Psychotherapy in Sexual Dysfunctions

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Although sex and sexuality are often used synonymously, there are differences in what the words connote. Sex in its abruptness conveys a sense of mechanical acts. There is little subtlety about the word. Sexuality, on the other hand, conveys a sense of progression from sensual awakening to intimacy. Sex connotes what the genitals do; sexuality connotes integrated and highly personal responses including, but by no means limited to, genital involvement (11).

Sexual dissatisfactions are virtually universal among individuals who seek psychotherapy. Hesitation, fright, repugnance, anger, withdrawal, or disappointment infect sexual participation whether or not there is an accompanying incapacity in performance. In fact, the more substantial the ego strengths and the more compensated the neurosis or character disorder, the more likely there are to be failures of satisfaction or impairment of sexual creativity rather than loss of function. What varies is the prominence of sexual complaints, either in consultation or in treatment. Sexual complaints may serve as the principal motivation for treatment, or may be mentioned only in passing. In an analogous way, sexual issues may emerge in treatment as the major arena of conflict and resistance, or may be of little importance.

When the sexual problem is the primary complaint, consultation reveals that sex has replaced sexuality. The sexual efforts are not over-stimulating, unusual, or shocking, but stagnant and unimaginative. Manipulation of orifices has replaced passionate caress. There is fear of giving fantasy its play and intolerance of the tension and controlled aggression in sexual hunger. The sex acts have a concreteness, an anatomical preoccupation, a paucity of fantasy, and a denial of intense emotion, all of which exclude sensuality and intimacy and stultify passion.

In listening to the patient's history and associations, the spouse often fails to emerge three-dimensionally. There seems to be little in the way of shared elements of experience which allows identification and empathic sharing of eroticism. Romantic gestures have become stereotyped and, rather than being enjoyed in themselves, provide the merest pretext for coitus.

The inhibited, mechanical quality of the sexuality, however, does not indicate that the person is without feeling or insight. His sexual inhibitions and fears may seem quite unreasonable, but he is at a loss to be rid of them.

The usual patient with a primary sexual complaint is a young or middle-aged adult who is married or wishes to be. Occasionally, such a relationship is longed for, but feared. There is a sense that it is desirable and possible to have a relationship with another person—usually, though not necessarily, of the opposite sex. In other words, there is a hunger for intimacy, as well as sexual release, and the sense that another person would complement rather than complicate life. Thoughts about children generate mixed feelings. Although there is a concern that children would be an economic stress and a psychological burden, underneath there is the capacity to feel that a child is also a blessing. The patient can perceive, however dimly, that as a child himself he was welcomed and loved at least to the limits of his parents' capacities. Sufficient emotional sustenance was available to him that he can conceive of sharing warmth with a new generation of children.

Clearly, such a patient deserves an opportunity to unfetter his sexuality, and his life, through psychotherapy. The patient's sexuality is our central interest because it is an integral component of his personal and biological enjoyment. His sexuality, however, cannot be viewed or worked with in isolation from the remainder of his personality. Although the sexually handicapped individual may in certain ways be unique in the construction of his illness and in his requirements for psychotherapy, universal issues of individual development, symptom construction and treatment cannot be avoided.

Psychotherapy

I have not met a psychiatrist, or practitioner from related psychological or humanistic fields, who did not claim to do psychotherapy. Yet, clearly, what is done and how it is conceptualized vary immensely. While this observation is inescapable in general, it is pointedly apt among those whose special interests are in the treatment of sexual disorders. In this subspecialty methods range from the most abstinent to the most intemperate.

I believe psychotherapy is defined by psychoanalysis by virtue of the elegant simplicity of its assumptions, methods, and observations, and its extended, intensive patient contact. The basic assumption of analysis is that what goes on inside the head, rather than what happens in the surroundings, is most germane to treatment. The patient's rules of thought —governing linkages of feeling, recollection, and anticipation—determine his strengths and pathology and provide the pathway to his recovery.

Fundamental psychoanalytic methodology consists of inviting verbal expression of thoughts and feelings, and then doing as little to impede and as much as possible to expedite the process without directing it. There is a repeatedly confirmed observation that, given a chance, the patient will do his best to manifest his difficulties in living form in treatment, and in the process hear, feel, and rework his conflicts. Frequent contact paves the way for the trust and security that bring guarded thoughts and feelings into the open and for the intense relationship that brings conflicts to life. For those patients, however, who would find the analytic combination of intensity with abstinence disorganizing, dynamic psychotherapy (the psychoanalytic derivative with the same fundamental assumptions) is the treatment of choice.

Other psychotherapies, in one way or another, most often constitute a retreat from the patient and from what is intrinsically emotional in his difficulties. Other methodologies, including those clinical efforts lumped together as "sex therapy," largely utilize counseling (i.e., giving advice or direction), direct

education, or manipulation through suggestion. The difference between counseling or educative approaches and dynamic methods is, for example, that rather than giving counsel, we would be interested in what counsel the patient might give himself (and in what way he might be suspicious of it or reluctant to use it).

Sex therapy is the creation of Masters and Johnson, growing out of their laboratory observations (7) and their treatment procedures (8), although in recent years they have appeared unhappy about some extensions and applications of their work. Central to sex therapy is the notion of the uniqueness of sexual problems and their treatment, about which I have previously expressed my reservations (10). Sexual problems differ from other forms of psychiatric difficulty in terms of the manifest symptom, but there are very few differences in the makeup of the illness. To illustrate what I mean, impotence and agoraphobia are clearly different symptoms (and the dynamics behind such symptom choices are important), but there is the distinct possibility that unresolved castration anxiety lies behind both. The phobic state in one case shows up as a fear of leaving the house and in the other as a fear of entering the female genital. The critical factor in the two situations is not the difference in the symptoms, but whether the fear stems from castration anxiety or a more primitive separation anxiety, since the focus of interpretation and concern would be different in the two instances.

Efforts have been made to explain the phenomenal success claimed for sex therapy, but my impression is that such efforts are unnecessary. Recent series (5, 12) have not substantiated the results published by Masters and Johnson (8) and claimed by others (4). Time seems to have passed by sex therapy. The loss of popularity is related in part to the failure to replicate success rates and in part to the well-known phenomenon of therapeutic erosion once initial enthusiasm is exhausted. An additional factor among some sex therapy teams is that clinical success seems to vary directly (factors of patient selection and prognosis being equal) with the latent sexual excitement between the co-therapists. Mutual erotic

interest investing the co-therapists' work seems to establish a libidinal field which temporarily fans patients' ardor. Once the work becomes routine and the co-therapists' interest in one another de-sexualized, success rates drop off (3).

If there has been a major benefit to the use of sex therapy it has been, almost paradoxically, in the education of the patients to the authentic nature of their difficulties. After a couple has been treated with the Masters and Johnson techniques, one partner or both may recognize for the first time the presence of internal resistances to working through a problem initially seen as educational and mechanical. In this sense, the techniques of sex therapy may occasionally be used as an introduction to treatment proper.

Sexual Development and Symptom Choice

In the last decade, simplified assumptions about etiology and symptom maintenance have marked much of the psychiatric writing on sexuality. Some serious authors have justified this simplification on the grounds of data reduction, a commonly employed and useful scientific procedure.

Data reduction, however, is more applicable in systems that operate through mechanical, although not necessarily simple, rules. Biochemical and biomechanical systems, unlike the patient and his fellow human beings, do not defensively disguise, rationalize, deny, forget, negate, reverse or substitute objects or interactions. No matter how complex and marvelous the chemistry of substrate and enzyme, whimsy or perversity is not part of it. When systems follow cut and dried rules, no matter how complex, data reduction is a reasonable goal. When the system is not only as intricate as the human mind but also motivated and capable of synthetic functions, data reduction can become reductionism. Presently, one of the clearest examples of reductionism in the field of human sexuality is the assertion that "homosexuality is like left-handedness," in other words, purely a biological variant (11).

Sexuality is not simply biology. In addition to physical processes leading to arousal, tumescence, and release, sexuality involves the capacity to trust and feel trustworthy, to merge and separate without intolerable anxiety, and to experience the sexual partner as a consort rather than an incestuous parental substitute. Sexuality, physically and subjectively, flows so smoothly when properly integrated that it seems almost natural, yet it is the product of a long, complicated, and difficult developmental sequence.

Although there are elements that are singularly sexual in development, sexuality does not ripen in isolation from other aspects of the personality. Sexual gratification is a single aspect of a broader capacity to feel good about others and to get satisfactions from them. Sexual disorders may present monosymptomatically, but are always strongly and pervasively attached to hidden neurotic conflicts and character defenses. A sexual problem in this light is simply one manifestation, although an important one, of a more complex disorder.

The patient's sexual symptom is a creative, though uncomfortable, synthesis of early experiences, childhood fantasies, and biological needs. Except in incestuous households, sexual performance ordinarily is limited in childhood to masturbation and eroticized peer-level play. Nonetheless, the roots of intimacy, fantasy, and sensuality are put down in infancy. The roots of emotions and behaviors are like the halting and stumbling first steps in learning how to walk that establish the base for future locomotion, no matter how skillful and sophisticated it may become. Similarly, halting and stumbling early formative experiences with intimacy and sensuality are the germs of later capacities for friendship, intimacy, sexual relations, procreation, and childrearing.

In sexuality, as in other essential components of the personality, there are developmental lines which may be traced through a convergent sequence from infantile emotional dependence to mature sexual and work relationships. In this progression there is an interplay among psyche, constitution, predisposition, and

environment to achieve, in the healthy situation, more and more satisfactory levels of mastery and integration. Personality maturation, as distinct from the simple accumulation of years, is dependent upon a “good enough” experience at one stage to allow, seriatim, personality consolidation at succeeding levels. Interference with the normal sequence is usually brought about by a combination of unfortunate relationships, untoward coincidence, constitutional predispositions, and the seductiveness or fearfulness of fantasy.

Sexual development involves the drives, object relations, the psychic structures, and aspects of the self. Although it is known that all these personality components participate in sexual growth, I don't believe the interrelationships and contributions of these factors have been well worked out and so it is only possible to outline a few points.

In the first few months of life, during autistic and symbiotic phases, the essential substrate for psychological development is an empathic and stable relationship between mother and child, which helps the infant deal with his poorly controlled tensions. An empathic mother-infant relationship serves as the feeling basis for comfortable and trusting intimacy in later childhood and in adulthood. From this relationship comes the basic sense that biological needs and tensions are acceptable and appropriate and will call forth an intuitively sensitive response. Without this basic sense, all intimacy suffers, including sexual intimacy.

Sexuality trapped at this oral level is marred by an insatiable emptiness which gives rise to perpetual efforts to extract sustenance from other people. The hopeless inadequacy of any response from others leads to efforts to exact revenge. Emptiness, envy, and destructive rage are the uncomfortable bedfellows of sexual expression.

At five months, or somewhat later, the child normally hatches from the symbiotic shell, slowly at first and then with gathering speed independently

moving away and dependently returning to mother in the process of establishing against her grid the capacity to relate as a separate and individual person (6). The child in difficulty at this stage will often manifest night terrors, chronic nightmares, phobias, fear of the dark, fear of being left alone, or a need for the touch of clothes, jewelry, and other items associated with mother. Relative failure at this stage causes separation to be experienced as abandonment and closeness to be feared as engulfment.

The father is important in the separation-individuation process, fostering the inquisitiveness and exploration that leads to separation and differentiation. He is a familiar and caring person, but outside of mother's immediate orbit. Where father is absent, uncaring, effeminate, devalued, or dominated by mother, he is also unable to help his sons dis- identify from mother or his daughters shift object choice. Feminine identification or failure to shift object choice has a variety of pathological manifestations in sexual life.

In the pre-oedipal, separation-individuation phase, the drives are strongly tainted with oral and anal components and butt against a severe, primitive superego. The drives, along with self- and object-images, are split into aggressive and libidinal clusters. Internalized objects and identifications are primitive. Sexuality arrested at this level is characterized by perverse trends, being particularly infiltrated with sadomasochism. Coincidentally, there is exquisite sensitivity to engulfment or abandonment with an uneasy oscillation in the degree of intimate contact permitted. In an effort to cope, devices such as fetishes, which are simultaneously bridging and distancing part objects, may be adopted and incorporated into sexuality.

A pre-oedipal appreciation of anatomic, behavioral, and biological differences between males and females leads to a gender identity—a basic sense of maleness or femaleness. I believe that the psychological basis of reproduction —the concept of oneself as an individual who can ultimately bring forth children —is laid down at the same time as gender identity formation. Disorders of gender

are associated with aberrations in the psychological fabric of maternity or paternity, with problems of abandonment and engulfment, with primitive internalized objects, and with severe splitting of self and object images along libidinal and aggressive lines. Developmentally, the gender identity disorders are closely linked with the perversions, but are intermediate between the perversions and the psychoses.

The incorporation of significant pre-oedipal psychopathology into a sexual dysfunction has effects in two directions. First, there may be severe impairment of sexuality to the point of lost function, or, second, in the effort to preserve sexual expression, sexuality may be modified by perversion or defensive externalization. In the more usual dysfunctions (e.g., premature ejaculation, impotence, and dyspareunia), dominance of pre-oedipal factors may lead to virtual loss of sexual performance. Pre-oedipal fixation, of course, is often evident in the perversions and the homosexual variants. Perhaps the most impressive defensive externalization I have seen was in a young man who requested sex reassignment. He showed the usual gender dysphoric detachment from his penis and, in fact, wanted it surgically removed. Nonetheless, he was sexually active with remarkable staying power and potency. He took pride in the admiration this elicited from his casual partners although he derived no pleasure and scarcely any physical sensation from the act itself. His penis was psychologically an external instrument. Although psychotherapy was strongly recommended, he did not allow through and, sadly, committed suicide a year or two following consultation.

The separation-individuation phase closes with the sufficient internalization and integration of the mother's caretaking and loving functions that the child can separate periodically without feeling abandoned or regressing in function. Following on its heels is the oedipal phase, during which relationships with parents become highly sexualized, complicated, and triangular. In the positive oedipal constellation girls become coquettish toward their fathers and irascible toward mother while boys are demonstrative,

beguiling, or compelling toward their mothers and openly resentful or belligerent toward their fathers. Side by side with the positive oedipus is the negative with an attraction toward the parent of the same sex. An amalgam of positive and negative oedipal longings and identifications makes up the ultimate sexual identification and object preference. Although negative oedipal identifications and object choices predominate in homosexuality, there are opposite sex identifications and longings for intimacy with the same sex even in the most heterosexual individual.

Negotiation of the oedipal stage is a landmark for integrated, individualized sexuality. If all goes well there is an integration of bodily representations, sexual object choice, and masculine and feminine identifications. Sexuality is thoroughly woven into drive structure, identifications, ego ideal, superego, and self. Because of this integration, conflict cannot be defended against in any realm of the personality without compromising sexual interests. Unsatisfactory' resolution of the childhood neurosis always compromises sexuality but most often in the direction of dissatisfactions without loss of function.

Latency is classically a time of relative quiet following oedipal storms, but I have never been impressed that boys or girls (particularly boys) were especially latent. They are simply less obvious about their sexual interests than oedipal youngsters or adolescents. Latency boys and girls don't like each other very much and frequently show their contempt. Contemptuous disinterest comes about, in part, as a result of the relative inadequacy of peers in comparison with the original parental object choices. Not only is the little boy licking his wounds after being rejected by his mother or muscled-out by his father, but he is upset about the inadequacy of the little girls to whom he must turn. The antagonism between boys and girls grows out of castration anxiety and penis envy to be sure, but is also designed to demonstrate how second best they feel each other to be. This process is reversed in adolescence with defiant overvaluation of peers, but the reversal is still part of the process of giving up parental objects. The more conflicted the attachment to parental objects, the more second best non-parental

objects seem. In some adult couples there is a continuing, nagging, bitterness at the age-appropriate partner which seems very much related to latency-age disappointments.

Latency comes to a stormy end with a surge of biological and psychological development. Changes in physical, coital, and reproductive capacities are new factors to contend with. Any and all areas of conflict are worked through again at a more sophisticated level. Behavioral disorders, antisocial activity, psychosis, depression, homosexual experimentation, or perversion may emerge as signs of long-standing difficulty. In the happy situation, personality consolidation in later adolescence serves as a basis for intimacy. Where the outcome is less fortunate, problems that were acute and flagrant in early adolescence often show signs of settling into a more chronic and crippling form.

The early phase of psychosexual maturity is marked by intimacy and marriage, the prospect of children, and beginning life's work. Later the psychological potential for procreation laid down at the time of gender identity formation finds expression in parenthood and another developmental stage is entered. With conception, gestation, delivery, and child-rearing, the adult's own developmental milestones are reworked in identification with his child and with his parents. Conflicts in the new father or mother may show up as symptoms and distress in the offspring. Alternatively, residual parental conflicts may be catalyzed into symptoms by an offspring's entry into a particular developmental stage. A striking example of this phenomenon from the gender dysphorics, in whom almost everything stands out in bold relief, occurs among a group of men with more or less transvestite histories (9), who precipitously applied for sex reassignment when their sons reached the ages of three to five. Their headlong flight into sex reassignment represented a concrete expression of negative oedipal wishes (in addition to developmentally more primitive wishes for fusion with mother) precipitated by an oedipally-conflicted son. The correspondence between the child's oedipal flowering and the father's anxious quest for sex reassignment indicated a peculiar identification with the child and a special

sensitivity to phallic and castration issues (15).

I have outlined some developmental issues related to clinical sexual dysfunctions. My purpose has been to emphasize the sexual symptom in a developmental context as a guide to meaningful diagnosis, prognosis, and treatment selection. The presenting symptom is a guide to treatment only when it is understood as being that outgrowth of a developmental sequence which is the most acceptable synthesis of unresolved conflicts. In sexual disorders as in other psychiatric problems treatment selection and prognosis turn on a determination of ego strength, patterns of defense, superego characteristics, level of drive maturation and the accomplishment of milestones in object relations.

In the clinical setting the commonest sexual symptoms are impotence in the male, anorgasmia in the female, and withdrawal from sexual activity on the part of either sex. Less common, although still prevalent, are premature ejaculation in the male and dyspareunia in the female. The perversions, homosexuality, and the gender identity disorders are of lesser frequency. Ejaculatory incompetence, the sexual anhedonias, and the sexual anesthesias are rare.

Certain sexual symptoms cluster preferentially with particular psychopathological states. For example, the full syndrome of the adult gender identity disorders is associated with pre-oedipal pathology showing up as severe borderline character problems. Similarly, the perversions show some borderline features, although the borderline pathology may be of a relatively mild degree in the well organized perversion. Ejaculatory incompetence is not a perversion, but it is a closely allied condition. Sado-masochistic practices, often of a severe degree, are a regular finding in individuals with retarded ejaculation and, not uncommonly, erection or intravaginal ejaculation requires antecedent sadistic activity.

The probable symptoms of a neurotic patient with a sexual disorder cannot be predicted with certainty. However, as I have mentioned previously, sexual

dissatisfaction without loss of function is more likely to be found in neurotic individuals functioning at an oedipal level. On the other hand, dissatisfaction accompanied by frank loss of function or obligatory modification of practice is more likely to be found in borderline individuals functioning at a preoedipal level. Sexual dysfunction, of course, may serve as the visible peak of a psychosis and unwary pursuit of the sexual symptom may precipitate personality fragmentation.

The neurotic choice of a sexual symptom presents intriguing problems. In my experience the sexual dissatisfaction or dysfunction serves at one time or another each of the following secondary functions: As a means of avoiding sexuality and as a means of having at least some sex; as a means of avoiding intimacy and as a means of providing at least some intimacy; as a means of sustaining and as a means of breaking up a relationship; and as a motivation for treatment and as the most substantial resistance to it. The primary function of the sexual symptom varies in its specifics from patient to patient although there is no reason to doubt that it serves as a compromise formation expressing the drive in limited fashion while incorporating superego sanctions and keeping the true aim or object of the drive out of awareness.

The Consultation Interview

Consultation interviews are conducted with the outline of sexual development in mind. Since assessment takes time, I ordinarily schedule three evaluation sessions. This provides the opportunity to take a thorough history, during which I take pains to notice the linkages between history and symptom and observe the patient's capacity to hear and work with his own material.

I begin by inquiring after the patient's life and what he can tell me about it, expressing a hope that in the process he will tell me the details of his symptomatology. If the patient is inclined to be silent or vague, I may ask what he has noticed about the onset of his difficulties, its timing, the events associated

with exacerbations or remissions, his best sexual experience, his worst, his fantasies, his theories of causation, and so forth. In terms of his life, I may ask him to tell me about his family, his hometown, his wife, etc. Although I may inquire about aspects of the patient's life, my inquiries are carefully framed as questions and not as veiled conclusions.

Inquiring after what the patient has noticed or can recall serves a number of purposes. It keeps descriptions in the patient's frame of reference and avoids hasty, often erroneous assumptions about the nature of his illness. Secondly, steadfast interest in the patient's observations assesses his curiosity about himself and powers of observations, both of which serve as measures of the capacity for self-explorative psychotherapy. Finally, in outlining his observations in detail the patient inevitably makes associations to developmentally significant events or people. The timing of the associations (i.e., their appearance in sequence with specific details of history or symptomatology) establishes presumptive links between history, symptom, and development. As associative points of contact between symptom and genetic history, such material serves to open the door to the meaningful parts of the developmental history.

A difficulty that inexperienced clinicians have with the developmental history is that they tend to administer it in the same way to every patient, almost as a standard interview. While the facts may be obtained in this manner, they are most often meaningless both to the psychiatrist and to the patient because they are not tied in to the patient's memories, affects, or associative linkages. Proceeding in the way I have suggested will uncover the same facts but the facts will come alive.

Extended, apparently unstructured history taking will also give the patient an opportunity to reveal his defensive operations. These essential ingredients of prognosis may show themselves in terms of what is missing from the history, as elements of character, and as reactions to the evaluator's questions or silence. It goes almost without saying that primitive defenses like denial, projection, and

splitting portend a difficult therapeutic time, whereas repression, reaction formation, and dissociations are likely to be less formidable (although never easy to work through).

Two insights are prerequisites to restoration of sexual enjoyment and function through psychotherapy: The first is a sense that internal blocks preclude emotional freedom and the second is a hope that things really could be better. For the patient to work on his symptoms usefully, it is critical for him to feel that the sexual inhibitions come from within, however much he may overtly blame his sexual partner or external circumstance. Treatment has little to offer the patient who believes that sexual gratification will be accomplished by changing partners or altering circumstances, or for the patient who has no hope that things could ever be different. For example, although homosexuality is a developmental aberration, the homosexual may be comfortable in his deviancy and be without motivation for treatment. On the other hand, the homosexual may feel hopeless about ever being different even though the inversion's central generative disappointments and conflicts are intuitively grasped. In the one case, there is no motivation for treatment and, in the other, no hope for it.

Once assessment is complete, the decision regarding treatment may be made. Where interest is in remodeling and not renovation, the patient may best be aided by counseling or support. Where there is both the interest in and capacity for personal restoration, analysis or dynamic psychotherapy may be recommended.

Treatment

A multiplicity of difficulties may be reflected in sexual dysfunction. Sexuality is plastic and multifaceted, lending itself to the expression of conflicts, fantasies, and aggressive and libidinal drives in subtle and highly personal variations. Sexuality involves objects and their representations in fantasy, allowing the reenactment of unresolved attachments. Sexuality, unlike breathing

or eating, is not essential for life itself and may be given up entirely, thereby serving as a vault for intolerable anxieties.

Sexuality is historically at the center of psychoanalytic theory. With the exception of the perversions, however, therapeutic specifics are scarce in the literature despite the ubiquity of sexual inhibitions and dissatisfactions. I believe the reason for the relative absence is that in any analysis sexual conflicts are always present and are dealt with as a matter of course. In other words, sexual problems are so universally dealt with that their very commonness has excluded them from attention. Since the early days of analysis they have attracted little technical commentary. In the following pages I will try to focus on a few issues which, if not unique to sexual difficulties, are more common or exaggerated in such conditions.

Although the general structure of analysis and dynamic psychotherapy is well known, I will outline some aspects that I believe are important. I establish from the beginning the fact that treatment will be open-ended, continuing until the patient is satisfied. Artificial time constraints, which are sometimes employed in sex therapy, focus the work but allow resistance to hold out long enough to cover embarrassing or conflictual material. I ask the patient to report recollections, thoughts, fantasies, bodily feelings, and affects as they come to mind even though the material may seem embarrassing, trivial, offensive, or in violation of some external confidence. It is my aim to aid in this self exploration through open-ended questions about the material at hand and through interpretation of roadblocks to free association and communication. I take special responsibility for maintaining the structure of the treatment situation. I am reliably present and punctual and free from telephones and administrative matters during sessions. I maintain an unwavering respect for the patient which I view as an integral component of the structure. Such respect is easy to sustain. The patient's sexual difficulties are a source of embarrassment, they are of immediate interest to him; treatment is a frightening experience, and a high degree of hope is riding on the outcome. He is also an extraordinary person.

Rather than simply living with his problems or demanding to have them accommodated, he has set out on a course of self-exploration designed to remedy them.

Respect for the patient, regard for the structure of the psychotherapeutic situation, free association, interpretation of resistance, and abstinence from immediate gratification pave the way for the analyzable transference. (Transference will come in any event, but will not be analyzable unless the preconditions of analytic structure are met.) Transference brings conflicts and fantasies into the immediacy of the therapeutic relationship, allowing dynamically important affects, object relations, and defenses to be replicated and observed in a current time frame. The transference makes vivid both unsatisfied claims for love and sexual release and prohibited aggressive feelings (13). Transference comes in behavioral as well as in verbal form, showing up in repetitive behavior in the treatment hour and outside. The greater the resistance to remembering and reporting, the more likely the transference is to take the form of repetitive behavior.

Transference operates Janus-like, in two directions, not only as a means to understanding and moderation of psychopathology but also as a stubborn resistance to successful outcome. The phenomenon of transference, however, fundamentally provides an opportunity for real work since a neurotic construction cannot be dismantled purely in retrospect or, as Freud (1) put it, "in absentia." Demands for transference gratification are given up only grudgingly, after considerable effort to make the transference wishes come true. The end point of treatment, of course, is not freedom from all transference, but rather replacement of primitive, conflicted transferences with direct and satisfying eroticism and mature sublimations.

It is not unusual for the patient to fall in love as part of the transference, although "falling in love" is an inadequate and trite description of a powerful and complex phenomenon. As Freud (2) pointed out, falling in love is induced by the

treatment situation rather than the charms of the psychiatrist, and its effects are in the service of resistance. Love seems to blossom just when the most difficult and painful material begins to emerge. Having a reputation as a “sex doctor” sometimes lends the erotic transference a more overt and concrete coloration. The demands may be for concrete and immediate alleviation of the sexual frustration. This tendency is more likely in borderline patients where the therapeutic alliance is tenuous and an observing ego difficult to sustain. In such patients the analytic or psychotherapeutic situation is often interpreted as an opportunity to achieve real satisfaction of transference longings, including sexual satisfactions. The assumption is that their difficult sexual situation could be corrected by accepting them as pupils or partners rather than as patients. The difficulties encountered are illustrated by a patient who, upon entering treatment, separated from her husband and made it clear that I was to function as her emotional support, companion, and regulator of her daily life. There were constant disappointed and vituperative attacks because I was insufficiently gallant and accommodating. The wish for immediate symptom relief is common among sexual patients. Other patients may have similar inclinations, but the tendency is more pronounced with sexual dysfunctions because of the publicity given rapid treatment. I deal with this unfounded hope for speedy cure by acknowledging the wish while pointing out the value of symptoms as markers of difficult areas. I assure the patient that he is always free to work on his problem by bringing up sexual associations.

It should go without saying that the patient is not taken up on his or her offer of love. However, since among sex therapists there are those who misunderstand the transference and prescribe their sexual attentions as medicine for the patient's frustrations, it may be necessary to make the point explicitly. Sexual intimacy with patients completely derails treatment. Treatment inevitably terminates without completion, although often not rapidly enough to prevent a great deal of wasted time, money, and therapeutic opportunity. The patient may at first feel elated at the attention or triumphant at toppling the

psychiatrist from his pedestal. In the final analysis, however, he feels betrayed. Transference love must be allowed to flourish, but for purposes of understanding and resolution. The analysis of the detailed characteristics of being in love brings to light the infantile and conflicted roots of the patient's symptoms.

Issues of the structure of the treatment situations and the manifestation of transference are as important in the treatment of sexual problems as in other conditions. Issues specifically related to the treatment of sexual disorders, however, can best be approached by grouping the patients according to the overall severity of their psychopathology. Although schizophrenic patients may have severe sexual pathology, it is often not sufficiently organized to deserve consideration as a syndrome. Not infrequently, the sexual symptom serves as a shaky bolster against decompensation and it is ill-advised to remove it. Among severely borderline, less severely borderline, and neurotic patients (including those with neurotic characters), organized sexual symptoms may be dealt with profitably for the patient.

The two more common organized sexual syndromes among patients with severe borderline pathology are the perversions and the gender identity disorders (gender dysphoria syndromes; "transsexualism"). There is considerable pessimism about psychotherapy in the gender dysphoria syndromes. In part, pessimism is warranted because of the severity of the disorder, but it derives, in part, from an assumption that the gender reversal is non-conflictual. If there were unconflicted core gender reversal, pessimism would be doubly justified. It is axiomatic in psychiatry that conflict heralds therapeutic opportunity; without conflict there is no energy driving the therapeutic process. In the cases I have seen, however, the apparent non-conflictual core gender reversal turns out to be a symptomatic compromise formation that is superficially ego syntonic as in the perversions. Some patients readily respond to the suggestion for exploratory work so long as their major symptom, the gender dysphoria, is not attacked head-on. The treatment of these patients is similar to that of other severe borderline characters and requires the

back-up of ready hospitalization. Since such psychotherapy is in the patient's own best interest, it should be a routine part of any evaluation for sex reassignment.

I proceed in a similar manner for the gender identity disorders and for the perversions which have severe borderline personality disturbances. In both clinical situations, head-on tackling of the perverse conviction only increases the patient's counter-resistance immeasurably. It is useless for this reason to make giving up the perverse practices or the search for sex reassignment the condition for treatment. The patient cannot comply since the symptom protects against ego dissolution.

I set the task of treatment as the patient's reporting his thoughts, feelings, and observations as they come to mind. Although this is standard analytic technique these patients are seldom, if ever, put in analysis proper since they cannot tolerate the regression it fosters. Whenever possible I arrange for twice-weekly sessions. I keep the patient sitting up and make myself more available as a "real person." What this means is that I am more encouraging, more sympathetic regarding the difficulty of putting thoughts and feelings into words, more obvious in my concern about the serious problems in the patient's relationships with himself and others, and more available by phone and for special sessions than I ordinarily would be within the constraints of psychoanalytic abstinence.

I never deviate, however, from the fundamental position that the task of treatment is for the patient to understand himself through expressing and hearing his thoughts, feelings, recollections, and fantasies as they come to mind. This is the only procedure that will put the patient into contact with the desperate conflicts and all but overwhelming affects which have led him to embrace severe and crippling symptomatology as a preferable alternative. It is difficult to keep in mind that the patient's self-exploration is the essential task in treatment since the patient will resist coming face-to-face with his feelings. He

will resist by attempting to have you guess (from the patient's point of view "explain") his thoughts and feelings, to have you endorse his perversion or quest for sex reassignment, or to have you take a stand against his practices. In a variety of ways he will attempt to make his manifest symptoms a battleground in order to completely eclipse the true work of treatment. Needless to say, when the patient's symptom may involve castration and penectomy (as in gender dysphoria) or other severe risk (as in eroticized hanging), it is difficult to resist the battle. It may be necessary to hospitalize the patient to protect his life and physical integrity; on the other hand, it is useless and counterproductive to decry the symptom. The situation is best handled by taking those steps which are necessary to protect the patient while at the same time being interested in the timing of the symptomatic eruption and the thoughts and feelings which accompanied it. Almost without exception, the eruption of the symptomatology will be due to unendurable tension unconsciously related to a loss, a separation, or envious rage at some perceived slight in the therapeutic or other meaningful relationships.

Interpretations of the transference are almost always directed toward loss, emptiness, feelings of personality dissolution, and rage rather than toward the developmentally more advanced concerns of castration anxiety, penis envy, homosexual attraction, or guilt. It is only toward the end of prolonged treatment that such higher order developmental issues may be the dynamics that are truly operative and therefore appropriately interpreted. In fact, as therapy proceeds and the relationship intensifies the transference may become psychotic in its intensity. Under these circumstances, I maintain a low threshold for hospitalization, particularly around times of separation.

The outcome of treatment with severe perversions and gender identity disorders may well not be the highest level of psychological integration. It is not uncommon for the severely crippling perversion which threatens life or physical integrity to be replaced by a more stable and less destructive paraphilia. For example, a stable homosexual state or transvestite depressive picture may be the

outcome of treatment of the gender dysphorias.

Analysis and psychodynamic treatment of borderline patients is often many years in duration since the slow accrual of ego strengths through contact, analysis of crippling defenses, structure building, and partial replacement of highly pathological internalized parental objects is required to transform concrete demands for satisfaction into a transference neurosis which may be analyzed in collaboration with an observing ego. Neurotic patients, for whom the difficulties with separation and oral fixation are not so severe, tend to move more rapidly toward an analyzable transference. In either case my experience is that the transference neuroses of patients with sexual disorders contain exaggerations of certain familiar elements.

In women with prominent sexual dysfunctions, feelings of genital inferiority, penis envy, and penis-breast-feces-baby equivalencies are marked. This is associated with a singular competitiveness between mother and daughter. These mothers have pushed precociously mature attitudes toward anatomy and reproduction, while at the same time making it clear that independence or separation, let alone competition, was intolerable. The father deepens the conflict and the regressive pull by encouraging a little-girl sexuality while being clearly unable to handle his wife. The patient as a little girl was in a situation in which her father could not provide a frame of reference sufficiently independent from mother to help effect optimum separation. He stimulated her but: could not establish limits on her infantile sexuality or help in her establishment of age-appropriate outlets and sublimations. Because of father's relative impotence, fantasies of mother's potency are extravagant, as are the fantasied consequences of competition with her. Fantasies of having been castrated or denied a penis by mother—who greedily appropriated all good things to herself (father, penis, breasts, and babies)—are unusually strong, the rivalry intense, and the guilt and anticipated punishment correspondingly severe. All drives are put under strong interdiction. Issues of control—including control of impulses, people, part objects, and events—reach proportions where the patient is frantic to avoid an

unguarded moment which might let a dangerous impulse escape. In the nature of the symptom, of course, efforts at control provide ample opportunity for the unconscious expression of rivalry, sadism, and rage.

Such women are anorgasmic for many reasons. They have not effected a complete separation from mother, nor are they completely identified as female. Their orientation remains strongly bisexual. Although the desire for sexual fulfillment is strong, their objects remain confused. Furthermore, men and sexual congress with them is a prerogative of mother so that sexual desire becomes contaminated with intense rivalry and guilt. Constant wariness against an unguarded thought or act virtually eliminates the possibility of being swept away to orgasm.

Transference and the transference resistance revive and intensify the conflicts and defenses in the relationship with the internalized mother. Separation and control are the early issues in treatment and only later does frank penis envy emerge along with the paternal transference.

Among men who are sexually dysfunctional, the fabric of their disability is woven out of an impressive degree of feminine identification. In borderline men, an aspect of incomplete separation-individuation includes a partial failure to dis-identify after having formed the primary maternal identification. Neurotic men have resolved their primary identification with mother, but form a secondary identification with the frustrator. Their mothers are cold, withdrawn, and often chronically depressed. Although there is no question these women love their sons, the watchword is responsible rather than empathic parenthood. There is very little spontaneity or joy in these families and the people within the household may lead rather isolated lives despite the spatial contiguity of their existences. These mothers have an unresolved attachment to their own mothers which has left them with conflicts surrounding femininity and maternity. Their masculine strivings are reflected in their marriage to a man with strong maternal leanings and often more than the usual feminine identifications. Through his

failure to provide a strong male object for identification and through the example of his rather feminine attachment to his wife, the father fosters feminine identification in his son.

The boys who grow up to be neurotic men with sexual problems are not usually effeminate or sissified to outward appearance. However, during the oedipal childhood neurosis the more than usual feminine identification materially intensifies castration anxiety. The fantasies of castration are all the more fearful because in some ways the boy must struggle with a longing to yield up his penis in order to express his feminine identifications.

As adults these men are usually premature ejaculators or impotent. The characteristics of their sexual lives most maddening to their partners, however, are the hesitation and passivity in their sexual approach. Their apparent timidity is not simply due to lack of confidence as a product of the erectile or ejaculatory dysfunction. The passivity continues even if the primary sexual symptom is relieved. The primary sexual symptom and the passivity independently serve multiple functions including to express feminine identification, to camouflage intrusive phallic strivings, to withhold satisfaction from the maternally-identified sexual partner, and to allay castration anxiety.

The transference usually develops with the patient being passive, dependent, and little-boy charming in an attempt to elicit encouragement, approval, and care. It is only later that the resentment, phallic strivings, and conflict around such strivings come into play.

I do not mean to suggest that either the dynamics or the transference of patients with sexual disorders is predictable. I do feel, however, that in women with sexual disorders issues of control, genital inferiority, and penis envy are especially prominent and in men with sexual disorders feminine identification is particularly problematic.

However the transference may be manifest, just as in the treatment of any

other neurosis or character disorder the transference neurosis is resolved by small increments through mutative interpretations timed to coincide with the emergence of emotionally laden material which is tinged with archaic fantasy and directed toward the therapist as a transference object (14).

If the patient is appropriately selected for analysis, interpretations are likely to be directed toward castration anxiety, penis envy, perverse fantasies, forbidden sexual impulses, and other areas which, in whatever derivative form, are related to issues of sexuality. I always keep in mind the uselessness of *en bloc* interpretation. It does no good to suggest to a female patient that her difficulties are related to "penis envy." Instead, following the policy of small increments, it is fruitful to observe that her fantasies suggest uncertainty about whether her lover's penis is attached to her or separate from her. If it is there, the patient should be allowed to discover penis envy on her own. A similar sense of discretion and tact about the patient's anxieties should accompany the interpretation of homosexual interest, feminine or masculine identifications, and the other anxiety provoking material.

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