

Psychotherapy: A Queer Space

Carolyn Stevenson, LCSW

ABSTRACT. Psychotherapy is a queer—meaning unconventional—space. It is an intimate, intense, and transitional space in which the therapist and patient are encouraged to “play” within their counter/transference. Optimally, this means it is a creative, expansive space where therapists and patients allow any thoughts, feelings, and fantasies to emerge, allowing formerly foreclosed or unknown experiences to be opened, considered, and better metabolized. Sometimes these explorations will involve erotic and loving feelings, thoughts, and fantasies, and some of the therapist’s sexual and loving feelings will be for patients of the same sex and/or gender, no matter how the therapist and patient self-identify. Therefore, to stay open to such feelings, therapists may find it helpful to employ a constructionist rather than an essentialist notion of sexuality. This paper demonstrates that contesting the sense of coherence of such identity categories as “heterosexual,” “bisexual,” and “homosexual”—or queering psychotherapy—more meaningfully reflects our sexuality. Contesting identity categories also allows intersubjective therapists to more effectively meet the needs of their patients in at least four important, interrelated ways: by helping therapists create a more expansive space, by better understanding sexual attraction, by staying open to same-sex (and other-sex) desire and love, and by combating homophobia.

KEYWORDS. Transference, counter/transference, intersubjective, relational, queer, homosexual, gay, lesbian, bisexual, love, sexual

Psychotherapy is a queer—meaning unconventional—space. It is an intimate, intense, and transitional space where the participants are

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not subject to ordinary distractions and where the therapist and the patient “play” within their counter/transference. Optimally, this means that it is a creative, expansive space where therapist and patient allow any thoughts, feelings, and fantasies to emerge, allowing formerly foreclosed or unknown experiences to be opened, considered, and better metabolized (Bridges, 1994; Davies, 1994). In doing this the patient and therapist “negotiate a mutually meaningful language, invent metaphors, coauthor a plausible narrative, develop portraits of the analysand’s object world, and engage together in the full tonal range of a relational duet” (Pizer, 1998, p. 53). To achieve this, the therapist needs “to be [as] curious as possible, open to all the alternate formulations one finds unfinished in oneself, including one’s reaction to the other” (Stern, 1997, p. 196). To do this, of course, requires the patient, as well as the therapist, to take emotional risks and to be open as to where these examinations lead.

Sometimes these examinations will involve erotic and loving feelings, thoughts, and fantasies. Indeed, many of the physical and behavioral patterns we associate with love relationships, such as an exclusive focus on one individual, synchronized movements, prolonged silent eye contact, shared meaning of experiences, also exist in therapeutic relationships. As Bridges (1994) noted, “Therapists do well to maintain an open mind about where the explorations of sexual feelings will take them. It is very possible that sexual fantasies or counter/transference will educate the therapist about him/herself” (p. 427). Some of the therapist’s sexual and loving feelings will be for patients of the same sex and/or gender, no matter how the therapist and patient self-identify. Therefore, to stay open to where such feelings may take the therapist and patient, therapists may find it helpful to employ a constructionist, rather than an essentialist, notion of sexuality. As this paper shows, contesting the sense of coherence of such identity categories as “heterosexual,” “bisexual,” and “homosexual”—or queering psychotherapy—more meaningfully reflects our sexuality and helps therapists to better understand the complexities and multiplicities of our own identity. Queering psychotherapy may also help therapists to be more effective and better meet the needs of their patients in at least four important and interrelated ways: by helping intersubjective therapists create a more expansive space, better understand sexual attraction, stay open to same-sex (and other sex) desire and love, and combat homophobia.

The next section discusses some of the major tenants of intersubjectivity, as well as how intersubjective therapists have started to employ a relational lens to look at erotic and loving counter/transference feelings. That is followed by a section that lays out two important reasons queer theory argues for a constructionist view of sexuality. Finally, the article briefly addresses the clinical implications of queering psychotherapy.

INTERSUBJECTIVITY AND COUNTER/ TRANSFERENCE

Intersubjectivity is one strain of various recent attempts to reconceptualize the therapeutic relationship from one in which the patient is viewed as a subject and the analyst as an object, to one which emphasizes the commixing of two subjectivities. This emerging view has been variously defined as intersubjective (Benjamin, 1995; Orange, Atwood, & Stolorow, 1997; Stolorow, Brandschaft, & Atwood, 1987), relational (Mitchell, 1988), mutual (Aron, 1996; Beebe & Lachmann, 1988), dialogical (Hermans & Kempen, 1993), two-person (Modell, 1984), and social-constructivist (Hoffman, 1991, 1992). It is beyond the scope of this paper to parse out the differences between these positions, so I will lay out some of the important philosophical underpinnings, using the rubric intersubjective.

Intersubjective therapists, who work out of a relational or two-person model, argue that counter/transference is a joint creation between the patient and the therapist, which includes all feelings, thoughts, and fantasies, conscious and unconscious, that each has toward the other, and which emerge from intrapersonal issues, interpersonal issues, or past and present object relations (Bridges, 1994). Intersubjective therapists still hold that the past plays a formative role in interpersonal behaviors in the present, but they contest the notion that transference manifestations are merely the projections of the patient's past relationship patterns upon the neutral, objective, and detached therapist. The therapist is never neutral because any action or nonaction on the part of the therapist, however small or large, inevitably affects the relationship and therefore the patient's experience of the relationship (Stolorow, 1994). They also challenge the idea that the therapist can decide reality, clearly separating transference distortion from objective

perception, because the therapist does not act from a position outside the transference manifestation; she or he is a participant in it and a contributor to it (Gill & Hoffman, 1982; Greenberg & Mitchell, 1983). Rather, through their encounters therapist and patient together make sense of and give meaning to reality.

Although the views of intersubjective therapists are widely divergent, intersubjective perspectives often include at least five important and interconnected critiques of the classical model of transference and counter/transference. First, transference is no longer seen as a merely intrapsychic phenomenon. Rather, it is viewed as a commixing of two subjectivities, each bringing his or her own presuppositions to that encounter (Greenberg & Mitchell, 1983). In this way, transference and counter/transference are seen as inextricably bound. As Kalb (2002) states, "The relationship ... is inevitably laden with both the therapist's and the patient's reciprocally intertwined constructions and actualized by both parties" (p. 122).

Second, the patient's transference may be, at least in part, a construction of her or his take on the therapist and the analytic encounter. Intersubjective therapists "reject the dichotomy between transference as distortion and non-transference as reality-based. They argue instead that transference itself always has a significant plausible basis in the here-and-now" (Hoffman, 1983, p. 45). Transference is a *mélange* of the "real" features in the therapist and the patient's characteristic presuppositions and perceptual matrices. Intersubjective therapists reject the notion of the "blank screen" and the idea that what the therapist intends or thinks she or he conveys is what is "real."

Third, transference is seen as an unconscious organizing principle. Intersubjective therapists hold that transference accounts for the ways in which the patient interprets the interaction with the therapist (Stolorow et al., 1987). Because all human relationships are inherently ambiguous, and the patient's perspective is one of among many possible perspectives, intersubjective therapists examine why the patient selects certain foci and how they "[represent] not only a way of construing but also of constructing or shaping interpersonal relations in general and the relationship with the analyst in particular" (Hoffman, 1983, p. 46).

Fourth, the concept of *counter/transference* has expanded to include the therapist's transference to the patient. Counter/transference was

originally thought of as the therapist's transference to the patient's transference. The patient's reactions to the therapist were assumed to be a distortion of the "real" therapist whereas the therapist's reactions to the patient were not. Intersubjective therapists, however, view transference as a cocreation of therapist and patient, at the same time not clearly differentiating transference from nontransference reactions (Gelso & Hayes, 1998). Within such a revised model the traditional understanding of analytic neutrality becomes untenable as does the traditional notion that the therapist alone knows what is "real" or "truthful" rather than holds a particular perspective and interpretation (Davies, 1994; Stolorow et al., 1987).

Finally, counter/transference enactments are seen as ubiquitous, inevitable, and even therapeutic (Aron, 1990; Davies, 1994; Gabbard, 1994b; Greenberg, 1991; Maroda, 1999; Mitchell, 1988; Schamess, 1999). As Davies (1994) states, therapists "assume—indeed, we rely upon—the hope that analyst and patient together will become enmeshed" in counter/transference enactments because these "can shed light upon the patient's current interpersonal and intrapsychic difficulties by reopening in the analytic relationship prematurely foreclosed areas of experience" (p. 156).

These five modifications signify a marked theoretical shift in the field that has affected all aspects of treatment and analysis.

EROTIC AND LOVING COUNTER/TRANSFERENCE

One way intersubjective therapists have started to employ this relational lens is by looking at erotic and loving counter/transference feelings, thoughts, fantasies, and enactments (Benjamin, 1994; Coen, 1994; Cooper, 1998; Davies, 1994, 1998; Gabbard, 1994b, 1998; Gill, 1993; Gorkin, 1987; Hoffman, 1998; Rosiello, 2000; Slavin, Rahmani, & Pollock, 1998). Many think this connection is not accidental. For example, Gabbard (1994b) argued that therapists are more likely to discuss erotic or loving feelings as a result of increased attention to counter/transference elements in the therapeutic setting. And Mann (1999a) argued that a focus on erotic and loving feelings is essential because "transference and counter/transference [can not] be fully understood until the erotic ... find its place in the process" (p. 13). Whatever the connection, what was once thought too intimate for therapeutic consideration is now being examined (Rosiello, 2000).

Intersubjective therapists view erotic and loving countertransference feelings as a "mutually constructed, intersubjective playground of transitional potentialities where meaning can be constructed only in the throws of recognition, destruction, and perpetual interaction between two actively engaged participants" (Davies, 1994, p. 168). The therapist's erotic responses are a significant aspect of the countertransference process (Davies, 1994; Davies & Frawley, 1992; Tansey, 1994). And the therapist can use those feelings (even before the patient is able to give voice to them) to deepen her or his understanding of the work (Bridges, 1994; Davies, 1994). For, like all countertransference feelings, erotic and loving feelings can have multiple and varied meanings which may signify important information about the patient, the therapist, and their relationship (Bridges, 1994). The therapist's openness to such feelings may allow for better understanding of the patient's meanings and motivations (Rosiello, 2000). As Gabbard (1994b) noted, erotic feelings are "gateways to a panoramic vision of the interior world" (p. 1086).

Davies (1994) argued that when the therapist is seen as a "full participant" in the patient's romantic struggles and she or he provides "certain protective, holding, and containing functions," the counter/transference enactments are healing. They open the analytic space to "previously foreclosed experiences" and they enable patients to "freely play and reconfigure themselves in more harmonious ways" (p. 157).

It is important to have such a space because erotic and loving feelings "often defend against ... other feelings, conflicts, and vulnerabilities that are more intolerable," (Bridges, 1994, p. 426) such as hostility and contempt (Celenza, 1991; Gabbard, 1994b), frustration and helplessness (Searles, 1979), loss and mourning (Gabbard, 1994b; Kavalier-Adler, 2003), vulnerability (Elise, 1991), and disappointment (Bridges, 1994). Lustful feelings may also defend against feelings of love, which many therapists find more difficult to acknowledge (Coen, 1994; Gabbard, 1994b; Heisterkamp 2001; Rosiello, 2000), though the reverse is certainly possible as well (Burch, 1996). For example, Rabin (2003) contended that therapists often use abstract and technical language to defend against their discomfort and anxiety about their deeply loving feelings toward their patients, rather than "experience-near terms such as *loving feelings* and *falling in love*" (p. 678). Another way therapists may

defend against their anxiety is to view countertransferential love as distinct from "real" love. As Slavin et al. (1998) argued, the sexual and loving feelings toward a potential lover may differ from similar feelings toward a patient "but the feelings are no more or less 'real' in one or the other" (p. 214).

Some therapists, however, view erotic and/or loving feelings in the therapeutic encounter as unreal. They contend that such feelings are a resistance to bringing unconscious material into consciousness, a transitional phase in treatment (Bergmann, 1987), and/or a possible slippery slope toward sexual misconduct (Brodsky, 1989; Strasburger, Jorgenson, & Sutherland, 1992). As Gabbard (1994a) noted, "Analysts who have become lovesick have lost the 'as if' nature of the counter/transference [that] compels them to action rather than reflection" (p. 205). Gabbard concentrates on the "as if" aspects of counter/transference love to decrease sexual misconduct by therapists. This argument suggests that therapists who confuse "counter-transferential" love with "real" love are more likely to become sexually involved with their patients (Gabbard, 1994b, 1998).

However merely because some therapists who are sexually attracted to or fall in love with their patients enact sexually, does not meant that therapists who allow themselves to experience such feelings will inevitably, or even will be more likely, to act on their feelings. In fact there is good reason to think they would be less likely to do so. Rather than insisting on a division between real and transference love, therapists may find it more helpful to concentrate on trying to understand the meanings and implications of their erotic feelings and what they can do therapeutically with those powerful feelings (Rabin, 2003; Rosiello, 2000).

Indeed, this is another reason therapists should remain open to erotic and loving feelings. An awareness of such feelings may actually help therapists from acting out (Maroda, 1999). Unrecognized, unnamed, or denied sexual and loving feelings may lead to destructive acting-out by patients or therapists (Bridges, 1994). Looking at the complexities of sexual and loving feelings as they arise in the analytic field may help therapists from compartmentalizing or splitting off such feelings; if such feelings are ignored, therapists may withdraw or show fatigue or disinterest, or show an abundance of other types of feelings like sympathy or empathy or engage in sexual misconduct (Bridges, 1994; Rosiello, 2000). In addition, examining these feelings

may help therapists avoid feeling the “too safe a distance between ‘the kind of therapist who might do that kind of thing’ and ourselves” (Davies, 2000, p. 222). When the therapist “experience[s] feelings of attraction with personal dread, guilt, or anxious discomfort” (Bridges, 1994, p. 424) or when erotic counter/transference remains unconscious, it “can freeze, sidetrack, or prematurely terminate a treatment” (Rosiello, 2000, p. 28).

Some, in fact, suggest that “the problem may be less one of behaving oneself than of allowing oneself to participate” (Wrye & Welles, 1994, p. 63). Indeed, what most threatens the success of therapy is when the therapist fails to fully and deeply engage with the patient (Gorkin, 1987; Mann, 1999a; Maroda, 1999; Rosen, 1999; Rosiello, 2003; Wrye & Welles, 1994). The development of erotic and loving feelings may even take the therapeutic work to a new and transformational level (Mann, 1999b). Indeed, another reason to try to remain open to erotic and loving feelings is that they may help facilitate therapeutic change (Coen, 1994; Gerrard, 1999; Gorkin, 1987; Hirsh, 1986; Mann, 1999a; Maroda, 1999; Rabin, 2003; Rosen, 1999; Rosiello, 2000; Stolorow & Atwood, 1984, 1992; Stolorow et al., 1987). As Gerrard (1999) stated,

Until and unless there can be felt moments of love for the patient by the therapist, the patient is not able to develop fully. I think it is only when a patient can arouse our deepest loving feelings (not empathy) that we can hope for a truly positive outcome from our work. (p. 30)

Perhaps this is in part because, as Rosiello (2003) stated, the therapist’s openness to erotic and loving feelings may deepen the degree of mutuality and emotional intimacy therapists create with their patients in a way “that no other aspect of human relatedness can accomplish” (p. xvii). As Mann (1999b) argued, erotic and loving feelings are

psychically binding, bringing each individual into a strong conscious and unconscious relationship with others. An erotic bond is forged at a deep emotional level that binds individuals into a relationship with each other at the deepest levels of fantasy. It seems that the transformational potential of the

erotic goes right to the heart of the therapeutic transaction ... and gives this process a good deal of its momentum. (p. 87)

Indeed, the mutual struggle to explore previously unknown feelings, within the self and with another, necessitates mutual emotional risk between the patient and the therapist (Rosiello, 2003). Therapists often avoid this struggle, particularly when it involves their feelings of love for their patient, because they feel too vulnerable. As Charles (1999) noted, "too often, neutrality serves as a pretense behind which we hide our own humanity. And yet, the unconscious communications passing back and forth between patient and analyst are often first grasped at the level of the counter/transference" (p. 9). We do, after all, always communicate our feelings, whether directly or indirectly via interpretation, silence, phrasing, framing, and so forth. To deny or minimize sexual and loving feelings between therapists and patients discourages self-honesty or trust of another, which some argue is "the foundation of psychoanalysis and therapeutic action" (Rosiello, 2000, p. xxii).

In addition, the therapist's openness to erotic and loving feelings often provides access to the patient's subjective experience in ways not available via verbal discourse (Davies, 1994). As Ogden (1999) noted, such feelings "pull to the foreground the nonverbal aspects of the treatment relationship while pushing the more familiar activity of psychoanalysis, the use of words to convey understanding and organize experience, to the treatment background" (p. 589).

Sexual and loving feelings and sensations "can symbolize a diverse array of psychological themes, such as wishes for fusion, separation anxiety, abandonment fears, strivings for autonomy, gender conflicts, gender inadequacy, disruptions in sexual desire, and conflicts over sexual and aggressive wishes" (Gould, 2001, p. 46).

Through "a premature foreclosure of erotic experience ... [w]e lose an entire aspect of self-organization and a different language" (Davies, 1994, p. 160) for understanding our patients and their relationships with others (Mitchell, 1988; Rosiello, 2000). If one of the goals of therapy is to reduce resistance to unconscious desires or reduce inhibitions, in part by better understanding such desires, then erotic transference provides a valuable means through which to achieve this goal (Kavaler-Adler, 1992). As Elise (1991) stated, "I do not think that I would have known of my client's internal world as

quickly, accurately, and deeply without my [romantic/sexual] counter/transference" (p. 61).

But, as Havens (1993) cautioned, the success of treatment depends not just on what the therapists discern about their patients, but also on what they discover in themselves. In addition to helping therapists understand their patients, counter/transference feelings may help educate the therapist about herself or himself (Bridges, 1994). In keeping with the spirit of intersubjectivity, it is important that therapists remain open to where the exploration of sexual and loving feelings will take them (Maroda, 1999). Adopting a fluid rather than a fixed notion of identity categories will aid therapists in this regard.

ESSENTIALIST VERSUS CONSTRUCTIONIST VIEW OF SEXUALITY

One reason intersubjective therapists may fail to remain open to where the exploration of sexual and loving feelings will take them is that they often rely, implicitly or explicitly, on an essentialist notion of (homo)sexuality. An essentialist notion holds that homosexuality is a biological state that exists in a minority of individuals and is constitutionally different from heterosexuality; it is naturally occurring, existing across cultures and throughout time, and it is involuntary and immutable. Because this view holds that sexual orientation exists even in the absence of cultural interpretation, an essentialist view of sexuality creates a bond between people with the same essence and, at the same time, distinguishes between people with different essences. This fixed notion of sexual identity precludes therapists from constructing a creative, open, and expansive relationship with their patients. To help intersubjective therapists expand their relational model to more fully include (homo)sexual desire, longing, and love, I suggest that we start to put queer theory in conversation with intersubjectivity.

A QUEER VIEW OF SEXUALITY

Queer theory, which developed in the early 1990s, grew out of a number of disciplines that emerged in the 1970s and 1980s, including

lesbian and gay studies, feminist studies, postmodernism, and poststructuralism. Queer theory argues that sexuality—as well as other identity categories such as gender and race—often seems eternal, essential, and true but is actually socially constructed and is therefore mutable and shifting. Although queer theorists and the subjects they study are widely divergent (and beyond the scope of this paper to explore in detail), queer theories often oppose an essentialist notion of sexuality for at least two important and interconnected reasons that are particularly relevant to the claims of this paper: sexuality is socially constructed and sexuality is broad and fluid.

Constructionist View of Sexuality

The first reason queer theory gives for arguing that an essentialist notion of sexuality is problematic is that sexuality is socially constructed. Social constructionism offers an alternative way of thinking that helps us think about sexuality. The philosopher Hacking (2000) posits that a social constructionist argument for X (in this case, X is the belief that homosexuality is a closed, biological category that is constitutionally different from heterosexuality) can be made when the following two conditions are met: 1) “In the present state of affairs, X is taken for granted; X appears to be inevitable” (p. 6), and 2) “X need not have existed, or need not be at all as it is. X, or X as it is at present, is not determined by the nature of things; it is not inevitable” (p. 12).

Social constructionism challenges the validity of “inevitable,” “natural,” and “closed” categories, such as sexual orientation. As Gergen (1999) stated, “such claims are born of historical traditions, fortified by social networks, sewn together by literary tropes, and legitimated through ... structures of power and privilege” (p. 5). Thus, social constructionism spurs social transformation because it recognizes that our sexuality is shaped by culture and can therefore change.

Indeed, a number of historians and social construction theorists (Burger & Kruger, 2001; Chauncey, 1994; Duggan, 1998; Foucault, 1978, 1984, 1986; Halberstam, 1998; Halperin, 1990; Howard, 1999; Katz, 1995; Murray, 2000; Winkler, 1990) argued that sexual behavior, rather than being trans-historical, trans-cultural, and natural, is embedded in and derives its meaning from specific histories and cultures. All forms of human sexuality—heterosexual

and otherwise—have a history, and thus “general laws about sexuality and its historical evolution will be defeated by the sheer variety of past thought and behavior” (Nye, 1998, p.4). Our contemporary categories of sexuality, therefore, are best not thought of, and legitimated by, their innateness.

Halperin (1990), for example, argued that our modern conception of homosexuality would have been unknown in ancient Greece. In that time and place, sexual activity mirrored (and marked) the societal and political hierarchy. (Athens was ruled by a small group of elite male citizens. Others—slaves, women, foreigners, children, and animals—had subordinate status.) There was no prohibition against male–male sex; what mattered was the kind of sex one had because people affirmed their status through sexual acts. A (male) citizen was supposed to be the active partner (inserting his penis into another’s anus, vagina, or mouth). It did not, however matter whether his passive partner was a woman, boy, foreigner, or male slave. Penetrative sex between (male) citizens of equal status, though, “was virtually inconceivable” (Halperin, 1990, p. 31). Thus, male–male sexual acts did not mark an essential homosexual nature; rather, they mirrored and marked social status.

Foucault (1978) argued that our modern, Western conceptions of homosexuality (and heterosexuality) did not arise until the 19th century:

The nineteenth-century homosexual became a personage. ... Nothing that went into his total composition was unaffected by his sexuality. It was everywhere present in him. ... It was consubstantial with him, less as a habitual sin than as a singular nature. ... The sodomite had been a temporary aberration; the homosexual was now a species. (p. 43)

Duggan (1998), expanding on Foucault’s work, argued that although the term and idea of *lesbian* were used as early as the 1890s, that usage was not prevalent until the 1930s or later. By the 1950s, a sexual/gender triangulation occurred with the construction of the “mannish” lesbian who competed with the “normal” man, both of whom vied for the “normal” woman (Duggan, 1998). These identities, like all identities, are social fictions, “a generic construction covering

over and standing in for a much more diverse array of historical gendered embodiments of sexual desires" (Duggan, 1998, p. 24).

Many other scholars (Burger & Kruger, 2001; Chauncey, 1994; Halberstam, 1998; Howard, 1999; Katz, 1995; Murray, 2000; Winkler, 1990) have examined different sexual constructions trans-historically and trans-culturally. This body of literature suggests that same-sex acts, variously conceived, have existed throughout time and across cultures, but sexual activity, as well as societal understandings of it, is bound to historical contexts. Our modern, Western sexual codifications, therefore, are fairly recent and culturally contingent. This does not mean that our desires are artificial; it means that we interpret our desires through culturally available concepts and possibilities, and that we perceive our desires as indications of the types of people we are.

The essentialist/constructionist debate is not the same as the debate over whether sexual orientation is a result of biology, socialization, or choice. Even if our desires have a biological basis, constructionists would argue that we give meaning to these desires in a cultural context. Conversely, even if we become lesbian, gay, bisexual, or heterosexual as a result of life experience, this does not mean that our sexuality cannot, in part, be biological. Therefore, emphasis on meaning in context is given priority.

SEXUALITY IS BROAD AND FLUID

The second reason queer theory gives for arguing that an essentialist notion of sexuality is problematic is that it is too narrowly construed to capture the breadth and fluidity of sexuality and also of gender. An essentialist notion of sexuality segregates all people into fixed, binary categories (homosexual-heterosexual), and it defines sexual orientation in terms of the biological sex (and implicitly the gender) of one's sexual partner: people are attracted to women (who are assumed to be female) or to men (who are assumed to be male). Often, though, peoples' lives defy this neat classification schema. For example, there is no reason to view sex as the only relevant characteristic. As Sedgwick (1987) argued, it is

amazing [that] of the very many dimensions along which the genital activity of one person can be differentiated from that of another ... precisely one, the gender of the object choice, emerged from the turn of the century, and has remained, as *the* dimension denoted by the now ubiquitous category of "sexual orientation." (p. 8)

Bisexuals, for example, show that gender and/or sex does not have to be the primary filter. Other characteristics, such as intelligence, sexual drive, or compassion, might be more important. (Many homosexuals and heterosexuals also view such characteristics as important determinants in selecting a potential sexual partner. However, they relegate the other characteristics to a second tier, behind the key filter of sex.) Indeed, many bisexuals hold that to eliminate half the members of the human race as potential sexual or romantic partners merely on the basis of their sex is a form of sexual discrimination.

Relatedly, this schema's insistence on monosexuality (homosexuality or heterosexuality) negates the range of sexual attractions people experience. There is a great deal of slippage between these binary (homosexual-heterosexual) or even trinary (homosexual-bisexual-heterosexual) categories. For example, some women view themselves as heterosexual but recognize strong attractions to other women; many middle-aged lesbian women have had prior sexual relationships with men; a male-to-female transsexual might continue to be attracted to women; a heterosexual woman might be involved with a male cross-dresser; and three men with the same sexual history might identify themselves differently (e.g., each may have only been sexually/romantically involved with women, yet one identifies as homosexual because he secretly longs to be with men but does not act on these forbidden feelings, the second identifies as bisexual because he incorporates his attraction to other men into his sexual identity, and the third identifies as heterosexual, despite his attraction to other men, because he has never acted on these feelings). Indeed, upon examination, these sexual identity categories are neither coherent nor stable (Butler, 1990, 1993). Female heterosexuality, for example, may be based on with whom a woman has sexual relations, to whom she is sexually attracted, how or with whom she has sex, how she identifies herself sexually, relationally, socially, or politically, and/or how others identify her.

SUMMARY

Given these critiques—that an essentialist notion of sexuality is problematic because sexual behavior cannot be understood separate from the specific histories and cultures in which it is enacted and that an essentialist notion of sexuality does not capture the breadth and fluidity of sexuality and gender—I advocate that therapists queer psychotherapy by adopting a constructionist view of sexuality.

Employing a constructionist view of sexuality more fully and meaningfully reflects our sexuality and helps therapists better understand the complexities and multiplicities of our identity. It embraces (rather than ignoring or hiding) the fact that our identities are culturally and historically constructed; that our identities are fragmentary, partial, and shifting; and that our identities are multiple and often hybrid. Thus, rather than assuming that people can be reduced to clear-cut, innate, and immutable categories, a constructionist view holds that our identities are constantly changing collections of meanings that we construct.

CLINICAL IMPLICATIONS

Queering psychotherapy may help intersubjective therapists be more effective and better meet the needs of their patients by opening up the analytic space within and between the therapist and patient. The notion of essentialist identities is ontologically problematic, limiting how the therapist and patient see themselves and one another and creating separation between them. Freed from such a notion, the therapist and patient are able to cocreate a more expansive space where both can play more fully. This expanded therapeutic space allows therapists to have a more open, playful, and creative view of and stance toward their patients. Viewing the patient through an essentialist lens limits how the therapist can take in and respond to the patient. It hinders the therapist's ability to "*play* with the paradoxical nature of a multiple self and its multifaceted relationship to the external world" (Pizer, 1998, p. 53). Whereas a constructionist view, by emphasizing performativity (Butler, 1990, 1993), multiplicity,

and deconstruction, helps to break open this space in new and unseen ways. This view not only expands understanding of gender, erotic choice, and identity but also more broadly helps the patient hold a more fluid, expansive, and creative worldview. One reason that this is important in a therapeutic setting is that it can help the therapist to "notice, illuminate, and counter the ways in which the patient ... seeks to foreclose potential space along familiar, repetitive patterns" (Pizer, 1998, p.53). This expanded self-awareness and worldview offers engagement, possibility, and potentially hope.

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candidate in the National Training Program for Contemporary Psychoanalysis of the National Institute for the Psychotherapies.

Carolyn Stevenson, LCSW, M.Div., is a fellow at the Harvard University Counseling Center. She graduated from the Smith College School for Social work in 2004, where she received the Eleanor Clark prize for best thesis and excellence in research. In 2002, she graduated from the Harvard Divinity School.

Laura Stovel, M.D., is a psychiatrist at the University of Alberta where she practices outpatient psychiatry with a particular interest in individual and group psychotherapy. She is also the Director of Psychotherapy Training for psychiatry residents at the University of Alberta.