Psychoanalysis and Homosexuality: Keeping the Discussion Moving

This paper contributes to the debate following the British Psychoanalytic Council's 2012 conference, 'Homosexuality and Psychoanalysis: Moving On' and their Position Statement on Homosexuality. After two world wars psychoanalysts, concerned to establish the credentials of their discipline, sought a more settled definition of sexual 'normality' than that of Freud, which 'naturalized' a heterosexual view of gender difference. Extending one aspect of Freud's thinking, homosexuality became accepted as evidence of a developmental retreat, even as a fixation at the oral stage of relating. As an identity founded on rejection of the reproductive 'reality' of the body, it was seen as a borderline condition. An individual who did not regard it as a problem to be cured was understood to be maintaining a perverse denial of their pathology. Same sex object-choice was narcissistic and led to the formation of unstable patterns of relating. In this paper I hope to show that psychoanalysis has in the past developed a theoretical bias that has distorted its view of the experience of lesbians and gay men and, in detecting and questioning this bias, we have an opportunity to make our discipline more open and responsive to the complex society we live in.

In January 2012 the British Psychoanalytic Council (BPC) agreed a position statement on homosexuality, which began: ‘The BPC does not accept that a homosexual orientation is evidence of disturbance of the mind or in development’. In doing this they were following the example of the American Psychoanalytic Association, who had first drawn up a statement of their own in 1991. The BPC's initiative was accompanied by a conference entitled ‘Homosexuality and Psychoanalysis: Moving On’. There was a palpable sense of relief among those who attended, and hope was expressed that it marked the beginning of a new era, leaving behind the troubled history of the relationship of British psychoanalysis to homosexuality. The BPC, readying itself to become a body with regulatory responsibilities as part of the Council for Healthcare Regulatory Excellence (CHRE), was seen to be taking an important initiative, bringing it into line with the Equality Act of 2010. This act had introduced ‘protected characteristics’ - to defend the rights of named categories of person who had been shown to be vulnerable to discrimination by employers and service providers. This Act identified these categories under the following headings: 'age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity'. The Act now extended protection to include cases of indirect discrimination where organizations could be shown to have policies which disadvantaged people in the above categories.

I am aware that the BPC's position statement was not welcomed by everyone. Some said that they felt it infringed on the autonomy of member organizations, the proper sources of authority on psychoanalytic theory. Others complained that it made it sound as if the belief in the pathological nature of homosexuality among members of the BPC was wide-spread, which was not the case. Some therapists felt that to suggest that members of the lesbian, gay, bisexual and transgendered (LGBT) community fall into a special category as patients was in itself discriminatory; that they have been seen in psychotherapy practices for many years, without this work presenting special challenges. However, this does not account for the enthusiasm that greeted the BPC's conference. In this paper, I attempt to explore why it has been necessary to draw up this statement.

Whatever the nature of individual members' practice, the founding organizations of the BPC are nevertheless seen as having practised discrimination against members of the LGBT community. It is believed that these are a group who have for many years been barred from training, and are thus under-represented in those organizations. In April 1995 the Association for Psychoanalytic Psychotherapy in the NHS invited the American psychoanalyst, Charles Socarides, who was well known for his view that homosexuality was a pathological condition in need of cure, to give the annual lecture. This provoked considerable protest and a Letter of Concern was published in a number of psychotherapy journals. Subsequently, there was a period of debate and activity, mainly outside the BPC
organizations, on this perceived discriminatory policy. During the last 20 years, there has been a growing literature exploring the attitude of the psychoanalytic profession in Britain to homosexuality and its conservative stance (see, for example, Barden, 2011; Denman, 1993, 2004; O'Connor & Ryan, 2003; Shelley, 1998). Little of this discussion, however, has found its way into the scientific life of the founder organizations of the BPC. Since the controversy surrounding the Letter of Concern has died down the atmosphere within these organizations has been described by Jeremy Clarke of the New Savoy Partnership, which represents psychological therapies in the NHS, as an ‘uneasy silence’ (Clarke & Lemma, 2011). And as far as the sexual orientation of members is concerned, the culture has tended to be one of: ‘Don’t ask; don’t tell’. Disclosure is not regarded as appropriate for a psychoanalyst or psychotherapist. It seems as if the atmosphere in the BPC is now finally beginning to change, and my title refers explicitly to my hope that discussion of these issues can keep us moving on.

The American Psychoanalytic Association's 1991 Position Statement on Homosexuality was issued to disengage psychoanalysis in the US from what Mitchell (2002) called ‘the suggestive-directive approach’ to work with gay men and lesbians, intended to ‘cure’ their sexual orientation, seen as a pathological deviation from normal development. British psychoanalysis has not produced crusading analytic figures like Charles Socarides, Irving Bieber and Lionel Ovesey, who shared the view that homosexuality was the result of a pathological rejection of an innately heterosexual drive. In fact, some analysts adopted a humane and agnostic tone on the subject. Glover gave evidence to the Wolfenden Committee, recommending that homosexuality be decriminalized between consenting adults and Gillespie (1956) wrote about his homosexual patients in a sympathetic and non-judgemental way. But in the UK the profession in general theorized homosexuality in their patients as a form of perverse behaviour, designed to defend the fragile personality against overwhelming psychotic anxiety. In spite of its removal as a pathological condition from the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1973, these ideas have not been thoroughly reviewed.

The History

How did this come about in a discipline which began with Freud, whose views on sexuality were scandalously liberal? His extended exploration of the nature of human sexuality, written between 1905 and 1920, opened with an exploration of 'The Sexual Aberrations'. He cited the condition of 'inversion' or 'having contrary sexual feelings' in order to argue for a thorough-going questioning of our assumptions about the sexual instinct. Although it was popularly believed that sexual desire was 'absent in childhood, … set in at the time of puberty in the process of coming to maturity' and was ‘revealed in the manifestations of an irresistible attraction exercised by one sex upon the other’ while its aim was ‘presumed to be sexual union, or at all events actions leading in that direction’ (Freud, 1905, p. 135), Freud set out to unseat this assumption.

A significant group of people existed who were attracted to members of their own sex, a phenomenon which could be 'found in people whose efficiency is unimpaired, and who are indeed distinguished by specially high intellectual development and ethical culture' (p. 139). There were many different forms of inversion, some absolute, some contingent, some allowing for a degree of bisexuality. Beyond this, lay groups of people whose sexual desire took forms which he designated as perverse, such as fetishists, exhibitionists and those who found pleasure in inflicting or experiencing pain. These phenomena demonstrated the wide variation found both in the nature of sexual aim and sexual object. In fact, Freud stated: ‘From the point of view of psychoanalysis the exclusive sexual interest felt by men for women is also a problem that needs elucidating and is not a self-evident fact based upon an attraction that is ultimately of a chemical nature’ (footnote, p. 146). He adopted an open-minded position on the causes of inversion but argued that ‘a bisexual disposition is somehow concerned’ (p. 143). Inversion did not simply occur in those individuals possessing attributes, mental or physical, associated with the opposite sex. Indeed the characteristics of 'masculinity' and 'femininity' were terms which were ‘among the most confused that occur in science’ (footnote, p. 219), and, when used to describe personality traits, seemed to be found standing for ‘activity’ and ‘passivity’ - which could be found in some combination in all individuals, regardless of anatomical sex.

Freud upheld this broad-minded attitude to ‘inversion’ in other contexts. As is well known, he wrote a letter in response to a mother who seems to have asked him what hope he could offer of a ‘cure’ for her son's homosexuality. He told her: ‘Homosexuality is assuredly no advantage but it is nothing to be ashamed of, no vice, no degradation, it
cannot be classified as an illness; we consider it to be a variation of the sexual function produced by a certain arrest of sexual development ‘…’ (quoted in Lewes, 1995, p. 20). He publicly supported Magnus Hirschfeld, an early pioneer of sexual freedom and homosexual rights, and he wrote, along with Otto Rank, to Ernest Jones, disagreeing with Jones's proposal to exclude homosexuals from analytic training: ‘We feel that a decision in such cases should depend upon a thorough examination of the other qualities of the candidate’ (quoted in Lewes, 1995, p. 21).

However, another current in Freud's writing developed his thinking about homosexuality in a different direction, as many writers have pointed out (for example, Drescher, 1995; Lewes, 1995; O'Connor & Ryan, 2003; Schafer, 1995). This line of argument led him to the previously quoted description of homosexuality as ‘produced by a certain arrest of sexual development’. Schafer points out that, although Freud radically questioned the subjective assumption that sexual desire was innately heterosexual, elsewhere, speaking scientifically: ‘He viewed the individual as the carrier of the reproductive organs and substances designed to guarantee the survival of the species’ (1995, p. 193). When speaking as a neurologist, he could imply that, from an evolutionary perspective, nature required that psychosexual development culminate in reproductive heterosexuality. Therefore, although Freud asserted that homosexuality was a variation of the sexual function, was not an illness and could be manifested in a person whose ‘efficiency was unimpaired’, he could nevertheless also describe it as ‘caused by a certain arrest of sexual development’. In the third of the Three Essays he describes how adolescence is dominated by a movement towards genital potency with a heterosexual outcome, in spite of bisexual deviation along the way, and the retention of traces of polymorphous perversity from the early stages of life. Although he makes it clear that an ‘inverted’ sexual orientation may have congenital roots, and that those who do not exist in a state of internal conflict with their nature will not present themselves for analysis, all his descriptions of his work with homosexual patients offer clinical accounts which demonstrate how their homosexual orientation has arisen defensively, having been deflected from an expected heterosexual course of Oedipal development. This is true of his monograph on the development of Leonardo (Freud, 1910), the homosexual phase in the case of ‘The Wolf Man’ (Freud, 1909), his account of ‘The psychogenesis of homosexuality in a woman’ (Freud, 1920) and ‘Certain neurotic mechanisms in jealousy, paranoia and homosexuality’ (Freud, 1922).

There are two Freuds: Freud the biologist, who speaks as an objective scientist of the phylogenesis of the species, and Freud the clinician, concerned with the internal world of his patients, attempting to shed light on our subjective experience of what it means to be human. Dana Breen (1993), in her introduction to The Gender Conundrum, suggests that Freud chose to maintain this bifocal vision of sexuality or gender identity because he recognized that we could never speak of them without becoming entangled in obscurity. She quotes Freud's comments from ‘The psychogenesis of a case of homosexuality in a woman’:

Psychological cannot elucidate the intrinsic nature of what in conventional or in biological phraseology is termed ‘masculine’ and ‘feminine’: it simply takes over the two concepts and makes them the foundation of its work. When we attempt to reduce them further, we find masculinity vanishing into activity and femininity into passivity, and that does not tell us enough. (Freud, 1920, p. 171)

Freud wished to convey that, although sexuality and gender identity can be thought about in bodily terms - ‘The Ego is first and foremost a bodily ego’ (1923, p. 26), they are also bound up with the mental representation of the body, a subjective experience which is ultimately elusive and unknowable in its essence. It is impossible to stand back from our identity as ‘man’ or ‘woman’, and see it from the outside.

Freud's views about the fluidity of sexual desire, and his theory of gender identity as something that emerged from processes of discovery and renunciation, were controversial from the outset. This is most obvious in his account of feminine development in which the experience of subjective discovery is foregrounded (Freud, 1931, 1933). The little girl initially believed herself to be ‘a little man’ and had a masculine understanding of the pleasure-giving potential of her body. Horney, Jones, and others contested Freud's theory of ‘phallic monism’, arguing that girls, like boys, must start out with some knowledge of the biological destiny implied by their anatomy. Klein, too, assumed that there were essential predispositions in boys and girls which shaped a gendered experience of the Oedipal stage. As Breen points out, it has been Lacan who elaborated the implications of Freud's account of the Oedipus complex as a process of subjective construction. Lacan (1973) approached Freud by means of a linguistic interpretation. The discovery of the phallus as something that can be missing or lost is not understood in physical terms, but rather as a powerful signifier which structures the language of desire and initiates the child into a web of socially constituted meaning, in which she/he must find a place. The fluidity of polymorphous perversity and the incestuous assumption that one can be the fulfilment of the desire of one's primary object belong to territory
which is foreclosed; indeed the only trace of its ever having existed is to be found in an after-echo - the individual's insatiable longing for a state of complete fulfilment which will never be fully satisfied. Jacqueline Rose explains Lacan's position thus:

Sexuality belongs in this area of instability played out in the register of demand and desire, each sex coming to stand, mythically and exclusively, for that which could satisfy and complete the other. It is when the categories ‘male’ and ‘female’ are seen to represent an absolute and complementary division that they fall prey to a mystification in which the difficulty of sexuality instantly disappears. (Mitchell & Rose, 1982, p. 33)

Breen demonstrates how this ‘difficulty of sexuality’ has divided schools around the world. Indeed, Freud, himself, did not always keep in mind the slippage and ambiguity involved in naming gender categories. In spite of his assertion that the terms, masculine and feminine, were ‘amongst the most confused that occur in science’, and having uncovered the complex process by which he believed a little girl came to recognize her femininity, he nevertheless fell into ‘absolute and complementary divisions’ of a dominant heterosexuality when thinking about the positive and negative Oedipus complex. It seemed to him that, whereas the ‘positive’ version of the complex is gendered and results in a sexual identification aligned with anatomy, in the grip of the ‘negative’ complex, the position has become ‘cross-gendered’ - ‘feminine’ in the case of a man and ‘masculine’ in the case of a woman. Although every individual may recognize in him/herself the negative position, this Oedipal matrix seems to suggest that the choice of love object, under the ascendancy of the negative complex, implies a repudiation of the body’s biological reproductive capacity, and thus a retreat from ‘normal’ development. In the third of the Three Essays, ‘The transformations of puberty’, Freud tells us that: ‘The sexual instinct is now subordinated to the reproductive function; it becomes, so to say, altruistic’ (1905, p. 207). In spite of the opening passages of the first essay, here the foundational expectation is of development in the ‘positive’ direction - that, if one is a woman, a normal developmental line will lead to desire for a man, and vice versa. If this is so, then a mature genital love cannot be imagined for an object of the same sex, except from an internal position of the opposite gender. ‘You cannot be what you desire, you cannot desire what you wish to be’, as O'Connor and Ryan (2003, p. 239) put it, quoting from John Fletcher (1989).

Thinking about this theory of gender ‘identification’, Judith Butler reflects on Freud's use of the term in The Ego and the Id where he says identification ‘may be … the sole condition under which the id can give up its objects…’ Here Freud goes on to say: ‘It makes it possible to suppose that the character of the ego is a precipitate of abandoned object-cathexes and that it contains the history of those object choices’ (1923, p. 29). Referring to his insight in ‘Mourning and melancholia’ (Freud, 1917), Butler suggests that, in gender identification, the loss of the same sex object remains unacknowledged and unmourned:

It seems clear that the positions of ‘masculine’ and ‘feminine’ which Freud (1905) understood as the effects of laborious and uncertain accomplishment, are established in part through prohibitions that demand the loss of certain sexual attachments and demand as well that those losses not be avowed and not be grieved. If the assumption of femininity and the assumption of masculinity proceed through the accomplishment of always tenuous heterosexuality, we might understand the force of this accomplishment as the mandating of the abandonment of homosexual attachments or, perhaps more trenchantly, the preemption of the possibility of homosexual attachment, a certain foreclosure of possibility that produces a domain of homosexuality understood as unliveable passion and ungrievable loss. (1995, p. 168)

Butler argues that this accounts for the anxiety that sexual uncertainty provokes:

Hence, the fear of homosexual desire in a woman may induce a panic that she is losing her femininity; that she is not a woman, that she is no longer a proper woman; that, if she is not quite a man, she is like one and hence monstrous in some way. Or in a man, the terror over homosexual desire may well lead to the terror over being construed as feminine, feminized; of no longer being properly a man or of being a ‘failed’ man … (p. 168)
From Butler's reading of Freud, it could be argued that homophobia is a psychic retreat from the confusion that we would feel, confronted by evidence that our settled categories are less settled than we would like. Indeed, this is one of the central difficulties that must be confronted by a young person growing up gay or lesbian, surrounded by peers who are grappling with their own anxieties about sexuality, and perhaps becoming the target of their projections in a bullying way. We will expect to find traces of this anxiety both in ourselves and in our homosexual patients. Perhaps it can only be named now when the demarcation line between traditional gender roles is breaking down, allowing the possibility for a more fluid sense of these binary distinctions to come into view. In societies which preserve more absolute differences between men and women, defences against this anxiety may result in harsh punishment of homosexuality, particularly when threatened by liberalizing pressures from without.

Gender- and sexual identity are inextricably involved with one another. And the history of psychoanalysis shows how difficult it has been to build on Freud's more tolerant attitude towards these obscurities. After two world wars psychoanalysts, concerned to establish the credentials of their discipline within the institutions of the time, sought a more settled definition of sexual 'normality', which 'naturalized' a heterosexual view of gender difference. Writing in the USA in 1940, Rado drew a clear line under Freud's ideas: 'It is imperative to supplant the deceptive concept of bisexuality with a psychological theory based on firmer biological foundations' (1940, p. 464).

Extending one aspect of Freud's thinking, homosexuality became generally accepted as evidence of a developmental retreat, even as a fixation at the oral stage of relating. As an identity founded on rejection of the reproductive 'reality' of the body, it was seen as a borderline condition, and an individual who did not regard it as a serious problem to be cured was understood to be maintaining a perverse denial of their pathology. Same sex object-choice was narcissistic and led to the formation of unstable patterns of relating. With the disappearance of any complexity or uncertainty in theoretical thinking about sexuality, the unconscious prejudices of the analyst could freely be expressed through generalizations about generalizations about homosexuals, particularly men, as a marginalized group. Some male analysts did not hold back:

I have no bias against homosexuality … [but] homosexuals are essentially disagreeable people, regardless of their pleasant or unpleasant manner … [which contains] a mixture of superciliousness, false aggression, and whimpering… [They are] subservient when confronted by a stronger person, merciless when in power, unscrupulous about trampling on a weaker person … (Bergler, 1956, quoted in Lewes, 1995, p. 3)

The homosexual ‘is ill, in much the same way that a dwarf is ill - because he has never developed’ (Allen, in Lewes, 1995, p. 137).

In 1962, Irving Bieber published an influential monograph, entitled Homosexuality: A Psychoanalytic Study of Male Homosexuals (Bieber et al., 1962), reviewing the work of nine clinicians with homosexual patients over a ten-year period. This became the standard reference text for the psychoanalytic view of homosexuality as pathology. Details were presented of the family backgrounds of patients to support aetiological theories. This study is one of the main sources for the idea that homosexuality in men arises in families where there are close, seductive mothers and cold, distant fathers. All the participants in the study were analytic patients and many had been diagnosed with serious problems, including schizophrenia. 90% of them had described themselves as unhappy with their sexual orientation. As Lewes puts it: ‘Thus, beginning with the assumption that all homosexuals were disturbed and using a preselected disturbed sample, [Bieber] found that indeed all homosexuals were disturbed’ (1995, p. 198). Charles Socarides stridently opposed the removal of homosexuality from the mental disorders listed in the DSM in 1973, and continued to argue this position until his death in 2005:

The obligatory homosexual has been unable to make the progression from the mother-child unity of earliest infancy to individuation. As a result there exists a fixation, with the concomitant tendency to regression, to the earliest mother-child relationship. This is manifested as a threat of personal annihilation, loss of ego boundaries and a sense of fragmentation. (1968, p. 30)

In the UK, there has been a lack of direct focus on the subject of homosexuality in recent years. At the BPC conference, Marilyn Lawrence (2012) suggested that the reluctance in British psychoanalysis to revisit theories of sexual identity formation might be a legacy of the Controversial Discussions. Fear of re-opening arguments about the nature and timing of the Oedipus complex has led to a shift of focus towards pre-oedipal phenomena in clinical work.
However, British psychoanalysis assumed homosexuality to be categorized as a perversion and the exclusion, on this basis, of gay men and lesbians from psychoanalytic trainings has inevitably led to ignorance among clinicians of the realities of the LGBT community. The tone in which many psychoanalytic papers about homosexual men and women have been written positions them clearly as objects of study rather than as potential colleagues, making generalized statements about ‘the homosexual’ as a clinical phenomenon. The deference that trainings within the BPC display towards earlier theorists can result in papers like this being offered to current trainees without comment or criticism. Here are examples from papers which are still used in training seminars:

The homosexual syndrome, as it has been described in relation to certain clinical types, is seen as part of a defensive movement directed at lessening anxiety or at creating barriers against eruption of unbearable conflicts, and quite often simply at ensuring survival … It follows that the homosexual solution is a defence which, when encountered, should be treated with the utmost caution, especially in those cases where its removal is under consideration. (Limentani, 1977, in Rosen, 1979, p. 224)

Most of my [lesbian] patients were conscious of an intense feeling of having triumphed over the mother, and a wish that she would feel abandoned and punished … There is a large measure of triumph over the father also, since the homosexual solution implies the denial of the father's phallic role and genital existence, and the proof that a woman does not need either a man or a penis for sexual completion. (McDougall, 1990, pp. 128-9)

Although they may accurately describe their patients as individuals, these analysts are generalizing from particular cases. They take no account of the part that social stigmatization plays in the stress that these patients are under; they assume that sexual orientation accounts for their patients' pathology. The attitudes of these analysts and those like them simply reflected their belief in the normativity of heterosexuality as a biological given, to which psychoanalysis had reverted after Freud's more questioning approach. Clinical literature of this kind should no longer be offered to trainees uncritically. Nancy Chodorow has said: “We psychoanalysts embed conscious and preconscious, unthought and unnoticed, pre-theoretical cultural assumptions … in our theories and thus shape what we see and hear clinically” (1999, p. 99). This has been an attitude that has affected us all, gay or straight, and until recently it is likely that homosexual patients would expect to meet it in a therapist whom they assumed to be heterosexual. But now that the LGBT community has raised awareness in society at large, and gay men and lesbians have begun to train in analytic therapy, the biases demonstrated by such clinical commentary can no longer go unnoticed (see Domenici & Lesser, 1995; O'Connor & Ryan, 2003; Shelley, 1998).

Changing Views of the Clinical Relationship

We are more aware now that patients such as those described above are likely to be members of a vulnerable group, who might indeed be responsive to the idea that their sexual orientation was the cause of their distress and persuaded that they should convert to a ‘healthier’ heterosexuality. Having internalized homophobic attitudes and struggling to come to terms with their sexuality, they could be in conflict with their identity, feeling depressed and finding relationships difficult. Richard Isay (1996) has written movingly about how hard he worked to fulfill his analyst's aspiration that he would overcome his homosexuality and embark on married life, a role that he later realized made him feel as if he was living a lie. Although our society is becoming more open to the complexity of sexual orientation, we know that the incidence of depression, suicidal feelings and self-harm is considerably higher among members of the LGBT community than among heterosexuals (Chakraborty et al., 2011). Both the

British Council for Psychotherapy and Counselling and the United Kingdom Council for Psychotherapy have recently condemned as unethical the clinical practice of therapists who claim to ‘remove unwanted same-sex attraction’, often motivated by their own religious beliefs.

Practitioners in the British tradition are trained to think of themselves as aspiring to a neutral, reserved stance. The task is one of reflective listening, providing ‘containment’ in the model of Bion, or Winnicottian ‘holding’, with the ultimate intention of contributing to the patient's deeper understanding of themselves. The infant-caregiver dyad has been a powerful organizing metaphor for interaction in the clinical setting, whether we invoke a developmental history model or focus on the here and now transference. In search of a deeper understanding of the patient's communication, the therapist consults his or her countertransference to see what it might have to say about the patient's use of projective identification. This metaphor privileges the interpretive authority of the therapist
whose job it is to promote the patient's awareness of themselves. Without the confidence of that authority, the therapist would find it difficult to maintain an attitude of steadiness which allows the patient the freedom of a secure setting to explore emotional reactions, associations and memories which he or she has previously been unable to recognize. Although, increasingly, we acknowledge our potential to be drawn into enactment and see it as a therapeutic tool - as in Sandler's (1976) role-responsiveness model, for instance - we see our task as that of holding the therapeutic frame, and perhaps in the process idealize our capacity for objective understanding.

However, the impact of post-modern cultural theory has meant that psychotherapists and psychoanalysts are increasingly aware of the psychological dynamics of prejudice and the stigmatization of difference. This introduces the idea that the therapist, like the patient, cannot be a neutral partner in the therapeutic relationship. Recently, writers have drawn attention to the impact that cultural difference, and particularly colour difference, can have in the clinical setting (for example, Dalal, 2002; Davids, 2011; Lowe, 2008; Morgan, 2002). These therapists argue that colour-difference is a potent category for the white therapist, arousing unconscious anxiety which can provoke a stereotyping response. Cognitive psychologists call this ‘spread’ (Dembo et al., 1975), referring to ‘the organizing power of a single characteristic to evoke inferences about a person’ (Wright, 1983, p. 32, quoted in Olkin, 1995, p. 55).

‘Homosexual’ is a characteristic with the power to produce ‘spread’. And, in recognizing the bias that has crept into psychoanalytic thinking about homosexuality, we can identify it in all theorizing which claims to understand ‘the homosexual’, ‘the homosexual solution’, ‘the homosexual syndrome’, etc. which singles out same-sex love as the central, organizing characteristic of an individual. If we see the distorted nature of this assumption, it becomes clear that it is the attitude of other people in the patient's life towards his or her sexual orientation which makes it appear problematic - attitudes which the patient may indeed have come to internalize. We must ask ourselves how this dynamic might affect the clinical relationship. Steven Flower (2007) describes how he had to process his own emotional response to his homosexual patients' sexual orientation, and sensitively shows how this influenced his work:

... I did not immediately recognize my own countertransference hurt and jealousy that it was my brother and not me (in the dream) he engaged with sexually. He needed me, I think, to feel the pain of being sexually excluded but, to receive this projection fully, I would have to allow myself to want to engage with him sexually. (2007, pp. 435-6)

Ryan (1998) and Frommer (1995) have both noted how rare it is to find a discussion such as Flower's of the therapist's countertransference in clinical accounts where a straight therapist is meeting a gay or lesbian patient. Frommer, speaking of a male therapeutic dyad, attributes this to the fact that both patient and therapist may share difficult feelings towards the sexuality of the gay man. Even though he may regard himself as liberal in his attitude towards homosexuality, this discomfort may inhibit the therapist's willingness to explore the patient's internalized homophobia, fearing his own response to the patient's potential erotic transference:

In order for the analyst to make contact with the patient's child self and attend to, unmask, and analyse the critical dynamics involved in the child's developmental experience which can lead to shame and self-hate, the analyst must be able to consider fully the psychic consequences of growing up gay in a social context which stigmatizes the same-sex desire and marginalizes those individuals who do not preserve the culture's mandated relationship between biological sex, gender and sexual orientation. In order to do this, he must first be able in his own mind to undo a prescriptive relationship between gender and sexuality … This aspect of the work ultimately entails the identifying and working through of introjects - something analysts do all the time. In this case, however, the analyst's ability to do this with the patient requires that he is first able to do it with himself. (Frommer, 1995, p. 80)

Frommer's argument here assumes the existence of diverse perspectives on sexuality and gender. He takes for granted that therapist and patient may not see things in the same way, and thus the therapist can no longer be confident in falling back on traditional theories to understand the patient's sexuality. This work requires the therapist to be aware of how she/he may appear to the patient, and of where ignorance or preconceptions might undermine the patient's trust. A relational model of therapy takes for granted that subjectivity is culturally constructed, and understands the dyadic therapeutic relationship as interactively and intersubjectively constituted. In the USA, following the influence of Mitchell, Ogden and Schafer, much contemporary clinical work is of this kind. Donnel
Stern suggests that all meaning made in clinical work ‘is not predetermined but created in dialogue’ (2010, p. 7). Ogden speaks of the participants' need to create an ‘Analytic Third’ anew in each encounter:

The art of analysis is an art form that requires not only that we struggle with the problem of creating a place where analyst and analysand might live, but also requires that we develop a use of language adequate to giving voice to our experience of what life feels like in that ever shifting place. (1999, p. 11)

Work with gay and lesbian individuals demands a reappraisal of those aspects of psychoanalytic theory that suggest a fixed hetero-normative view of gender identity formation. Leaving aside the issue of gender reassignment, which deserves separate consideration beyond what can be discussed here, most therapists today would recognize that, however stable the field of gender categorization appears, the individual patient in therapy does not experience him- or herself as discretely defined within a settled ‘identification’. Although core gender identity is assigned to a child at birth or even before, each one of us develops a sense of our gender as a form of habitus, using Bourdieu's (1980) term: as ongoing, lived experience, inevitably in internal dialogue with the images of masculinity and femininity we encounter in our formative relationships, and affected by stereotypes we see reflected in the external world.

Butler suggests, even more radically, that gender could be considered ‘as a corporeal style, an “act” as it were, which is both intentional and performative, where “performative” suggests a dramatic and contingent construction of meaning’ (1990, p. 190, original italics).

Although it may be only certain individuals who experience their gender identity as ‘performance’ in the way Butler suggests, we need to be aware of our susceptibility to binary stereotypes which prevent us from remaining open to psychoanalysis' original insight that there is no settled way to be a man or a woman. It is tempting to find ourselves thinking about the apparent ‘feminine passivity’ of gay men or the ‘masculinity’ of a lesbian. Issues of space and confidentiality prevent me from exploring more fully how important I have found it to question my own countertransference assumptions in clinical work with lesbian patients but I illustrate it with two brief vignettes. One woman, who dresses in casual clothes and never wears a skirt, turns out to wish, not to be masculine, but to be ‘invisible’. She wishes to stay below the radar, disliking her feminine body for its vulnerability, but not wanting to be seen as ‘butch’. She feels very frightened of being stereotyped as a ‘dyke’ and secretly longs to dress up and be glamorous, in a safe context. Another lesbian patient described how difficult she had found it to believe in her own sexual experience, and to ‘come out’, to herself, let alone the outside world. Although gay men's sexuality had been criminalized, she pointed out that a lesbian's had not been considered to exist - how could she admit to herself her own active and passionate sexual desire for another woman? Having described to me how she sometimes wanted ‘to tear the clothes off’ a woman she was attracted to, she was then very upset by a dream in which she had a penis. We explored the possibility that telling me about this exposed her to the fear that I would reject her desire, seeing it as unnatural, and leave her with feelings of shame and confusion about herself.

Adolescent awakening to sexual attraction towards the same sex can be confusing and shameful. E. M. Forster's novel, Maurice, was written in 1914, but did not appear until 1971, eighteen months after his death. Forster, who is supremely good at capturing the vague and confusing nature of internal experience, describes here the feelings of his hero, a somewhat unimaginative, middle-class boy, not yet fully sexually awake, on settling into life in his Cambridge college:

Once inside college, his discoveries multiplied. People turned out to be alive. Hitherto he had supposed that they were what he pretended to be - flat pieces of cardboard stamped with a conventional design - but as he strolled about the courts at night and saw through the windows some men singing and others arguing and others at their books, there came by no process of reason a conviction that they were human beings with feelings akin to his own. He had never lived frankly since Mr Abraham's school … but he saw that while deceiving others he had been deceived, and mistaken them for the empty creatures he wanted them to think he was. No, they too had insides. ‘But, O Lord, not such an inside as mine.’ As soon as he thought about other people as real, Maurice became modest and conscious of sin: in all creation there could be no one as vile as himself. No wonder he pretended to be a piece of cardboard; if being known as he was, he would be hounded out of the world. (Forster, 1971, p. 23)
We must recognize the crucial importance of this experience of self-discovery for someone who senses that his or her sexual desires are different from those of peers. Psychoanalysis is only beginning to recognize the deep impact of internalized homophobia, and a gay man or lesbian's continuing experience of being different. Drescher describes how, even as a gay man, he can be surprised by this:

Gay men and women, who are otherwise reasonably adjusted, often display enduring feelings of intolerance for their own homosexuality. Lesbians and gay men must continuously decide who or what they will tell and will not tell about themselves. Should one say ‘I’ or ‘we’, speak as a single person or as a couple? Should one let people know which neighbourhood, resort, movie, play or club they attended over the weekend? Life is a daily accretion of these experiences and coming out is a process that never ends. This results from a combination of internalized fears and criticisms, external realities and hard experience. Antihomosexuality in the culture forces gay people to constantly think about ‘their’ proper place. (1996, p. 233)

In the USA, where it is possible for gay and lesbian analytic therapists to be more open about their sexual orientation, these issues can receive more attention, including the controversial question of the therapist's disclosure discussed courageously by Isay (1996). In the UK most BPC organizations have not reached this point, and it is to be hoped that gay and lesbian candidates in training are able to find sufficiently supportive contexts, where they can reflect on how issues of sexuality are raised in seminars, and how these differences impact on their clinical work with both gay and straight patients.

Drescher has pointed out that we commonly speak of ‘a homosexual lifestyle’ rather than simply ‘a life’, and one of the most powerful stereotypes of gay male sexual behaviour is that of the ‘cruising homosexual’, who does not look for a settled partnership, but lives in a world of shifting, addictive part-object relatedness, possibly sadomasochistic. Therapists, when faced with a gay or lesbian patient who is not in a settled relationship, might be inclined to wish for a ‘healthy’ therapeutic outcome where the patient becomes part of a committed, monogamous couple. At a symbolic level we speak of the developmental achievement of an internal image of the parents in creative intercourse. But this is not an image that necessarily maps onto the experience of gay and lesbian relationships, which, until recently, had no means of achieving collective recognition and sanction. When meeting an individual, gay or straight, who does not practise monogamy, perhaps we should first ask what such behaviour actually means to them. This area can become difficult to explore if the patient fears the moralistic judgement of the therapist, and becomes either ashamed or completely silent about the details of their intimate sexual life.

Similarly, we have heard reports of analytic condemnation of lesbian couples who want to have a family, and have their babies by donor insemination, not to mention reactions to those gay men who become parents through the use of surrogates. The traditional analytic view has been that a child needs a parent of each sex in order to develop a balanced internal world (for example, Rose, 1990). However, the evidence so far suggests that same sex couples need not bring up damaged children (Fitzgerald, 1999; Patterson, 1997). But this can feel like uncharted territory in which a therapist, with no previous exposure to such issues, may feel at sea.

The challenge that work with lesbian or gay patients presents to the psychoanalytic psychotherapist is to recognize how different things may look from where each partner in the relationship is standing. A crucial requirement in a collaboration which allows the therapist to attend to unconscious communication is that of finding the capacity for ‘orientation’ (Di Ceglie, 2013) towards the patient’s perspective, without which the therapy cannot be experienced as containing. The impact that the external world may have had must be acknowledged, before an exploration of the internal world becomes possible.

I hope to have shown that psychoanalysis has in the past developed a theoretical bias that has distorted its view of the experience of lesbians and gay men and, in detecting and questioning this bias, we have an opportunity to make our discipline more open and responsive to the complex society we live in. We should return to the open-minded curiosity and self-questioning which Schafer (1995) points out goes best with being consistently analytic.

References


