacting sexually, but that women did not find pornography with two gay men exciting. Person (1999) proposed a psychodynamic account of why this might be so. However, it emerged that this asymmetry was factually incorrect

Early History

Jim's father was 80 when we started working together. Before Jim was born, his father had been successful professionally. However, when Jim was 3, his father underwent brain surgery that went awry, and it left Jim's father unable to work. He spent most of his days sitting in a chair in the living room. His father's immobility and the scars on his scalp were frightening to Jim.

When Jim was 5, his mother and he went to a beach resort, where she met Sam, an uneducated but very handsome waiter, and began the affair with Sam that lasted the rest of her life. Early in the analysis, Jim claimed to have had no conscious awareness when he was a child of Sam's role as his mother's lover, although he knew they spent much time together. Not only were there frequent trips to the resort on weekends, but the mother spent every Wednesday out of the house. She claimed to be playing cards with girlfriends, although Jim remembers her returning, smelling of liquor and sex. She was having a regular mid-week rendezvous with Sam.

Jim was an only child and received much attention from his extended family. He spent a good deal of his childhood trying to latch onto strong male figures and repeatedly losing them. His maternal grandfather was a vigorous man who took Jim out for various sporting activities, which he loved. But the grandfather died of a heart attack, which—it was said—was caused by too strenuous exertion. After that, Jim avoided nearly all sports.

There was another reason Jim avoided physical exertion. At the age of 6, he was pestering his mother, who was working in the kitchen. She warned him to leave her alone, but he persisted, and finally she threw a pair of scissors at him. They pierced his calf so deeply, that they stayed there, perpendicular to his leg until his mother pulled them out. Jim still had the scar as an adult. Not only was it visible on the skin surface, but nearly every time he recollected the trauma in a session, or felt it somehow reenacted in the transference, he felt a sharp leg pain. This experience was critical in his development. One could say he was fixated to that time—he would remain a pest, he would pester women, but stay out of reach of their scissors.

(Blechner, 1998). Some Japanese girls like to read comics with romantic stories between two men, called *yaoi* (boy's love; see Thorn, 2004), and some lesbians like to watch gay male pornography (Bernstein, 2010), as was made widely known by the film *The Kids are Alright*.

Stoller (1979) has argued that the source of all perversions is the expression of hostility. Although aggression may be an important factor in voyeurism, I think that at least as strong a motivation for the voyeur is his own safety from the fantasized aggression of the woman. Many voyeurs think, "If she only knew that I was looking at her . . . ." If she only knew, then what? Usually, the answer is, if she only knew, she would be furious, and she would do something hurtful to me, like throwing a pair of scissors at me. The primary erotic scenario of Jim and other voyeurs combines a forcible approach to the woman while warding off humiliation, rejection, and outright physical trauma.

Nierenberg (1950; see also Friedman, 1959; Metzl, 2004) came to a similar conclusion: "The scoptophilia served not only as a means of expressing his sadism but also as a means of defending himself against it. Expressing aggression through looking is certainly less dangerous than by physical contact such as touching" (p. 162).

In school, Jim was an indifferent student. He had trouble concentrating, and teachers noted his distractibility and elevated anxiety level interfering with what seemed a high native intelligence. At the age of 14 he began to smoke marijuana regularly, and was still doing so at the time treatment began. I asked him, in the beginning of treatment, to stop his marijuana use for the duration of the analysis. I was startled by how suddenly and completely he was able to do so. I noted to him the strength of his will-power, and wondered what he might be able to do if he harnessed that will-power productively.

He combined his voyeurism with technical wizardry—he was a true modern-age voyeur. Through a combination of telescopes, cameras, infrared lighting, and video equipment, he was able to make high-resolution photographs and films in the most difficult photographic conditions. He was able to get good photos of women inside their apartments more than a quarter mile away. With all this technology, Jim could engage in voyeurism without the usual dangers to voyeurs of being arrested for trespassing or breaking into people's homes.

Jim was fascinated by the Three Stooges, and in his scholarly manner, he had studied them so deeply that he was an expert on them. He explained to me in one session how the apparent violence and aggression in their movies is faked. Some of the violence looks terrible, as when one of the Stooges shoves his fingers into another man's nostrils. If one watches the movies in slow motion, as Jim has done, one can see that the hand stuck in someone else's nostrils is actually made innocuous by

the other person's moving his head in such a way as to prevent any damage. A similar tactic makes the blows on someone's head not really damaging. I noted the parallel with his voyeurism—it seems invasive and damaging, yet, for the most part, it seems to do no harm. The woman being watched does not know it.

A primary theme of the treatment with Jim was aggression—how you modulate your own aggression and how you protect yourself against other people's aggression.

Jim told me his favorite joke:

> One man says to another: "Take a look at that pig over there with three legs. Isn't that disgusting?" The other man replies, "Don't call that pig disgusting. That's a great pig. That pig saved Momma's life. A while ago there was a fire on the farm, and Momma was asleep upstairs, and that pig started squealing like crazy. He woke up the whole farm, and Momma got downstairs in time. If it hadn't been for that pig, Momma would have slept through the fire and been burnt."
> "Gee, I'm sorry," the other man says. "I didn't realize that it was such a great pig. But tell me—how did he come to have three legs?"
> "Mister! A great pig like that, you don't eat all at once!"

The essence of the joke is the sudden reversal—the man who had been defending the pig's honor so vociferously now lets us know that he has eaten the pig's missing leg. A person who was admiring turns out to be also aggressive. And it is questionable whether it is any sign of veneration to the pig to eat him leg by leg, rather than all at once.

In the case of Jim, the joke had other resonances for him. The missing leg connotes castration and the damage to Jim's leg with the scissors. And there is also the ambivalence toward the mother. The pig saved Momma's life. In doing so he bought himself more time. There is no easy way out. If the pig in the joke saved Momma, he will live on for a while, castrated. But if he had not saved Momma, he would have died sooner.

Jim's other favorite joke came from Rodney Dangerfield: "I turned on the light, and the switch fell off. Then I reached down for my briefcase, and the handle came off. Now I'm afraid to take a piss!" The theme of potential castration is here, too. When his mother threw the scissors at him and hit his leg, he may have thought she was trying to castrate him. Also, the joke implies: "If I am so destructive to everything around me, what harm could I do to myself?"

Right before his baby was born, Jim found a more comfortable apartment that would better accommodate his family. He was ambivalent about moving; the old apartment was perfect for a voyeur, because it was on a high floor. The new apartment was on a low floor and would not allow as many voyeuristic possibilities.

Four days before leaving his old apartment, Jim had an "orgy" of voyeurism. He watched woman X, his favorite, and then started to call her repeatedly on the telephone. Finally, she left the phone off the hook. He thought, "Oh, boy, I can listen." But because all he heard was a television set, he eventually got bored and hung up. He drew the parallel with his own childhood: "I'm a pest and I pester her. It's just like what I did with my own mother. And then she threw the scissors at me." At this point in the session, the pain in the scar on his leg returned.

Jim often clowned as a means to hide his anxiety. He did this with me at the beginning of most sessions, and I interpreted its function to allay his initial anxiety in seeing people. His work as a freelancer required that he constantly be setting up professional contacts. Yet he was quite inhibited about doing this. I noted that nearly every time that he did finally make some kind of professional contact, it resulted in a job, right then or sometime in the future. Talent was clearly no problem for Jim. We worked on this issue a good deal, and analyzed his inhibitions about self-assertion, related to a negative identification with his invalid father and a fear, based on his traumatic loss of his grandfather, of exertion leading to death. We also worked on how he could be less off-putting. His great talent took care of the rest, and his professional success improved enormously.

The therapy included a good deal of work on the dynamics of Jim's marriage. I thought that if there was to be any reduction of his voyeuristic activities, the problem of providing a good sexual alternative had to be solved. Jim's wife refused psychotherapy, although I thought she needed it. She had been attacked as a young adult and was fearful of sexual contact. She complained that Jim's voyeuristic activities denied her normal sexuality, that he had "stolen" her sexuality. Yet we noticed that when Jim did approach her sexually, more often than not she would reject him, or withdraw her interest during love-making.

At one point, Jim described a pattern in his marriage, in which his wife is always nagging him to do his share of the work at home, and he deliberately and, in his own view, unfairly avoids it through all possible means. I interpreted this as an attempt to defend his father's honor

against his mother's degrading attacks, like a revolutionary, through passive resistance, as well as through his voyeuristic activities. He felt that this interpretation was a breakthrough, the kind of thing he had been waiting for during our work over the last four months and the four years of treatment that he had had with his previous analyst.

It emerged how much aggression he felt was in his household growing up. His father's bodily damage was, in Jim's view, the result of his mother's abuse. He thought that if she had not actually caused her husband's illness and immobility, she nevertheless did everything possible to encourage his passivity and avoided things that might have led to his rehabilitation. In the analysis, he hypothesized that she did this so as to be undisturbed in her affair with Sam. Later he revised this, thinking that she kept Sam in a subordinate position as well, and that it might have simply been a wish on her part to maintain dominance over men.

Jim initially had serious doubts about my competence and wondered, "What if he is a clown in a suit?" (It is interesting that I thought that he was a scholar dressed up like a clown.) In general, however, he seemed to admire me. This picked up on the developmental process that had stopped when his grandfather died. About six months into the treatment, he started to worry about his attachment to me. He cried out, with much trepidation, "I love you, and I don't know what to do about it." He feared that his love for me meant that he was a homosexual. I told him that it could be so, but that not all men who love other men are homosexual. Otherwise, there could be no close bonding between men, or, between a father and his son. Or a grandfather and his grandson, for that matter.

Fortunately for the treatment, I found Jim's peeping per se rather harmless, except when he started to call "his ladies," to spy on their identities, or plan to go to their buildings and peep through their windows.[18] When he said that, I told him that he would be breaking the law and risking arrest, and he just could not do that. And he did stop it. I did not realize until much later how this had been an enactment.

The treatment of a voyeur, or anyone who has a sexualized ritual, requires creativity. I found myself going through many untraditional techniques to gain access to Jim's secret world. When he suggested he bring his slides of nude women to the session, I assented. (This is not unlike

[18] Fantasized coercion or intrusion is quite different, from a legal and social perspective, from actual physical coercion or intrusion.

Stoller's [1979] approach with a pedophile of having him bring his favorite pornography into a session, and using that as a means of clarifying, in great detail, the factors that are exciting to him, and the unconscious scripts that are the essence of his sexual excitement.) With each slide, I asked Jim, "What about it was most exciting?" After this session, Jim told me that he enjoyed showing the slides to me, but felt I was too analytic.

Around this time, Jim told me a dream:

> I'm in a hotel in Phoenix. I'm looking out the window at a parking lot. It's my car. Someone does something with one car and a bunch of them get rolling, including mine. It gets smashed in the front. I think, "Oh no, not again." I call down to the lobby. A woman answers. I yell, "One of your fucking guys just ruined my car." She is perturbed at my language. She says, "How do I know it was one of my guys?" There is a guy my age, talking about how much they will give me to fix my car. They ask me, do I want to get it all fixed? I want my car all fixed.

I noted how much Jim wants himself all fixed. I also noted that he is much more assertive and angry in the dream than he has allowed himself in person with me. This unleashed much emotion. Jim spoke about how much the analysis cost him; he was concerned that it would cost as much as a new car, which he wanted. He said, "I could have had a Taurus!" In the end, would the analysis seem worth it?

Jim and his wife had decided shortly after the birth of their child to move to another state, and the move was scheduled in about six months. Jim was ambivalent about the upcoming move because he felt the therapy had been going well. He asked to increase the frequency of sessions from two to three per week because we had limited time left to work together. I asked him what his aims were for our work in the time remaining, and he stated that he wanted to be free of his voyeuristic compulsions. I agreed to increase the frequency of sessions, but said that, given his goal for treatment, he would have to work more intently at limiting his voyeuristic activity during this time period, and see what would happen. He whined and complained, became a bit of a pest about it, but finally agreed. He referred to this plan as "our experiment" and, despite his complaints, seemed genuinely enthusiastic about it.

My aim was not a behavioral extinction of his voyeurism. Rather, I was hoping that the underlying anxiety would become clearer if he stopped the peeping. While he was under the pressure of this ban on peeping, many important issues came up. Most immediate was the question of

his persistence: Could he stick to a task and apply himself to it, even when it was a task he had set for himself? He reported at first that the experiment was a failure; he was not able to completely curtail his voyeuristic activities. I noted that, having had one difficult week, he seemed to be ready to throw in the towel, and this brought up the general question of his determination and persistence.

As often as Jim slipped up, the experiment was hardly a failure from my perspective because of the wealth of material that emerged. During this period of the analysis, most of our attention was centered on Sam, the man with whom Jim's mother had her affair. (I had by this time realized that Jim's unusual way of speaking, which was a combination of uneducated slang and very proper English, may have combined the speech styles of Sam and Jim's mother.) Sam's importance was heralded when Jim brought in a letter Sam had just sent him, congratulating him on the birth of his son. "Look at what a dope my mother was carrying on with! Look at how stupid he was!" he said. There was no question that the language was bad; Sam spelled the word "lonesome" "L-O-A-N-S-O-M-E," and there was no evidence that this was a deliberate pun. But there was also no question that the content of the letter was beautiful. It was full of genuine concern for Jim, his wife, and son, full of joy at their happiness, and offering generous help to them. When I read that letter, I knew that Sam was more than an interloper in the family. I suspected that he was a father-substitute, probably quite a decent one.

The emergence of Sam's role in Jim's life took turns that were surprising. Jim recalled how his mother wiped his behind after a bowel movement until he was about 6. When Sam discovered this, he became outraged, and told Jim to wipe his own behind. There were other memories that emerged, one after another, all with the theme of how Sam took stands about Jim's upbringing. In general, Sam acted like a father who sets limits. In a similar way, in the analysis, I enacted this same function when I told Jim he could not go to the home of the woman whom he was watching from a distance.

But Sam had his own problems with limits. He was a compulsive gambler. I wondered if there was an unconscious connection between Sam's gambling compulsion and Jim's looking compulsion. Jim seemed intrigued by this, but then it emerged that Sam was quite interested in looking at women himself. Earlier in the analysis, I had asked Jim if anyone he knew growing up was also involved in voyeurism. He had said no, but now he started remembering that Sam was always pointing

out women's breasts to Jim and his mother. One time they were in a car, Sam and Jim in the front, mother in the back, and Sam was singing the song, "I'm a Girl-Watcher," and he improvised on the last line, "And I love to watch their titties bouncing up and down." I said to Jim, "Maybe Sam and you had voyeurism in common." And Jim said, "Oh, no, Sam's not a voyeur. He just liked to watch women. *I'm* the voyeur." I said I was not sure that he could have that honor all to himself—that both of them were voyeurs, but that Sam was blatant about it whereas Jim did it by stealth. Not only did the women Sam watched know he was doing so, but so did the people who were with him, including Jim and his mother.

After that, Jim began to remember that Sam not only watched the women, but often went over and approached them. He recalled,

> There would be a good-looking woman at a hot-dog stand, and Sam would go over and say, "Nice weather we're having." Most of the time they would just grunt, but sometimes he was able to strike up a conversation. I felt so embarrassed. I guess I may have felt discomfort with knowing that this guy, who was so nice to me, was making it with my mother, my father's wife, and now, here he was, trying to cheat on my mother.

This next week, Jim became very excited about the treatment. He said,

> This stuff with Sam feels like a breakthrough, and it keeps bringing up more and more. First, I remembered that Sam used to watch women, then I remembered that he used to sing "I'm a girl-watcher," with his line about the titties, then I remembered that he didn't only watch the girls, but he'd go over to them and try to pick them up, and then I remembered that sometimes he would try to introduce me to them, and I would be really embarrassed, and say something stupid to break it up. Maybe he was being like a good daddy by introducing me to the girls, but what was he doing with my mother, and why were they trying to hide it, and what did that mean for my real daddy?

Shortly afterward, Jim's wife invited a male friend from work, Lou, for dinner. Jim was looking out the window and saw the girl across the street doing her laundry in the nude, and he called over Lou to watch with him. To his surprise, he did not feel like filming her or masturbating. I wondered if this incident was a reenactment of the memory of voyeurism as a joint act with Sam. In retrospect, Jim's insistence on the loneliness and deviance of his voyeurism seems, in retrospect, a resistance to

remembering how intensely connected he felt to Sam in his voyeurism, although guilty toward his own father. At this point in the analysis, Jim still enjoyed watching women, but it had less of a compulsive and lonely quality, and had become less of the primary aim of his sexuality.

Jim moved out of state with his wife and son. I felt he derived certain benefits from the analysis. He became much better at negotiating his work-life and getting the success he wanted. He was able to be less awkward, more socially adept, and he could use his anger better when necessary. He clarified many of the hazy details of his past, things that he had suspected but not known. He was able to place a severely traumatic memory, his mother throwing the scissors at him, in a context that made sense and that allowed him to work on his irrational fears of bodily damage from women. He was able to reconnect with his good feelings toward Sam, who was effectively a second father, and to make use of those feelings in the transference and to continue his development within our relationship. This led the voyeurism to become more of an optional activity instead of a compulsion. He could also come to terms with his intense desire to be a good father.

Discussion

The case of Jim indicates a number of special factors that were involved in the meaning of his voyeurism and the effect of the treatment. The first has to do with fathering. Jim's actual father has been incapacitated by surgery and was left relatively immobile, able to see what was happening around him but not able to act. Jim's watching of women without actually interacting with them may have represented an identification with his father. In addition, the analysis uncovered Jim's mixed feelings towards his mother's lover, Sam. Although Sam was originally represented as an intruder into the family, it emerged in the analysis that Sam had taken a positive interest in Jim and been a constructive influence in his upbringing. This led to profound ambivalence and repression of the ways that Sam had helped Jim's upbringing, as well as being a role model for a man who likes to look at women. Jim became aware of how significant, in good and bad ways, fathering had been in his own development. It was no accident that being a good father was Jim's stated reason, at the beginning of treatment, for eliminating the voyeurism from his life. The impulse for voyeurism may have been converted from a solitary, driven action to a socially shared interest. By rediscovering the mixed influence

of Sam, corrupt yet benevolent, Jim was able to integrate a more stable male imago, strong, talented, and competent, and capable of combining lust and aggression.

An additional factor in Jim's sexual development was his mother's aggression toward him, crystallized in the scissors that she threw and that pierced his leg. This contributed to Jim's own aggression against women and his fear of their retaliation; in his voyeuristic activities, he could attack women with his eyes and his cameras, while still remaining safe from their counterattack.

The case of Jim illustrates five principles that have been outlined in treating a patient with an unusual sexual pattern. The five principles are:

1. Take seriously what the patient wants out of treatment. And if you cannot, be open about it; tell your patient that you cannot go where he or she wants to go, and then refer the patient to someone who can.
2. Learn the facts. Educate yourself as much as possible about his or her sexuality.
3. Support your patient in finding sexual satisfaction and loving intimacy in the best way possible.
4. Study how the patient's sexual feelings may be mixed with other emotions and strivings.
5. Be ready to observe enactments with your patient's sexuality, that may clarify its meaning and significance for him or her.

To the degree that Jim's analysis was successful, it was due in part to Jim's substantial motivation to change. In this, he was different from many voyeurs, who come for treatment because their wives have discovered their voyeurism and threaten divorce if the man does not seek treatment. In such cases the prognosis is bad, unless the man discovers a motivation for eliminating the voyeurism instead of just placating his wife. In Jim's case, the wish to attenuate the voyeurism was internal and deeply felt, which can make all the difference in prognosis.

Conclusion

Ultimately, we all want to help our patients. A psychoanalyst needs to understand another person's sexuality on its own terms. Sexuality is a

core part of human experience, and sexual difficulties can be a large part of the issues for which people seek psychotherapy. In order to help patients, the analyst must learn the facts of human sexuality, a huge area of knowledge that needs constant refresher courses. No one person can know from his or her own small island of personal experience the huge continents of possible sexual life. Harry Stack Sullivan said that we are all more simply human than otherwise, but the ways we are different from each other, especially regarding sexuality, are important. We must learn from our patients what they want to achieve in treatment and be open with them about whether we can and are willing to help them achieve it. Our aim is to support our patients in finding sexual satisfaction and loving intimacy in the best way possible for them.

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