

MURIEL DIMEN, Ph.D.

LAPSUS LINGUAE, OR A SLIP OF THE TONGUE?

A SEXUAL VIOLATION IN AN ANALYTIC TREATMENT AND ITS
PERSONAL AND THEORETICAL AFTERMATH

Abstract: Sexual boundary violations are as old as psychoanalysis itself. Yet, although this professional, intellectual, clinical, and personal dilemma is receiving more attention in the literature, it endures. Do analysts not want to think or talk about it? Is our shared shame, or even ambivalence, in the way? Is the primal crime inherently unstoppable? The author examines her own experience of a sexual boundary violation from clinical and theoretical perspectives. Locating her analyst's transgression in its 1970s cultural history, the article attempts to decipher what led up to it: What did the analyst do and not do, say and not say? How did the analyst's character combust with her author's to produce a conflagration about which the analyst never spoke and the author/patient remained silent for thirty years? And under what circumstances can the damage inflicted by such an ethical lapse be transformed?

Keywords: Silence, enactment, erotic countertransference, feminism, patriarchy, ethics

*Freedom of expression has its roots in pride,
and is, in essence, an expression of human dignity.*
—Orhan Pamuk (2005)

Introduction: The Hug and the Hard-On

WHEN I WAS A GRADUATE STUDENT IN ANTHROPOLOGY, long before I thought of becoming a clinician, I entered treatment with an impeccably credentialed psychoanalyst. I was 26 and it was 1968, an era of political, personal, cultural, and intellectual change, but in which women's sexual subjectivity was still officially less than their own. In November 1973, I was about to attend an annual anthropology conference (I was by then an assistant professor), set on sleeping with a man I'd met the previous year. Off and on, I'd been sharing this plan with Dr. O and

Contemporary Psychoanalysis, Vol. 47, No. 1. ISSN 0010-7530
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was now relating my excitement, fear, and adulterous guilt. Though I'd often discussed sex, I see, looking back, that this was the first time I was owning my sexual intentionality. Doubtless, feminism and the so-called "sexual revolution" (aided by the 1960s birth-control pills and New York State's 1973 legalization of abortion) were, for me, synergizing with psychoanalysis to recuperate a way of self-knowing that had been closed off for too long, an unthought-known reason I'd sought treatment.

The session ended, Dr. O walked me to the door, I said, "I'm scared, I want a hug." (This was not the first hug: in the spring of the preceding year, when I was grieving my father's death, he sat on the couch to put his arm around me.) As I was ending the embrace, I kissed his cheek; I do not know whether there'd been a kiss before, but I don't think so. And then he said, and this was a definite first—and last—"No, how about a real kiss?" So—it wasn't even a question, because, as the quip goes, there's a "trance" in "transference"—I kissed his mouth. He returned the favor with his tongue—at which point, I recall—as I write—a feeling of shock, and then a feeling of ignoring the shock. He chuckled: "Oops, I'm getting a hard-on, I better stop." In me, nothing or, rather, awareness of nothing. Call it a confusion of tongues.

I left, went to the conference, had disappointing intercourse, never saw the guy again, returned to analysis, did not speak of the hug or the hard-on or the French kiss, and never did anything like it again in a treatment that lasted for seven more years. Dr. O did not mention it either.

Dr. O's professional background made his silence odd. Had he been classically trained, we might deem his lack of speech technically mandated: no matter what the analyst does, it's the patient's perception of it that matters and is in need of investigation (Brenner, 1979). The ordinarily loquacious Dr. O, however, held the analyst to be a person just like the patient: the analyst is not a cipher but a contributor to the relationship. And he regarded the patient as responsible, an adult like the analyst. He believed the psychoanalyst should routinely acknowledge and sometimes even discuss the patient's reception of the analyst's particular presence. Had Dr. O stuck to his last, however, the treatment would have soon ended. Instead, it was prolonged by the silence vitiating it.

Dr. O, you should know, fed me well. His voice and cadence, familiar to me from my mother's, were a comfort. And, unlike my father, whose narcissism took a different path, Dr. O listened. *A man who listened.* O brave new world! That was enough, a phallic presence with a mothering heart. Gender and power were never more beautifully married, a

solution that, needless to say, became a problem. My transference neurosis—call it penis or, better, phallus envy—was that his masculinity would free my own voice. Nestled in this powerful patriarchal transference—was it love?—I grew. In the idealizing glow of his care and modeling, an engaged, engaging, vocal self, abandoned early on, returned. My confidence burnished, I wrote my first book (1977), switched careers from anthropology to psychoanalysis, and left my marriage.

All this took place next door to a profound dissociation. I would go to sessions with what I privately called “hopeless hope.” Blind faith, I would call it now that I can think. Unconsciously, that’s where I wanted to stay, and indeed could stay, because, absent symbolization, *nothing* had happened and no time had passed. Sometimes I think of myself as having been a Lorenz gosling (Brigandt, 2005), as one is in deep analysis. Except that’s how I was from the initial phone call and apparently that’s how I wanted to remain, in a state of total trust and worship, that necessary but dangerous state of attachment (Bowlby, 1982) we call “imprinting” (Brigandt, 2005). Dr. O’s silence not only enhanced dissociation and protected me from the shame that blankets fear, it drew on and intensified the originary trance.

I always remembered the hug and the hard-on, I always recalled that tongue slipping into my mouth, but I couldn’t sort any of it out. The memory lived without affect, as though in two dimensions. Post-Dr. O, whenever I tried to go beyond the mere recounting of who did what to whom, I would feel only hunger and an overwhelming sadness that led to an obsessive questioning of every other turning point in my life. Attempting to manage this painful flood alone, I could not locate a chain of significance. More precisely, what happened between Dr. O and me had not been an object of knowledge until I wrote about it and had the exchange afforded by writing and speaking with the psychoanalytic community and others. It simply *was*. In the absence of mutuality (Aron, 1996; Benjamin, 1988), feeling could not be contained (Bion, 1962), knowledge (Ogden, 1994) could not coalesce, nor could there evolve an “I” to hold the self-shards together (Bromberg, 1996; Rivera, 1989).

Because an enormous ambiguity surrounds and infuses Dr. O’s lapse, it seemed sensible to entitle this article “Lapsus linguae.” Literally this phrase translates as “a slip of the tongue,” an expression giving my second title, which I have in turn put as a question, because what went on in that treatment is not at all limpid (indeed, were it so, this long article would have been unnecessary). In psychoanalysis, we apply the rather

concrete Greek *parapraxis* (an act or deed gone wrong; Freud's *Fehlleistung* (faulty action [Strachey, 1901]) to that which *lapsus linguae* connotes.

The Latin, in contrast, simmers with imagery; according to the *Oxford Latin Dictionary* (Glare, 1982, p. 1002), "*lapsus* can have several senses [in historical order]: (1) simply falling down or slipping; (2) a smooth gliding motion, e.g., slithering, creeping; (3) a fall from favor or high rank; (4) the fact of falling into error or misconduct, failing, lapse" (Schein, 2010). This layer-cake of meanings seems apt: the slithering tongue, the fall from grace, the creepy misconduct. Happily, *lingua* puns too, signifying "tongue" as organ and speech (Glare, 1982, p. 1032–1033), a doubling whose special relevance to this familiar, albeit unique, situation will become clearer later on.

In this article, I want to restore depth and time to an instance of a phenomenon that happens frequently when the person in need is young and female (but also sometimes male), and is seeking help from an older male (but also sometimes female) authority. This ongoing violation of trust is barely thinkable in the vocations marked and marred by it—from the religious and spiritual to the medical and secular, including, I must emphasize, all brands of psychoanalysis. So I want to try to think about that fragmented experience, to repair and fill it in by drawing on my own history, as well as on profession-wide ideas and practices that have evolved exponentially since my treatment with Dr. O (who, it should be said, is no longer alive). I hope this project will also contribute something to the discourse on boundary violations.

To do this, I must disclose, selectively, a bit of myself. Autobiography is, of course, subject to various dangers: one is not one's own best historian, and memory is not a value-free scientific method (not to mention the problem with self-analysis, which is, as they say, countertransference). But autobiography is all I've got. Here was the classic trauma, which I kept from myself: the only one I felt could help me was the one who had harmed me, whom I needed, and in whose trustworthiness I therefore urgently had to believe. For Gabbard and Pope (1989, p. 118), sexual boundary violations by analysts may sow doubt, inclining patients to "postpone [. . .] grief work and hold on to the fantasy that someday [. . .] [incestuous] wishes will be gratified." Indeed, one prod for staying in treatment as long as I did may have been a dissociated hope for a repeat performance: a few years past the treatment's second and final end (not recounted here), I was startled to discover a fantasy that Dr. O was

to have been waiting for me at the end of termination road. My struggle in writing this account has been to balance my loss, grief, and fear of shame with the capacity to think (Bion, 1962; Fonagy, 2002). Indeed, perhaps I became an analyst—a process I will later assess—to help me think about something that did not bear thinking, to speak the unspeakable, and to grieve while speaking.

In what follows, I consider the roots of Dr. O's lapse in this strange treatment, which can be deemed both a success and a failure. His transgression issued from the mix of what he, as I perceived him, and I, as I perceive myself, brought to it; conceptual lacunae and technique poorly used; and dangers inherent to psychoanalysis. In Part I, I trace how my muteness wed Dr. O's silence, fashioning an analysis laced with an incestuous streak, a matter I take up theoretically as well as clinically in Part II. In the Conclusion, I reflect on psychoanalysis' collective dilemma: the primal crime of sexual transgression.

Throughout, I will be bearing in mind the professional, intellectual, and cultural contexts in which the analysis took place and in which my reflections have emerged. In that sense, this article may be read as an account of an era in which the deep structure of psychoanalysis began to change. My treatment with Dr. O bridged the late 1960s and the early 1980s, an epoch that generated patients' rights, democracy in the consulting room, the acknowledgement of parental sexual abuse of children, and of course, what preceded them all, women's liberation.

I. The Sounds of Silence

Reinvented by *Nachträglichkeit*, memories are uncertain possessions. When I first began this article, I believed the most shocking piece of Dr. O's betrayal to be his sexual transgression. In reaction, I had shattered: one part of me flourished in its attachment to psychoanalysis, the other lived in terrible, mute remembrance. Writing this article has set these two parts of me in conversation with each other and with the psychoanalytic world. This colloquy has in turn revised my estimate of Dr. O's most stunning perfidy: in the context of the talking cure, his resounding silence, as much as his intrusive act, broke his compact and my heart. Ferenczi (1933), of course, taught us this a long time ago, but it's one thing to read and another to live.

Breaking my own silence has recast the past. Crucially, a seemingly unique moment—indeed, it had been fabricated by dissociation *as* a sin-

gle instant—now appears as, so to speak, *primus inter pares*. Dr. O's *lapsus linguae* was one among many more mundane clinical missteps in my work with a man whose character put a particular spin on a particular sort of treatment, for good and for ill. At the same time, it remains not only a symbol of profound betrayal, but the thing itself: signifier, signified, and referent in one. If, in my memory, the hug, the French kiss, and the hard-on came to stand for the analysis' corruption, the event also stood out because it entailed a sexual act whose repair would have required sexual speech from a self whose pre-Oedipal shell had, at the time, barely cracked.

Looking back, I think that it actually was my silence that I wanted psychoanalysis to cure. And in this treatment I did in fact encounter the new, speaking experience I sought, as well as the same old stuff I didn't know I needed to get rid of. In ways both generative and destructive, Dr. O's countertransference matched my transference all too well. When I was in treatment with him, there emerged a voice that felt more true to my self than any I'd so far heard come out of my mouth or onto paper. At the same time, however, as I began to speak, Dr. O advanced his desire, and then neglected to speak of it, and so a small but vital piece of me just shut right up, went dumb, continued on its silent way. In no treatment is everything aired. But his silence, enhanced by my muteness, fit a pattern in which mutual reflection—on who I was, who he was, what was (not) going on in our relationship, how we might mutually map it—had no place.

Dr. O's Help: Mourning My Mother

Oddly enough (or perhaps not oddly at all), only with Dr. O did I begin to comprehend how damaging silence can be. One of the underlying troubles that drew—or drove—me into treatment was my inchoate response to mother's unexpected death. Except that she had died when I was 20, nearly six years before my first visit to Dr. O, and I was silent about this loss from January 1963 to December 1968, almost six years. It's not that I never spoke of it at all. But I was emotionally silent. I did not know how to grieve, and neither did anyone else in my family. We just went about our lives. For me—as, I suspect, for others in this culture—"process" would become a verb of intimacy only a decade later, in the 1970s, when therapy became a household word in the United States. My family—and friends, and graduate school peers, and husband—did not know that talk was helpful; some still don't find it so.

When, early on, Dr. O asked me how my mother had died, I replied in

black and white: “She was a statistic.” Nonplussed for what would be only two or three times in the years I knew him, he managed to ask me what I meant. As though reading an obituary of someone remotely familiar, I explained that she’d died after a major routine surgery—removal of her thyroid—but that my father had not ordered an autopsy—had preserved the silence—and so the cause of her death was unknown. All my family knew, from some random nurse’s notes, is that in the wee hours my mother, unable to breathe, rang for help. After a tracheotomy, she rang again but—somehow we know this—no one answered. Silence in the dark hospital night.

Responding in Technicolor, Dr. O exclaimed: “That’s not a statistic, that’s a catastrophe!” I do remember the honor I felt upon hearing Him, whom I held in awe already, use such a big word about my little life. The certainty with which he spoke—and with which, we will have to acknowledge, I must also already have endowed him—was a blessing. Looking back, I see that he had properly mirrored my suffering’s magnitude, for which I will always be grateful. I had determined to dry my tears with probability because, lacking both the hard facts that would have been produced by an autopsy and the embrace of a family comfortable with mourning, I could not bear her death’s meaninglessness.

But, in Dr. O’s office, where emotion was knowable and meaningful, this abrupt loss was no longer just one of those things, an insignificant statistic in the history of a population: it mattered. It would never have occurred to our family to place an obituary anywhere, but now, with Dr. O’s assured protest supporting me, my mother’s death made it into *The New York Times* of my mind. My cry, my grief, my attachment mattered. Having received the recognition I didn’t know I was waiting for, I became able to recognize myself, my needs, and my wants. I even began to allow myself to want to know, to investigate my loss, and naïvely phoned my mother’s cousin, a physician himself, for enlightenment. That he could have had no information to offer after so many years was irrelevant: the point is that knowing and wanting to know finally felt safe.¹

The newspaper metaphor is no accident. With Dr. O, I began to (re) find my own voice. I was already claiming possession of it with the en-

¹ I have tried, first during my treatment with Dr. O and then years later, to get the hospital records. But St. Joseph’s Hospital of Far Rockaway, having been closed down twice by the New York State Department of Health, went out of business for good sometime in the 1970s, its records buried in the caverns beneath Great Neck’s North Shore Hospital—imagine the final, ironic scene of “Raiders of the Lost Ark.”

couragement offered by the feminist world I was helping to build as I inhabited it. Still, Dr. O's authorization of my interior life's newsworthiness played no small role in the (re)discovery of my literary self. Writing had come easily before high school, but until midway through my treatment with Dr. O it was a source of terror and paralysis. Likewise with public speaking: facing an audience, I would go mute for a minute as all meaning shredded, the muteness recapitulating my regular, more sustained silences in class throughout college and graduate school. Speech, writing, and voice returned to me both imperceptibly and in sudden leaps even as that flawed treatment proceeded so unevenly.

Dr. O—and, to be sure, psychoanalysis itself—filled a void with meaning: instead of a blank in time, there was tragedy. Without fear of mockery for, as my family usually sniped, “taking yourself too seriously,” I could begin to treat myself with delicacy. I know this seems a contradictory experience to have had with a man who confessed to be a bull in a china shop. In fact, he once recounted, with glee and delight, that his supervising analyst had signed off on his training with the words: “If he can't get in the front door, he'll use the window.” But second-story men are not necessarily unkind. Once, after a tearful session capped by recovery and reconstitution, Dr. O smiled: “I feel like a parent who's just put his kid in her snowsuit and tied her scarf, and is sending her out to play.” That he was the subject of the sentence and I, the object, may be one reason it sticks in my mind. Still, some tenderness made it past the self-involvement that consistently wizened his technique.

His identification as a nurturing parent made an indelible impression. Its strength goes some way toward explaining why I stayed in treatment after his egregious transgression, why I overlooked the selfishness (or shall we call it narcissism?) of his desire, why I kept the faith for so long. It was not only that I fell for him—became imprinted like a gosling—when, having rung him for an appointment, I first heard him speak. What sacrifice—of speech, knowing, self—would you not make on behalf of a man who grasped what you could not, your horrified and helpless vision of your mother drowning in her own blood?

Who spoke when your father did not? I knew the immensity of my father's grief: as the funeral home emptied, I spied him, alone facing a corner, his body caved in by tears. But I did not go to him. I never mentioned his pain and neither did he. After the funeral, someone—I don't know who—handed me my mother's wedding band, as well as a pearl ring given her by my father when he'd risen a bit in the world. Intentionally, I refrained from telling him I had the jewelry, because I feared men-

tion of it would hurt. Meanwhile, he was frantically searching for the rings, because, of course, he knew they'd been in the hospital safe, and he wanted me to have them.

Word and Deed

Will it now seem ungrateful if I notice what Dr. O did not do? Speaking where there was silence, Dr. O helped me mourn. Stepping in instead of abandoning me to my grief, as we in my family did to each other, he named the tragedy and empathized with the anguish it entailed. This "corrective emotional experience" (Alexander et al., 1946) was itself good. But a little inquiry would have come in handy. Speaking from long clinical experience, I wish that, at some point, he had also helped me wonder how unthinkable it had been to register my loss as tragic. Psychoanalysis is not about just ameliorating the patient's state. As I have learned from my own work and subsequent treatments, it is about helping the patient know what helps, which provides at least some of the wherewithal to make a life.

To know what helps in turn depends on recognition, and so it is up to the analyst, in recognizing the patient and receiving her recognition in turn, to assist her self-recognition (Benjamin, 1988). This process entails guiding her through, by participating in (Sullivan, 1953), a reflective process that takes place in a relationship, which itself becomes the object of that reflectiveness as well (Ogden, 1994). This mutually contemplative process by the two knowers in the room (Mitchell, 1997) aims to enhance the patient's self-understanding in a healing way.

To do this, however, analytic technique demands a little humility, a virtue not in great supply in Dr. O's particular consulting room. The certainty with which he pronounced on the immensity of my mother's sudden death had its downside. For example, during some turbulence in my outside life or within the treatment, he would often report, with a sagacious air, that he had sailed these perilous passages before. Of course he had. But it was his absolute self-confidence that he had already charted this territory that would totally reassure me. On reflection, however, it would have been better had Dr. O at least noted how hard it was for me to bear my fear and doubt, instead of simply telling me not to worry because he knew what he was doing.

Perhaps, though, the pleasure in being able to supply what I craved, to embody omniscience, proved too enticing. In this regard, he resembled his peers: Which analysts, trained in the 1960s like Dr. O, did not regard themselves as already *knowing* the map of psychoanalysis? Forget

whether they were classical or, like Dr. O, postclassical: prior to that magical cultural shift called the Sixties, the Doctor Knew, the patient did not, and most providers and consumers accepted and relished this hierarchy. After all, it was only in the 1990s that analysts began querying what the analyst really knows (Mitchell, 1997; Chodorow, 1996).

It goes without saying that the context for my treatment with Dr. O was a hierarchy skewed by sex. Not only as a doctor but as a (heterosexual) older man, Dr. O occupied a prestigious social and economic position. Not only as a patient but as a (heterosexual) younger woman, I was awed. He talked down, in a way once styled as avuncular but now, in the light of feminism, can be named for what it was: patriarchal. And, an admiring girl glowing in the eroticized light of an older man's brilliance, I ate it up, while keeping my feminist activism mostly out of the room, protecting it from his casual contempt, and preserving for myself the glory and soothing of his certainty.

Dr. O's sins of commission and omission were due, then, in part to his era and the state of psychoanalysis at which I first encountered it. To history and gender hierarchy, however, we must add character, and here we find a deep and damaging contradiction. Dr. O was a brash and cocksure man who would wax fulsomely on uncertainty. True to his psychoanalytic philosophy, he would focus on my fear of not knowing: he often emphasized that, if only I could accept the inevitability of uncertainty, I would be far less anxious. Not a bad idea, either, if he had not been so certain about it. Surely my current appreciation of the limits to knowledge has something to do with his influence: when I entered analysis I believed anthropology ought to aspire to truth-producing science, but by the time I terminated, I was in the throes of proto-postmodernism. Still, it is ironic that, given Dr. O's evident intelligence, as well as his inclination to reveal himself, he never took note of the mordant contradiction between what he said about uncertainty and the certainty with which he acted, between his words and his deed.

In this instance, and in general, Dr. O seemed content, even determined, to *do*, to act. Sometimes his action was concrete and gestural—the granted hug—but just as often it was symbolic and linguistic (Harris, 2005). Indeed, maybe his erection, an action if there ever was one, did not spring only from testosterone. Maybe it (and the hormonal flow) arose from his use of his tongue, as an organ first of speech and then of Eros and power. Remember how his speech act turned the hug into the hard-on: he redefined the terms of my embrace by labeling the “real” kiss, thereby, through his eroticized authority, invalidating the buss I'd

given him and dignifying the kiss he demanded. Transforming my active reach for shelter into passive submission to his word, Dr. O found his way back to doing, not to mention (patriarchal) power. Was he unsettled by my claim on that amoral, impersonal sexuality about which *Three Essays* is so passionate? Was he threatened and excited by my anticipated adulterous foray into an earthy and explosive sexual milieu remote from his office? Either way, he resorted to what he himself might have deemed a security operation—which was also a power move to preserve a patriarchal masculinity (Corbett, 1993) whose foundations were being shaken by a feminist earthquake (Frosh, 1983; Goldner, 2003).

I think that Dr. O generally saw himself as a warm, generous Daddy-Mom: his expressiveness and volubility went a long way to make up for my mother's depressive coldness. "Healing in the maternal transference/countertransference" might describe this crucial aspect of my treatment with him. However, in my view, the analyst is not another parent; his or her job may be to soothe, but not only by doing. Analysts should also think with patients about healing so that patients can notice something about their own needs. This is not exactly a matter of interpreting or not interpreting the positive transference or not. Rather, we would say now that it is about reflecting on the repair, on finding the new in the old or, even, the new in the new (Boston Change Process Study Group, 2008). In helping you to re-represent your experience, the analyst offers the means to reclaim and regenerate your own life.

Whether he acted soothingly or sexually, Dr. O usually did so without processing. I think he mostly shot from the hip. The high-calorie emotional diet he served was crucial to my psychic malnutrition and I devoured it. But it lacked a critical nutrient: shared self-reflection. Clinicians are familiar with that stubborn resistance to processing the "unobjectionable" (Stein, 1981) transference: things are proceeding apace, the patient appears to be improving or having insights or progressing in one way or another, the analyst is proud. It is harder to hold on to the advice Sullivan allegedly gave—"God keep me from a therapy that goes well [. . .]!" (Levenson 1982, p. 5)—than to savor the feeling, "If it ain't broke, don't fix it."

Sotto voce

Psychoanalysis runs on the ordinary silent energies by which people stumble their way to each other (Coles, 1998). It puts projections and counterprojections to work, turns them into tools, systematizes them, and makes them explicit. Assessing this complexity, Levenson (1983, p. 72)

argues that the analyst and the patient always do what they are talking about: “every verbal exchange [. . .] every interpretation, consists of a piece of behavior with the patient and then a commentary, in speech, on that behavior. The commentary, the content of the interpretation is [. . .] the metamessage.” Clinical theory then directs the clinician to decode this recursiveness—transference and countertransference—into voice, with the patient, this pattern that, first informally established in the family kitchen, repeats in the different lexicon of the consulting room.

Recursion suggests, in a funny way, that silence, or at least what is unspoken, is inevitable and even vital to the talking cure (Stern, 1997). On the one hand, the important thing about free association (if there really is such a phenomenon) is when it stops—when silence breaks the flow, and the repressed or dissociated signals its presence. On the other hand, sometimes we do what we say before we can say what we do, because, in some cases, we cannot know what we have to say until we materialize it by enacting it. Then, according to current enactment theory (see Leary, 1994, for a review), our raw material comes alive before our eyes in a tangible drama. In the analyst’s and analysand’s collective hands, enactment becomes fodder for conversation, from which they create the liberating analysis. Then again, sometimes silence is merely about private space, the clinician’s or the patient’s, and as such ought to be left alone (Winnicott, 1971; Khan, 1974).

The silences between me and Dr. O, however, constituted one big recursion. In other words, silence that reflects anxiety (i.e., not talking about an enactment) can itself be an enactment. One thing you could say about the me who came to see him: I did not speak very much, which is probably a surprise to those who know me now. The habit of wordlessness, as I learned from my second analysis, was not exactly innate. Or if I tended toward silence, I also made it a way to survive. Many years ago, friends would experience my quietude as withholding, even hostile. Maybe the sound of inhibition inverts the unconscious attack, but I was aware mainly of the fear of sounding stupid. Shame was my constant companion. Now, casting my eye back, I see that quieting myself—dissociating what I saw and felt and knew—helped me manage my internal life. I was making a strenuous effort to wrangle emotions, passions, and thoughts that felt too noisy in my family and the world.

Family rules authorized loudness for my father and brother, while my mother tiptoed around, whispering the words “*Sotto voce*,” and I was what they called “quiet.” Which I knew wasn’t a good thing, even if

my mother, leaning on Italian (which no one spoke, but which perhaps seemed refined, not coarse like her parents and husband), urged everyone to hush. The failures subtended by quietness—tantamount to being good—heightened my sense of a core defect. My silent manner stumped my parents. That I knew, with the same dissociation with which I knew they settled for it in the face of more obtrusive troubles—my father's brittle narcissism, my mother's depression, and my brother's near-delinquency. Anyway, the social worker to whom my mother took us for family therapy said, "She's okay, leave her alone." My brother was the identified patient, while my father's fearful and selfish, if gender-normal, refusal to attend sessions, ruined my mother's brave intervention.

Within the blankness that lulled my teeming mind and was also meant to calm my storming family, I was lonely (as, I now think, I was with Dr. O, though neither of us realized it). Unfortunately, under the indirect rule of *sotto voce*, any expression of distress would come across as, and sometimes indeed was, merely obstreperous. My own expressiveness would, in turn, further reduce both my mother's self-esteem and my own; my failure to validate her inflamed my shame. Only my father had the privilege of apparently shame-free, wordless self-expression—the smack here, the shake there, the storming out the door for the rest of the day. His brutality, mantled by silence, was unveiled only when I began peeking: my second analyst's hunch caused me to query extant kinfolk (my father's death followed my mother's by nine years) about family violence. When I was 18 months old, said a cousin 20 years older than I, she overheard her mother speaking to my mother, who was worrying that my father was being "too rough" with me. Did "rough," I asked, mean hitting or shaking? "Oh, not hitting, I think, just shaking," replied my cousin.

Three points to note: my father was shaking me; my mother may or may not have been stopping him, or trying to; and she wasn't sure anything was wrong. Of course, a third-hand report about an event from over a half-century ago needs many grains of salt. That my father also brutalized my brother (who attests to this) proves his capacity for violence, which I must have witnessed. Surely both culture and character were active here. In my parents' immigrant families of origin, beatings and verbal abuse were routine, a legacy of cultures where corporal punishment was standard and immigration brought economic hardship as well as political and cultural safety. That my father seemed to have no hesitation about physical abuse and that my mother appeared to ques-

tion but nevertheless put up with it—this difference may have had also to do with gender as well as character. Certainly the blue-collar chip that he wore on his businessman's shoulder had something to do with his attractive cockiness, defiance, and tendency to bully.

A quiet girl patient must have been a mixed blessing for Dr. O. He never addressed my paralyzed silence as such—and to have done so at the times of my most shameful muteness would have been tactless—but even then, I could tell from his repeated efforts to work around my voicelessness how trying he found it. Clumsily persistent, Dr. O would often ask, “What’s in your head?” Perhaps making him toil gratified me, but mostly I felt helpless. It may be that all those years with him laid the groundwork for my second analyst’s success in helping me to put words to my silence. Or it may be that my second analyst eventually addressed directly that which held my stubborn muteness in place, the helpless shame I wore like a *burka*, which, hidden in plain sight, Dr. O never mentioned, at least not until it was too late.

Pre-Oedipal Delight, Oedipal Shame

Writing this article has gradually heightened my awareness. Now I see that, at the same time as the pre-Oedipal, maternal failure was being repaired, an uninterpreted Oedipal and (mostly) paternal repetition was taking place. If the one signals the success of the treatment, the other marks its failure. Even if it is generally recognized now that pre-Oedipal and Oedipal matters and themes show up in a mix, separating them helps me think. For example, it allows me to put into its proper context Dr. O’s denigrating response to my admiration for a professor who’d researched the ritual use of hallucinogens among the Jivaro of the Brazilian Amazon: “Aw yeah, he’s an academic, he’d *have* to do those drugs.” My puzzlement upon hearing his castrating words emerges now clearly as a life-preserving but also stubborn defense against dismantling the savior-mother so as not to unveil the destroyer-father.

If my silence obstructed Dr. O, the scope it offered his self-expansion must have been a delight. Or so I guess. This was a man full of himself, I can now safely say. From the vantage point of an altered psychoanalysis and a changed me, I can avow the appeal of this off-putting quality to me, a person whose self seemed like something no one would want, let alone be full of. When Dr. O spoke, he seemed to enjoy himself, to stretch out into his words and ideas. Looking back, I see myself enjoying his (macho display of his) enjoyment. I see myself watching in both imprinted awe and heterosexual wonder someone so apparently free and

happy in his expressiveness. I see myself craving such delight and pride. Now, as a clinician, when I find this yeasty pleasure rising (Smith, 2000), I try to take such (hierarchical) self-indulgence as a warning: why is the room filling up with my voice, not my patient's? But as a needy patient, I was inspired to imagine myself a free speaker who liked herself while speaking.

If my silent rapture was implicated in a heterosexual gender hierarchy, it may also have been part of an uninterpreted pre-Oedipal (maternal and/or paternal) transference. It was a joy to be spoken to, and with, and in front of by him. I was always happy to be with people who spoke fluently, because then I had to be neither lonely nor verbal. But, with Dr. O, this safety had wings of ecstasy. When Dr. O mused on ideas and philosophy, he seemed to take me into his confidence. If little of what he said has lasted, I do recall my (unstated and unanalyzed) bliss. His flattering implication of a mutual intellectual footing resumed a trajectory I'd lost when my mother died (and never had with my father). He offered a life of the mind that she'd pined for and, judging, for example, by our memorable museum trips, wanted to share with me. Inferring from my own experience of patients who are excited to be with me, my rapt attention encouraged him, and the pleasure he took in me was likely fueled by my intensity.

Perhaps each patient brought him this pleasure. But I felt special, a treasure bought with silent shame. Fascinated, if also slightly repelled, I swallowed his "stick-with-me-kid" insinuations. When, on occasion, he used that patronizing cliché, he may have been playing, but irony is not the best dialect to use with a five-year-old excited by an idealized grown-up. Needless to say, our habit of engaging without noting the quality of our interaction would have fed my dissociation of how his paternalism both drew and disturbed me. For instance, a year or so after I had begun analytic training, he said, in that off-hand macho manner he liked to affect, "Theory? That's for the geniuses. You and me, we're mechanics, we stick to technique." You will not be surprised to hear that I was struck dumb by his misrecognition of my interests, as well as by his splitting of theory and clinical work. Could he have missed my passion for theory manifest in my graduate anthropology career? Perhaps I had been indirect, or maybe the theorist in me did not show very well (and in all likelihood theories of cultural evolution did not interest him). Nor is it a secret that, even after 8 or 12 years of treatment, patients can still surprise us with unsuspected traits and interests.

You might count this as a grossly botched pre-Oedipal paternal coun-

tertransference (Benjamin, 1988), but I think we were in the Oedipal bramble as well (Cooper 2003). Dr. O's ignorance of a central aspect of my intelligence dashed my hopes for the meeting of minds that never took place with my father. Certainly his creation of a hierarchy between the intellectual and clinical practices of psychoanalysis—his splitting—put me in a bind. Pulled toward the “us” he made of him and me, and away from the “them” he proposed we were not, I found no space clear of shame. To have accepted his characterization of “our” interest in technique meant to gain mutuality with him but disown what I valued in myself (the theory part), which was a loss akin to the shame of deficiency (Stein, 1997). But to have claimed the theory side at that precise moment would have been to claim genius, risk the shame of excess (Stein, 1997), and lose him. Thrilled to be among the honest elect, if also humbled and embarrassed to join the laborers (my class mobility was not irrelevant to this treatment), I elected neither to interrupt his inverse snobbery nor to damage his pride: I declined to observe what I unknowingly apprehended—how his narcissism disguised his intellectual self-doubts.

Dr. O took no interest whatsoever in analyzing the Oedipal transference/countertransference, only in enacting it. From time to time towards the end of my treatment, I would complain: “But we’ve never really talked about my father.” No response. I dreamt of a man in a Speedo with a mesh crotch. This reference to barely veiled male genitalia would surely, I thought, lead us to my father, sexuality, and, I see now, the erased enactment, not to mention Dr. O's other narcissistic self-display. Nothing. I did not know how to push it further. All I recall is a later, rather mad prediction he made as if in reply: “One day, you’ll dream about a desirable man, maybe at a conference, and he will be your desire.”

II. Desire and the Incest Taboo

However much Dr. O might have helped me (re)start my fire, he often stood in its light. Invigorated, perhaps, by the patriarchal dialectic animating us, he rarely left me alone-while-being-held to discover my desire's vicissitudes. Instead, in a mutually exciting way, he inserted himself into my lack (Lacan, 1966; Bernstein, 2006). Clotting my desire with his, he generated a holding pattern—a psychological incest—in which we hung in a sort of suspended animation for far too long. It is futile, if ir-

resistible, to wish he had done things differently. Still the longing for what might have been can inspire a search for what could be. In what follows, I will assess Dr. O's Oedipal failure. Although he and I did not—could not—talk about it then, now I can delve into that atmosphere thick with longing, frustration, and shame by using some new ideas about desire, Oedipus, and incest.

Dumbshows of Desire

Desire is about longing, not having. It may be sweet or poignant or terrible. But without it, one is as without appetite. And its preservation is accomplished, at least in part, by the prohibition on incest. Desire entails several paradoxes, and it seems useful to lay them out here because they manifested so oddly and silently in my treatment with Dr. O. Chief among these is desire's ambiguous location both between and within those who feel it. Claude Lévi-Strauss (1949, p. 12) mines the irony: desire, he aphorizes, is our "only instinct requiring the stimulation of another person." The relational version might be that desire emerges in relationship but, belonging to the child alone, survives only if lightly held, even benignly neglected, by the authorized caretaker(s).²

Eluding the neat binary between one-person and two-person psychologies, desire centers a tricky debate that one must enter, if perhaps, as Levenson (1994) writes, with trepidation. In one-person terms, desire seems to spring full-blown in intrapsychic process, almost a species characteristic. In the linguistically-based Lacanian view, it emerges as a consequence of the failure of speech, of the gap between the Imaginary and the Symbolic. From a two-person vantage point, however, desire turns out to be oddly intersubjective. Lacan (1966), in turn, mindful of Lévi-Strauss's assessment of desire's doubleness, situates its origin in a relation that is, all the same, not quite a relationship: as the yearning to be the object of the (m)Other's desire, it emerges in pre-Oedipal (maternal) intimacy, a nexus situated, however, in the presymbolic Imaginary. Levenson (1994) would have it both ways, insisting that "desire requires

² As Freud (1913) already knew, it is vital to locate the incest taboo in culture. Outside psychoanalysis, the incest prohibition has been variously theorized. Evolutionary biology deems it an adaptive mechanism, because genetic inbreeding generally endangers species survival. With marriage and kinship as subtext, anthropology argues that the taboo, by sanctioning particular sexual and procreative relations, forces families to intermarry, thereby, in Lévi-Strauss's (1949) view, weaving the bonds of society itself or, from other angles, at least darning them. Thus, transmitting and/or maintaining the incest prohibition becomes a social function that might be dubbed a sexual third.

another person" (692) while stressing the "peculiar paradox built into this wish to find one's completion in the regard of the Other" (693).

Between and between, desire tends toward the cryptic, a quality attended to in several psychoanalytic traditions (with which I wish Dr. O had been more familiar). Winnicott (1971) and Khan (1974) place it in a private self that, to one's pleasure and regret, no one else can access. Laplanche (1976), in turn, deems it an enigma. Beamed from the maternal (or, as one might now emend it, *parental*) unconscious—always already sexual—(Kristeva, 1983), desire registers in the infant's psychic reality as an "enigmatic message" that, in its muteness (Stein, 1998), eludes the promised clarity of the talking cure.

Desire's wordlessness often reduces us to bumbling idiots. Yet (or therefore), analysts need to create a way at least to talk about this "alien internal entity" (Laplanche, 1976), whether or not it manifests as explicitly sexual or not. That desire is mutually experienced and meaningful (Fairbairn, 1954; Mitchell, 2000; Davies, 1994) is certain. That shared speech—intersubjective understanding—can decipher its meaning is, however, less clear. What analysts can do, which perhaps the parent cannot and certainly Dr. O did not, and which patients like children need to hear, is to acknowledge and articulate this unspeakability.

If Dr. O's *lapsus linguae* showed rather than told, I gave as good as I got, or maybe better (this story is not without my own aggression). Some years later I put on a dumbshow. Dr. O's Danish modern couch was oddly positioned: its foot abutted the wall and its head protruded into the room. His chair, four or five feet away, was angled at about 45 degrees to the head of the couch, thus affording him a full-length view of his reclining patient. When I sat down on the couch or rose from it, I faced him. But one day, at session's end, I reversed my action. Instead of facing him as I stood up, I impulsively swung my legs over the couch's far side. Feeling an obscure frustration devoid of any accompanying thought, I knew I was protesting, but had no idea what. Nor do I recall our discussing this pantomime at all (which doesn't mean we didn't).

His gratifying look of surprise, which greeted my good-bye, was nothing compared to what happened another time, when, having risen on the usual side, I turned away from him and began lifting the couch along its length in order to flip it. As I was doing so, I glanced back to see his eyebrows practically somersaulting. But he only said, "Watch your purse, it's going to fall." Setting my bag on the floor, I turned the couch over. I

am pretty sure, though, that, before I left, I righted it and replaced the pillow that had landed on the ground.

At that early date, Dr. O could not have read Little's (1990) later account of smashing Winnicott's vase. Still, let us congratulate him for having survived this disruption of his office, and for having stayed his anger at my attempted parricide (Loewald, 1979). Let us sympathize with him too. In the face of a patient's act, who is light on their feet? By definition, Lacan (1973) insists, the Real leaves most of us speechless most of the time. It is only after the fact, upon reflection—usually with someone else—that we can begin to name, with varying degrees of success, that which refuses symbolization. Myself, not having had the chance to talk this over with my analyst, I am going to talk it over with you, with the community that, as I will relate, I chose in Dr. O's stead.

Looking back, I want, first, to read my very modest temper tantrum literally: What was I trying to upend, halfway through my treatment, by turning the couch upside down? Something about the consulting room? Or *his* consulting room? Psychoanalysis? The couch itself? Was there an old order I was trying to overthrow in those days when cultural revolution and political protest were either in the air or recent memories? Maybe by making the medium my message, I was pointing out (a gesture in itself) that he was doing something too. Perhaps I hoped my mime would make silence speak. It is hard not to infer that his dumbness, his not-speaking, was my target.

But, in writing, I am also drawn to the symptom's specificity. If incest was in the air, Oedipus was not far away either. It is worth noting that I did not remove from the wall the line drawing of the prone naked woman hanging above the foot of the couch. Half-aware of the unsettling fantasies and wishes it excited as I gazed at it three days a week, I might have wanted at least to protest that this décor sexualized the room or, rather, that Dr. O had eroticized his office with it. Instead, I wrote a poem about it, but never told him. Did I fear he would retaliate, invalidating my complaint by deeming it a projection of my desire? Or having penned the verse only 14 months after Dr. O's lapse, was I reluctant to disturb sleeping dogs?

Here, I suppose, was an iatrogenic repetition compulsion. Or shall we call it collusion? Enactment? If I wanted to turn my back on the treatment's rot, maybe I also wanted to keep it hot. Doubtless, I wanted Dr. O to want to look at me all day too. But, I see now, I would have felt so

stupid had I shouted: “You think she is more beautiful than me and I hate that and I hate you for making me feel jealous and ugly by hanging this drawing where I know you gaze upon it too!” Jealous of an image? How immature is that? I needed help with this triangle but got none.

This silence—mine, Dr. O’s, ours—about what his décor meant to me entailed an unanalyzed Oedipal repetition. It prevented reflection on the fact that, for me, sexual crudeness, disrespect, and love came in the same paternal package. Consider my fascinated horror in the face of my father’s sadistic lewdness. For example, his jest at a family Thanksgiving—“Are we having sliced breast of Marilyn Monroe?”—could register and be assessed only in my second analysis. Who knows what primal scene fantasies Dr. O and I might have come upon had we scrutinized my response to his aesthetics? Instead, I just felt sick, sensing but unable to speak my gloriously self-abnegating desire to slice and dice myself so as to win a patriarch.

Typically transforming anxiety and shame into thought, I now recall noting that, like me, the artist’s model was lying down. At the time, I failed to connect the dots. In contrast to me, for example, she was physically naked but a psychic cipher. I, on the other hand, was trying to undress for the doctor in hopes he would heal my torment. From my second session onward, I believed that, if I told the whole and especially the most shameful truths to this man who knew better, I would get better. And maybe, I may have gradually come to hope, he would love me more than her.

No, when I got up, I flipped the couch instead. I do not think I was exactly trying to show that I disliked that couch or its weird positioning. Perhaps I was defying his injunction at the beginning of treatment: “You can do whatever you want except spit on the floor or break up the place.” Except I did, as I noted, clean up after my fit. Perhaps, then, I was flipping the bird at the whole set-up. Consider this: even if the viewer saw the model as though from the foot of the artist’s divan and me from the side of Dr. O’s couch, still Dr. O, from his rather more in-charge position, commanded a view of both of us, differently naked, lying on our backs, the object of his gaze. At ease in his slightly reclining chair, not hidden behind analytic neutrality but, rather, clothed in his power to disclose whatever he pleased about himself (or not), even as I was obeying the command to reveal all (Foucault, 1976)—he could contemplate not only her pulchritude but my young embodied self, which was, I now understand, far more attractive than I knew or could handle. (Although

tempted, I will refrain from speculating about his fantasies of two prone, bare women in his visual field.)

To put it starkly, the room's layout made him its subject and the analyst—in this case, me—his object. That he seemed in charge of his desire was made more exciting by his charge of me. Dr. O's masterful vantage on me (and the image) was pleasing, titillating, and deeply distressing. Once, I seem to recall, he voiced pleasure in my stocking-ed legs; it may have been when, six months into treatment, I was considering the couch. If I can still picture his smile, I recall only nonsense: he liked (women) patients to lie down, he said, because "I get to look at their legs." I was, I see now, both delighted and dismayed that he shamelessly acknowledged exploiting the couch, not to mention the patient, for his own pleasure. I was also jealous of these other patients, as well as unsettled by his mentioning them. Decoded in hindsight, his remark unconsciously introduced, without analyzing, the Oedipal dynamics already at play. But at the time, my mind grasping at nothing, I found only the shamed suspicion that, as the cliché goes, he said that to all the girls, a fairish bet because he was really talking about no one but himself.

In fact, I have a hunch that central to his self-image was being a man who made no bones about his enjoyment of women, who, he believed, enjoyed his desire. Yes, I can imagine that, working in emotionally corrective mode, he thought his compliments would heal my fractured and frightened sexual narcissism: perhaps, at least momentarily, believing in the omniscience with which I endowed him, he may have thought that I could take his (hetero)sexual appreciation of me as the truth about myself. Yet, even within such a sad and harmful delusion, had he inquired how I might feel about his admiration, he might at least have helped me to my own language, desire, and mind. Given a moment to name my shamed pleasure in being only (*only!*) the object of his desire, I might also been able to claim the more tacit wish to sit not on his lap (a desire he once attributed to me in a fit of ill-timing) but in his chair, to command a view not so much of the patient as of myself.

Dr. O should have kept the noise of his desire to himself. I do not fault him for having it; I fault him for not making room for mine. Sex may encompass both relatedness and enigma, but that it remains a site of selfishness (see Stein, 2005) makes it dangerous—if also by that token exciting. It is good to remember Freud's (1908) original insight about the amorality of desire. This ruthlessness may show up in mind as well as actions, in incest of the heart as well as of the body. Indeed, for Dr. O and his pro-

fessional kin, perhaps being the object of patients' (unregistered) unrequited love/lust is as gratifying as sexual intercourse itself.

Intersubjectivizing Oedipus

So maybe civilization begins when parents (not, *pace* Freud [1913], the siblings) recant their incestuous desire. By tradition, the incest taboo is read through the Oedipal drama, which stars a unique subject of desire, a child who must single-handedly manage triangulated love and hate (Freud, 1913, 1924). To be sure, the father has a supporting role, for he disrupts the (incestuous) mother-son merger so as to redirect the boy's desire away from his mother (and father) toward a future mate.³ But, in this classical account, the parental objects otherwise lack subjectivity. Postclassical revision, in contrast, thickens the Oedipal plot, recognizing that insofar as the play is only internal, it tells but part of the story. Fairbairn (1954) and, to a lesser extent, Kohut (1977) cue the dyad: The child is not onstage alone. Front and center are the parents as subjects; their pleasure, inhering as it does in object-relation, influencing if not generating the child's.

Erasing sexuality from the equation, however, this quiet revolution overcorrected, a problem remedied by later relational revisions, especially Davies (1994, 1998, 2003) and Cooper (2003). Not only do these new narratives resexualize the Oedipal child, they also recognize that parental sexual desire circulates in the family field altogether. The classi-

³ I remain uneasy with the classical implication that mothers, or women, cannot self-regulate. The notion of father as principal moral guardian is troubling. Although I understand that Freud and Lacan claim to describe and account for the intrapsychic process by which the turbulent triangular space is traversed, I cannot help being distracted by the sociology: the prevalence of father/daughter incest, which is the most common sort of intergenerational intrafamilial sex (Turner, 1996). So if the paternal principle is deemed to interrupt the Imaginary in which mothers' and children's unboundaried incestuous desire flourishes, nevertheless the relative frequency of paternal incest suggests that fathers might have a bit more difficulty actually regulating their own incestuous acts. Likewise, even if one accepts a woman's place in the psychic interior as a signifier for absence, women still have a subjective life. By definition, then, mothers are capable of self-reflection and hence self-regulation (Benjamin, 1988; Ruddick, 1980). And, if the lesser frequency of maternal incest is any indication, their capacity for self-awareness and self-management might very well mean that their need for the regulating father has been exaggerated, thank you very much. Perhaps it is only my experience with Dr. O that makes me want to consider incestuous desire at once unconsciously motivated, subjectively experienced, and intersubjectively (and socially) lived. But I do not think that is the only reason I would prefer a narrative that allows for both interiority and intersubjectivity, dyads as well as triads, and for parental self-regulation in relation to the incest taboo, itself seen as a Third (Benjamin, 2006) that both contextualizes parent-child relations and permeates adult psychic process.

cal model has the Oedipal parent (i.e., the father) aiming to preserve his conjugal rights (which reads as a power move as well). But, according to this construction, the father does not reciprocate: he does not surrender his desire for his son as his son forsakes his desire for the parents. Post-classical models, in contrast, redraft the Oedipal story by construing both desire and its renunciation as intersubjective. Together, Oedipal adult and child forswear their mutual sexual desire, with the former facilitating the latter's renunciation.

Costarring in these emergent Oedipal narratives, therefore, are the parents and their sexual desire, whose underexplored and possibly even buried psychoanalytic history (Balmary, 1979; Krüll, 1979; Masson, 1984) contains a puzzle or two. Some archeological work being in order, I wonder whether some light might be shed if, heuristically, we were to divide the Oedipus from the incest taboo, using them as twin lenses through which we could view the same drama? If, that is, we consider the Oedipus as speaking to children, could we construe the incest taboo as addressing adults, even while we view both processes as concurrent and interpenetrating? This stereoscopic view might amend a lacuna in the new narratives, whose perhaps necessary tendency to occlude a triad in favor of a dyad two-dimensionalizes a three-dimensional process.

As I see it, the Oedipus, a developmental crucible, infuses a nascent psyche with a particular genre of desire in a triangular space. At the same time, the ban on incest embargoes the materialization of adults' desire in dyadic relation to their children (and, in the background, to the other parent). Possibly delivering a developmental torque of its own, the incest prohibition addresses substantially formed beings, the adults in charge who, adept at personal and intersubjective multitasking, can hold the other(s) in mind without erasing the self; tend relationships (dyadic, triadic, multiple) without the self-sacrifice from which children need protection; and, in fact, find this juggling act self-enhancing (a partial job description for analyst and parent alike; see Cooper, 2003; Davies, 1998, 2003).

These twin injunctions on desire's realization are interimplicated, their accomplishment is interdependent. The Oedipal fiat demands that one abjure the fantasy of sexual and personal completion with one's parent(s). But one cannot achieve this loss without the parental willingness to endure the complementary loss (Davies, 1998, 2003), that is, to tolerate and grow from the suffering caused by the ban on materializing one's sexual desire for one's child (a submission implicit in Loewald, 1980). This inter-

subjective context, in which adults can reap the bittersweet power and pleasure of helping children toward their own sexuality, resonates in the analytic dyad, where it requires reflection as well as (in)action.

The Analyst's Refusal and the Patient's Desire

As goes Oedipal resolution, so goes the adult incest taboo: neither is ever fully accepted or resolved. The relation is likely causal: to the degree that adults' own Oedipal closure is always only partial (Meltzer, 1973) and precarious (Freud, 1924), their observation of the prohibition becomes as difficult as it is necessary. Lingering Oedipal regrets, stirred in adult fantasies of revitalized fulfillment, haunt analysts too (Gabbard, 2008; Twemlow & Gabbard, 1989), even Dr. O. However intersubjectively carried such ecstatic fantasies of repair, still their disposition belongs finally to the person in charge—parent, analyst—who must register their presence but forego their realization. Achieving this surrender—tolerating the permanence of sexual melancholy—is no small task (Davies, 1998, 2003). It requires support from various sources, what Benjamin (2006) calls the moral third but also all that is denoted by *le nom du père* in its protective as well as disciplinary sense—community, culture, morality, the Law. This accomplishment is crucial: the negotiation of desire that constitutes one's life flourishes when tended by another's restraint.⁴

Dr. O's refusal to examine Oedipal dynamics inhabited an intellectual and clinical void. He did not employ the classical one-person model; and a two-person model of sexual desire, in which adult desire may serve as a technical consideration is, as I have noted, still in the making. At the same time, other factors were at work. Framing that void were not only flaws in his training and gaps in psychoanalytic knowledge, and the enduring power dynamics of authority and of gender, but, I am sorry to say, basic character faults too. Woulda, coulda, shoulda. Yet I cannot help but wonder what might have happened had psychoanalysis offered a theory of adult incestuousness as a partner to its theory of Oedipal longing. Might all the Dr. Os out there, including my own, have been able to keep their desire to themselves and leave room for their patients?

What I wanted was a paradoxical—and reparative—relation in which “me-first” happily puts itself second. What I got instead was a “me-first” on parade, its glow magnified in and by my delight. To be sure, he did

⁴ At least within the culture I know, for I am too much of an anthropologist to make this a universal claim.

opine on my identificatory wish to be the center of my universe. Still, the sort of reflection I required was rather more mutual than Oedipal, a sort of dyadic version of the triad, what we can now call the pre-Oedipal homoerotic transference/countertransference (Benjamin, 1988). I needed to hear more about us, less about him. I have no idea whether, beyond (I suspect) reductively deeming his passion for me “natural,” he mulled what he did and felt. He should have. But then, given that he had materialized his phallic desire, I needed him to show his analytic desire too, to make some version of his private musings public between us, so that together we could process what was going on for me, what his actions and feelings had to do with mine.

As is well-known, if perhaps infrequently articulated, analysts’ ability to contain their own desire with self-awareness equates to parents’ observance of the incest prohibition. Such self-conscious containment creates and protects a gap in which the patient’s subjectivity can come into its own (Bernstein, 2006). Bound to the mast of professionalism and care, analysts, like Odysseus (Wilner, 1998), ought to hear but not dance to the music of patients’ desire. Their holding back depends on their cultivated capacity to recognize and contemplate their own desire (hence the required training analysis).

Recursively, in fact, the two abilities, to reflect on desire and to contain it, enhance each other. One may read Odysseus’s mast as phallic (*le nom du père*) (Schein, 2009). Or, with Benjamin (1998), one may theorize the labor of holding and reflecting as a (traditionally) maternal practice: revising the active/passive binary, she argues that passivity is not just activity’s opposite, but also signifies containment. Others (e.g., Davies, 1998; Cooper, 2003) style this work as an analytic capacity, technique, and obligation. They argue that, by detecting and analyzing adult sexuality, analysts can decode and manage sexual countertransference.

Conceived thus, the taboo on adult incest causes a rupture—the parent says “no”—that allows one to know one’s own desire. By making room for child or, *mutatis mutandis*, the patient, the two-person materialization of the incest prohibition cultures a one-person experience. The ban, observed, opens a space (in Lacan, a lack [Mitchell & Rose, 1982]) that is at once full and empty (which might be as good a description as any to capture the feeling of desire). This opening is replete with potential: the option of sex between parent and child or analyst and patient, ruled out, transmutes into the child’s/patient’s potency and fantasy (see Samuels, 1996, p. 310). The parent/doctor who slips desire’s leash leaves the child/

patient at once famished and over-full. By contrast, analysts who contemplate their passion for their patients can exchange stolen pleasure for the sense of a job well done. They can savor a subtle, privileged view of dependents becoming what they need and will: autonomous (Cooper, 2003). Or, to be more realistic, analysts may get to survive the equally delicate pain of watching patients make their own errors and discover that they no longer want what they once (thought they) did—which may, indeed, be one way to capsule the Oedipal resolution.⁵

In revising the psychoanalysis of incestuous desire, it is important to render desire as neither wholly discharge-driven nor solely object-seeking. What matters is that, insofar as the ban on incest is observed, childhood's bolus of longing and loss, of disappointment, shame, and anger, is part of growing up. Parents cannot save their children from it, just as analysts cannot save patients. Indeed, they foster it and, with it, an interior space for imagination, wish, and fantasy. One of those predictable life wounds that Freud warns about, the suffering of unrequited love, is also key to a certain freedom: having endured it, one both gains oneself and is spared the unbelievable confusion attendant on one's desires being granted by the very other from whose desires one is trying to free oneself. One is granted the room to create oneself as if one were autonomous. I am here varying Benjamin's (1988) paradox of separation. If independence requires separation from the (m)other on whom one depends, so claiming one's desire, in all its impossibility and ambiguity, rests on having it separately and, in effect, differently from those with whom it birthed and still lives—and who understand the pain they inflict.

Hence my wish that Dr. O, the man who listened as well as talked,

⁵ Can tantrums signify the ineluctable, fatal twinning of parental failure and unrequited love? If so, then, when recurring in transference, they need interpretation. In my case, they required countertransference analysis as well. I am guessing that, if Dr. O had mulled his desire and its object-relational context, then maybe, rather than flinging things around (albeit in slow-motion), I could have identified my tangled sexual, filial, and romantic longings. Instead, my tantrums fed on a mess of unregistered desire, disappointment, shame, and anger. In the relational view, such a vortex may be a developmental certainty. Or so my reading of Fairbairn's (1954, p. 113, n. 1) revision of psychosexual theory suggests. As he sees it, (sexual) frustration registers as rejection. It is true, he writes, that "frustration" might accurately describe the classical Freudian construal of drive denied its outlet. But if, as he proposes, libido seeks and enjoys connection, then frustration means that a desired attachment with another has failed. To the extent that such failure registers as lost love, the object's dis/regard will in turn seem repudiating. Taking this further, I would add that rejection morphs into humiliation insofar as the child, sparing the beloved and needed object by faulting the self (Winnicott 1975; Guntrip 1973), comes to feel like a fool. Finally, shame snarls with (more) unwelcome anger and, *voilà*, a tantrum.

would have helped me utter the dilemma of our real relationship: getting what I wanted—emotional and corporeal incest—kept me from realizing my need, that is, a validation of the legitimacy of my complaints. If you can reflect on it, unrequited love permits you to sense your desire *as distinct* from, other to, the desire of the other who matters to you as much as your own life. But you need someone else to help you do it. This growth takes place via the experience—or maybe even a fantasy—of being held by a parent or analyst or teacher or author or, I suppose, even an idea. Symbolizing the previously unsymbolized, the abjection (Kristeva, 1982) that survived results from such restrained containment, and constitutes a painful, profoundly personal corner for self-knowledge and self-containment (perhaps Eigen's [1981] "area of faith"). You need to be able to experience your desire, abject and soaring, with your parent who is feeling this too and knows it and is intentionally not acting but is instead bearing the poignant sight of your passion as it bursts into flame, you with whom your parent has identified, whom she or he identifies as her or his own, and whom she or he is allowing to live.

When, instead, that noisy "confusion of tongues" (Ferenczi, 1933) clogs the space that ought to have been full of nothing but piercing possibility, longing dries up. A dream I told Dr. O: "There was a man named Sussman, I think we knew him in the country. Out of his lower bicep, which had somehow been pierced, drained a liquid, a mixture of sugar, vinegar, and water." Dr. O did not opt to interpret "Suss" as referring to the contemporaneous idiom for discovery: "to suss something out." Nor did I. Instead he chose the bucolic reading: "*Süss-man*, sweet man, aren't you talking about your feelings for me?" He ignored the vinegar (semen is only sometimes sweet) and, in an unconscious, sublimely self-immolating blow-job, I let him do it by acting as though his omission (emission?) had not taken place. In this narcissistic evasion of the bittersweet, he resembled my father, who, unable to bear criticism or imagine himself as hurtful, appeared to ignore love's ambivalence.

You need, as I say, someone to help you. And although an adult love relation may offer this help, it is fairly unlikely. I have often wondered about women I treat, as well as those in my acquaintance, who pine for lovers they cannot have. My sense, speaking from my own experience too, is that those suffering this particular variety of unrequited love—especially the heterosexual subjects of *Women Who Love Too Much* (Norwood, 1985)—want someone they cannot have because they want not an object but a boundary. (This may also be true of some men.) Unavail-

ability symbolizes the limit they long for, the incest prohibition observed in heart and/or body. They aim to redo a vital if bungled childhood process, not to self-destroy.

They seek their own desire. They want *not* to be able to have their parent(s), despite a mutual longing (Samuels, 1985, p. 168), so as to be left with nothing *but* their own private desire in all its differentiating, lonely pain and hope. Unfortunately, if, as an adult, you try this “do-over” with lovers whose self-restraint in service of your growth neither can nor ought to be expected, you may waste a lot of time. You are better off in therapy. Even so, the repair is hard—Freud (1937) sometimes thought it impossible—and to have it reinfllicted by that selfsame professional is a terrible betrayal of psychoanalysis’s promise. Apropos my marital problems, Dr. O once quoted *Otello*, who says of himself (after he has been apprehended for killing his wife): “one that lov’d not wisely but too well.” Why didn’t he apply that to us?

Splitting the Difference

If, when I was in treatment with Dr. O, he was big and I was little, now our positions are reversed: in the analyst’s chair (literally and figuratively), I can observe and assess him from a position of authority. That my work with him made this reversal possible is ironic. Curiously, it was in the very (academic) year of the initial transgression that I began to consider becoming an analyst. It has taken me a long time, and the writing of this article, to understand what will have been immediately obvious to the reader: Becoming an analyst was one gigantic save. I had placed all my faith and trust in this man. In our first five years, I mourned my mother with him. During the fourth, I endured a year-long walking breakdown, in the latter part of which my father died. So when, 18 months after that death, Dr. O’s lapse revealed his untrustworthiness, I had nowhere to go. My real father gone, I had only his disappointing stand-in. I could not bear the pain, which I could begin to register only after I ended my 30-year silence. In retrospect, I see that I was stuck: I lacked the internal structure to engage full-on the heartbreak, anger, and disillusionment that would have rushed in had I relinquished whatever guilty pleasure keeping that incestuous secret had bestowed.

So I leapt. I split the difference—choosing to change jobs, I left Dr. O without leaving him. Call it my own private Oedipal resolution. Finessing the gendered snares faced by a girl working her way out of the Oedipal funhouse, I chose to take him at his word and reach for the phallus my-

self. I was going to do what he did. But I was also going to do what *I* did. I was going to be an analyst, like him, and I was also going to continue what I was already doing, which is writing and speaking about what mattered to me. Indeed, even though I did not publish my first clinical article until about 15 years after I'd begun training (Dimen, 1991), my literary life gathered steam as new ideas, topics, and genres found their way to me.

This radical shift had a rational context: by this time, I was becoming disenchanted with my first profession. Although my awe for anthropology endures, by 1973 my zeal to share its wonders with students was waning. At the same time, psychoanalysis was working its transformational magic. Early in college, it had flashed on me, while reading Durkheim (1930), that life's jumble could be decrypted. Just so, as a patient, I quickly saw, with poignant clarity, that the mind's mishmash held meaning too. Add to that an excitingly systematic way to think about women and desire—despite the feminist anti-Freudianism of the time, it was plain to me that psychoanalysis was just what the doctor ordered (Dimen, 2003)—and I was hooked.

Did my embrace of psychoanalysis permit me to identify with, differentiate from, and (even) exceed Dr. O? Yes, but that's not the whole story. As my analysis heated up, Dr. O's support was helping me become more intellectually confident and active. Inspired by his favorite image, Prometheus's theft of fire, and willing to incur its risks (striving for the phallus always fails), I deployed my gains not only in the academy. Even as I lay on the couch, I had climbed onto the barricades; weirdly enough, I entered psychoanalysis in the same year as I joined my first consciousness-raising group. Throughout my treatment, women's liberation, as I have hinted, served as a parallel home. So as, in Dr. O's office, I was both kindling and damping my own speech, my voice was already shifting into new registers in the study groups, protest politics, and (academic) thinking that have marked second-wave feminism. Sisterhood's righteous and unstinting, if also sometimes rivalrous (Buhle, 1998), encouragement empowered me to speak out even as Dr. O's office rang with the sounds of silence.

For me, psychoanalysis and feminism were not either/or. I needed both. It would be banal to say that feminism was the protective mother intervening in paternal incestuousness. Movements such as psychoanalysis and feminism do not work like that. Furthermore, each of these, even if historical antagonists, carried similar hopes for the self and for change

(Dimen, 2003; Mitchell, 1974). But, as it turned out, psychoanalysis recapitulated the hierarchy from whose domination I was seeking release and, paradoxically, both enlivenment and authorization. Feminism, less attuned to (though preservative of) interior life, created a temporary utopia in which women were authorizing themselves outside patriarchal limits. Dr. O helped me to a new self (albeit in certain ways a false one that required repair by later treatment), but I could not have cultured that self without the nurture of feminism.

That life transformation, like this writing, constituted my personal compromise formation. If I could not save the actual relationship, I could fix it by proxy; if Dr. O wasn't going to help me, I was going to help myself. It was as though I transferred my attachment from him to a set of intellectual and clinical practices that meant a great deal to me, to him, to the damaged us. Coming closer to him while keeping my distance, I was going to make good on his promise. That this operation bootstrap entailed calling in the cops—the Third that Dr. O seems not to or could not have known—was not in my mind at the time. Now it looks like an unconscious wish: I am asking the psychoanalytic community to bear witness to one of its recurrent mistakes.

I have also beaten Dr. O at his own game. Theory is only for the geniuses? Maybe not. Or maybe it remains to be seen who the genius is. I do hope that this critique of my incestuous analysis with him advances a bit our grasp of a crucial intersubjective process in a way that sheds some clinical light. (Unlike him, I am not so willing to split theory and technique.) I am no longer ashamed, as I once was, of having taken inspiration from the man who hurt me. If I was identifying with the aggressor, perhaps I was also competing, aiming to do what he did but to do it well, better, right. Women too inhabit the Symbolic.

It is true as well that, by historical accident if nothing else, I am now on top. In the era when Dr. O and I worked together, psychoanalysis was starting to take a beating for its interpersonal and ethical transgressions, an attack that has only intensified. Being around when therapy was being deidealized and democratized was not the only way I had history on my side. I entered the field at a time when women's increasing prominence began contributing to the profession's long-deferred, but intensifying recognition of its sexism and homophobia. That psychoanalysis could not continue to demean or erase the feminist critique surely helped me to achieve my own voice, standing, and recognition for integrity and moral authority.

So, having the upper hand by virtue of the reversal of fortune between

analyst and patient, as well as by my own, post-Dr. O achievements, I no longer had, when I began drafting this article six years ago, to look him in the eye. Perhaps, instead, I looked down on him, secure in the knowledge that I could afford to dismiss him and thereby not have to confront him. For these reasons, this writing may be retaliatory and unfair to Dr. O, who, now dead, cannot reply. I cannot help that. If I cannot quite forgive him the damage he did, and even if no speech on this topic is pure (Harris, 2010), including my own, still I hope my reflections on the strange mutuality of our never-analyzed enactment, on my gains as well as my losses, will serve as sufficient mourning.

I had two terminations with Dr. O. The first occurred after a decade of treatment; I do not recall its impetus. But, a year later, I returned for two more years, attending sessions only weekly, sitting up. I took notes after each session because, as I saw it, I was trying to understand something that had eluded me. Those notes seem to have vanished in the course of a domestic renovation or two. But I don't need them anymore.

Conclusion: The Problem that Won't Go Away

When I began this article, Dr. O was, as far as I knew, alive. Were he still alive when I finished it, two things are certain: news of it would have reached him, and personal honor would have demanded I confront him. As it turns out, his death has spared but also deprived me. Without a doubt, had I arranged to see him, I would have managed my terror, anger, and shame by bringing a colleague for support during what I expect would have been an unpleasant 50 minutes. I cannot imagine Dr. O welcoming my accusation, nor do I see him taking a long-awaited opportunity to reflect with me. You never know, of course. He might have surprised me: as I write, I imagine his apology and my eyes well up. I feel obliged to say that, either way, the confrontation would likely have been salutary. Still, whenever I think of having missed it, I usually feel more relief than regret.

You may be wondering why I did not go to him before. Here is the paradox: had I not written this article, I could not have found "the words to say it" (Cardinale, 1975). Not only, now that I think about it, did my slow comprehension require his absence to find life. It required someone else's presence. Only while writing for an audience I expected would listen, could I recover the meanings in what otherwise was rote reporting. It took, one might say, a village, a relational process: I fashioned a repair for myself by noticing, at a moment when I could imagine some-

one open to me and when a suitable speaking invitation came my way, that I was, to my surprise, ready to tell (Dimen 2005a). (The context for my seizing the day was of course thick: a third treatment relationship, other major life events, and the like. But that is another story.)

As meaning returned, shame receded. Before writing this article, I dwelled somewhere on that continuum from seduction through exploitation to abuse—neither thought nor sense, only a wish echoing in a paradoxically shame-filled vacuum: “this isn’t happening.” Performatively, shame intensifies itself: you are ashamed, therefore you feel you deserve shame. Abjection (Kristeva, 1982) solidifies, and you prefer to go on as though nothing has happened. As I spoke out, however, my shame, which marred those silent decades and even the first couple of tellings of this story, gradually subsided, even if it resurges now and again. I have been fortified by the praise and, yes, the criticism called forth by these tellings: speaking despite my own and others’ (willful and unconscious) efforts to stop me, I have dined so well at the banquet of respect that shame no longer persecutes me. Rather, it has become interesting.

On Not Naming Dr. O

I would like to say that my shame, having dissipated, no longer demands vengeance. When I began this project, *Schadenfreude* beckoned: I did indeed fantasize the malicious triumph of naming Dr. O. I cannot imagine doing so now. No, at this moment, I rue the whole damn thing: if I have emerged from this enigmatic treatment intact, I am also scarred. Not only that: some of this grief may, sad to say, contain traces of that self-sacrificial love that recoiled from injuring the one I loved and the relationship I treasured, the loyalty that prevented me from connecting the dots during that three decades’ silence.

At the same time, though, my discretion is pragmatic. Although it would be dignified and ethical to say I want to protect his family and colleagues, I am not so noble. Were I to name him, attention would flock to his character and devolve into gossip. I have needed to tell this story for personal reasons, but in the course of doing so have come upon matters vital to psychoanalytic work, and I want the focus to be on them. This story bares complications that trouble us in daily clinical life, as well as mysteries in how we think about mind, relationship, and treatment.

Consider my appellation for him. “O” situates our working relationship in psychoanalytic tradition. It conjures the putative inventor of the cure we use, and puts that praxis into question. “O” honors Bertha Pappen-

heim's determination in treatment, and her independence and originality in the rest of her life. This sobriquet also summons the sexual transference/countertransference on which Anna O's analysis with Josef Breuer foundered. It asks: If sexual acting out, or enactment, is so venerable as to be inevitable, what becomes of us? How do we ensure that analysts stand by those whom they have harmed?

By dubbing him Dr. O, I also wish to evoke the protagonist of *The Story of O* (Declos [Régal, 1965]), the gendered power dynamics the novel depicts, the thralldom of sexuality, and the novel's place in contemporary sexual and feminist history. Perhaps by reversal—naming him after her—I am attempting to turn the tables, which, as you saw in Part II, I literally tried to do one day. But I also mean to ponder the conundrum of one's own contribution to one's own suffering. *The Story of O* has two endings, in one of which the protagonist, O, seeks her master's permission to kill herself. At this moral and clinical juncture, feminist and psychoanalytic interests meet. How, asks feminist thought (e.g., Benjamin, 1988; Butler, 1990), are women complicit with their own subordination? *Mutatis mutandis*, psychoanalysis is equally fascinated: how do people play into their own tragedies? In this personal article with theoretical implications, I have struggled to maintain this moral tension: On one hand, I call both of us to account; on the other, I call a spade a spade: the guy hurt me.

Psychoanalysis on the Spot

In the most classic way, an analyst hurts the person he's supposed to help and he won't even talk about it. And it's not even a patient who's complaining. Or, rather, the complainant is indeed a patient but is also an analyst who has ideas about the ins and outs of mistakes, their rectification, and their erasure; who knows something about our profession's sexually addled history; and whose authority merits attention. If it were just a patient crying foul, we could sympathize but also protect ourselves by splitting: us against her, analysts against patient, good against bad. Perhaps the analyst was doing a bad job; because good psychoanalysis does not include this sort of mistreatment, it is therefore, properly speaking, not implicated. Or maybe the analyst was a rotten apple; throw him out and we are safe. Or, if worse comes to worst, the patient is a bad egg. Too bad. But *we* are fine.

But we—a collectivity to which I belong—know better: the problem of sexual infraction is endemic. We have not, as yet, made it go away, and

therefore we feel a shared, often mute helplessness that renders us anxious and ashamed. Anxiety and shame may be occupational hazards. Arising for many reasons, they evaporate fairly quickly in the case of run-of-the-mill mistakes—bungling an interpretation—or even “delinquencies” (Slochower, 2003)—e.g., making a note about something personal—and, of course, neglecting to inquire about the impact of any of these errors. Many a time, Dr. O slipped up in this way. So have I. So have you. Ken Corbett (2009, p. 187) put it,

Luckily analyses rarely, if ever, turn on such micro-moments; rather they are held and built in a different experience of time—a web of contingent associations and an ever expansive relay of construction/reconstruction that moves unhindered through past, present, and future; such that [for example] an intervention can drop a stitch and pick it back up in the next thought/association.

Some infractions, however, are less micro than others. Insoluble, unmetabolizable, they block vision and thought, and create a shared dilemma. In their shadow grows not only shame but stigma or, as Erving Goffman (1986) defined it, “spoiled identity.” Such violations, sully the whole, taint each of us. To the extent that professional identity is also personal (as it tends to be in the professional-managerial class [Ehrenreich, 1989]), the offender’s shame rubs off on everyone else, including the victim.

Nowhere is this truer than at the spot where psychoanalysis planted its flag; not even tax evasion bears such a stigma. It was psychoanalysis that named sexuality the site where pleasure and danger combust, each serving as the other’s fuel. Yet this is the place where psychoanalysis keeps shaming itself, or being shamed. Plainly, the sexual anxiety that plagues civilians bedevils analysts too. Psychoanalysts have extraordinarily important ideas about sex. But we also have our unique sexual madness, nor do we escape the maddening sexual hierarchies and disciplinary practices that, both culturally instituted and personally meaningful, inform our desire.

Mix all that with indigestible regrets about the inevitable flaws in the very means by which we learn our trade and you get, on occasion, something toxic. Analysis does not fix everything, not even for analysts, and a fall from grace that can produce stubborn idealizations. Indeed, as Masud Khan (1974)—no slouch in matters of abuse, sexual and otherwise—opined, this shortfall may propel some into the profession: “those [. . .]

content to live with their problems seek treatment” (p. 117), whereas those who seek training are those who, in their delusion, hope for cure. That he was wrong—civilians want cure too—is not the point.

Analysts live with the discomfort of incomplete Oedipal resolutions, lingering incestuousness, and unrenounced attachment needs. Transference, home to extraordinary transformation and unspeakable pain, is never completely resolved. Angry and disappointed by our own, our analysts, and, yes, psychoanalysis’ limitations, and somehow shamed by all this imperfection, we are stigmatized by the analyst who commits a crime and then by the patient who blows the whistle. Our ambivalence riding high, we want to be rid of the disturbance they create, as do the exploited patient and exploiting analyst themselves.

A Psychoanalytic Transvestite

My tale unsettles a discourse that nests the analytic relationship, what cultural historian Raymond Williams (1961) calls a “structure of feeling.” Consider what happened when, in response to another conference invitation, I proposed a paper assessing collegial responses to the first iteration of this article (Dimen, 2005a). At first, the committee moved to disinvite me: they deemed me unethical towards Dr. O, who, bound by confidentiality, could not defend himself against my charges (for a similar predicament, see Cornell, 2009). I protested and, upon assuring them that Dr. O was deceased and would go unnamed, they reinstated their invitation and I gave the lecture (Dimen, 2006).

My injury and anger having yielded to curiosity, I found myself wondering what panic would impel analysts to concoct the nutty idea that patients are subject to an ethical code. I imagined, to put the best face on their rescission, that the committee must have felt torn between competing loyalties. Impelled to protect both damaged patient and impugned colleague, alarmed as (even) psychoanalysts tend to be by sexual impropriety, they didn’t know which way to turn. So they compromised by inverting the usual binary. Not the analyst but the patient was in power; not the patient but the analyst needed protection. The analyst was no longer shamed by his sexual infraction; rather the patient was shamed by her ethical breach.

Perhaps my having presented myself as both analyst and patient had created a “category crisis,” a moment when the familiar arrangement of things was put up for grabs. Literary theorist Marjorie Garber (1991) coined this term to account for the presence and function of transvestites

“in texts as various as *Peter Pan*, *As You Like It*, and *Yentl*, in figures as enigmatic and compelling as d’Eon and Elvis Presley, George Sand and Boy George.” A category crisis has, she argues, a “resultant ‘transvestite effect’” that, in confounding the usual discrete categories of male and female, focuses “cultural anxiety, and challenge[s] vested interests” (p. 17). As both analyst and patient, I became a sort of analytic transvestite, panicking the authorities who moved to regulate my speech (Foucault, 1976).

Not everyone with a story like mine could have had a hearing. Nowadays a patient would no longer be dismissed out of hand, as she most certainly would have been in Dr. O’s era, but her legitimacy probably would not be as solid as that of a professional analyst. In contrast, my professional privilege to speak as an analyst gives me a leg up so that I can be heard; that I have written substantially about sexuality makes such a hearing even more likely. Yet the very reason we are willing to attend to a respected colleague who unveils an experience of sexual malfeasance puts us at risk: authorized as a knower (Foucault, 1976), she is privy to the family secrets that everyone agrees not to talk about.

Written from both perspectives, then, my account puts the profound and reassuring binary into question, which the alarmed committee tried to recoup by maintaining the dichotomy between analyst and patient, but switching their attributes. This mad swap hints at a panic of the sort that ensues when, as anthropologist Mary Douglas (1966) proposes in *Purity and Danger*, culturally constructed polarities are breached. Cultural symbolism, she explains, often lines things up in pairs. Whatever falls outside such conventional dualities creates disorder, thereby becoming dirty and dangerous. My psychoanalytic transvestite story is just one of those disorderly things. There exists in psychoanalysis a deep structure that aligns analyst and patient in two separate columns: knower/known, wise/ignorant, powerful/needy, and so on. My tale mixes categories. Like other marginal creatures and things, “unborn children and pubertal initiands in some tribal cultures, or ex-prisoners and mental patients in our own,” as Garber’s (1991, p. 7) explication of Douglas puts it, I and my story enter or generate a state of “‘contagion’ and ‘pollution,’” both endangered and endangering.

Not only does my effort to hold myself in mind as both seasoned analyst and naïve patient merge opposites. It also challenges the implicit hierarchy behind the seemingly coeval pairs: analyst the greater being on top,

patient the lesser on bottom.⁶ Sullivan's (1953) two-person model tried to heal this binary inequality between analyst and patient by relativizing the pair: the former as comparatively well, the latter as comparatively ill. Relational psychoanalysis continues this equalizing deconstruction by both validating patients' wisdom and acknowledging analysts' influence and participation in enactment, not to mention iatrogenesis (Boesky, 1989; Mitchell, 1997; Renik, 1998).

I add another step. I would like to undo the dissociation and hierarchy that structure the internal categories, the "self-states" (or "subject positions") of analyst and patient. Each analyst has had at least one analyst, each has therefore been a patient, each of us is, therefore, both top and bottom, empowered and abjected. Yet even though we know that much of what we learn about treatment comes from our own treatment(s), we find it strange to imagine that there are, in effect, two self-states alive in us at once, each with different knowledges. Instead, a no-person's land seems needed, because of the analyst-patient hierarchy and its toxic traffic in power and shame.

Can we inhabit the space between (Bromberg, 1996)? If analysts can hold themselves as wise and ignorant, powerful and weak, can they also imagine themselves as both self-contained and abject, and continue working? What state of mind would that balancing act entail? Some combination of the depressive position and skepticism? I speak at once as both recognized, dignified clinician and desperate, mute patient who has found her voice. I am an insider who has trained and studied and written, entered second and third treatments, and wants to confer with her colleagues about a personal dilemma in terms of the complications marking our field. And I am outsider, perhaps standing in for all the patients whom we have all damaged in lesser or greater ways and who insist on recognition and empathy.

More than one colleague, crumbling under the weight of this demand, has resorted to rationalization. Often, for example, I have been congratulated for my courage in telling this story. One time, I dared look a gift horse in the mouth and asked why I was being praised. "Because," my colleague replied, "you put yourself in a bad light." Talk about regulatory practice. In her view, telling this story made me look bad because, when

⁶ That the analyst has less power than the patient both structurally (as the patient's employee [Dimen, 1994]) and dynamically (as, for example, the patient's transitional object [Winnicott, 1953]) is of course true but not my point here.

the sexual transgression happened, I was an adult, 31 years old, not a virgin, married. I had entered psychoanalytic treatment of my own free will. Which, of course, was true.

Except, of course, it also wasn't. What my friends couldn't entertain was a not uncommon paradox: like other free agents driven by suffering to our offices, I too was desperate, a shameful thing to admit among civilians and, it may be, even among professionals. And (or but) as we know, desperate patients cannot be asked to be responsible in the way analysts are. A central feature of "professional [analytic] responsibility," writes Mitchell (2000, pp. 51–52), assessing Loewald, is to bridge the patient's organized and disorganized mental states. This bridge helps the patient, now relieved of that mature psychic labor, to enjoy "freedom from conventional accountability" in which states of "unintegration" may be productively mined.

I do not think I am alone in forgetting, on a day-to-day basis, how at risk patients feel, how frightening it is to denude oneself of the defenses that protect but also construct and constrain, to be the unhappily ill one longing for the state of grace embodied by the happily cured analyst, the gosling worshipping the god. Might we see writ large, in my history with Dr. O, the mundane hazard of being a patient? When your doctor breaks the faith, your own faith trembles. And when you are, as I was, psychoanalytically uninformed, greatly distressed, and much regressed, you cannot afford to lose your faith in the process. So you don't notice, and you don't notice that you don't notice, and you don't bring it up, because you fear he will either disavow or acknowledge his role: if he's bad and denies it, then you're crazy, and if he's good and cops, then you have no right to be angry and your anger makes you bad and so it's your fault and, *voilà*, you've no right to speak at all. And you don't tell anyone else because you don't want them to tell you to leave the analyst whom you need beyond reason.

Primal Crime

That the hardships and humiliations of being a patient linger, unremarked, amidst the gratifications (Smith, 2000) of being an analyst creates a certain personal difficulty, if not also a professional opportunity, that has been insufficiently addressed. Maybe the moral hierarchy between analyst and patient, the us/them dynamic, issues from the shame and stigma of being a patient in the first place, the enormous comforts of treatment to the contrary notwithstanding. Maybe this explosive combi-

nation of power and shame in the analyst/patient hierarchy has something to do with why sexual betrayal of patients by analysts is a systemic hazard: it has nowhere to go but up and out. Analysts suffering the dissociated, unforgettable abjection of having been patients may indeed find themselves inducing that very feeling in their own patients, in order to cleanse themselves and, thus cleansed, to become pure and strong. Hence, perhaps, the draw of that “subtle continuum” of gratification, which, as identified by Twemlow and Gabbard (1989, p. 72), “reminds us that the potential for exploitation of patients exists in all of us.”

That the analyst knows indicates another subtle dilemma: professional shame. The analyst, knowing, knows that there’s something wrong, something to be ashamed of. But the act we least want to be caught in is the act of self-shaming. We do not want colleagues to transgress, and, by identification, are shamed by such sexual misconduct. More poignantly, the condition we dread being found in is self-shame. We do not want anyone to know that we are ashamed, because being ashamed, as is familiar from childhood, means *we know we are doing something wrong but cannot—even do not want to—stop ourselves*. As analysts, we aware of our common problem (Celenza & Gabbard, 2003), a primal crime that we have not yet solved. We do not, however, want this crime and our knowledge of it to be public, either among ourselves or the laity, lest we risk the shame that shames. No wonder that, for all our contemporary acceptance of analysts’ fallibility and even selfishness, when it comes to the primal crime of nearly every analytic institute—that is, sexual exploitation—not curiosity but preemptive, regulatory silence carries the day.

Let’s not kid ourselves: the problem is not going away, anymore than incest is about to disappear. But perhaps there is a way to keep the impulses toward it in mind, fantasy, and speech, to ensure that, when countertransference infractions happen, the analyst knows how to discuss them. To do that, analysts need to be able locate sex in relational context. For a long time, sexuality had dropped off the psychoanalytic radar. We can be relieved that it is once again in our sights (Green, 1996 1997; MacDougall, 1995; Bach, 1995; Kernberg, 1995; Lesser & Domenici, 1995; *Psychoanalytic Dialogues*, 5(2), 1995; Davies, 1994, 1998, 2003; Stein, 1998; Widlocher, 2001; Fonagy, 2008; Blechner, 2009), for we may thereby find a language in which to address our recalcitrant difficulty.

Many reasons have been offered for this temporary if protracted eclipse: the repudiation of reductionist orthodoxy; the runaway success of ego psychology, attachment theory, and the two-person psychologies;

classical theory's incapacity to incorporate insights about sex and gender from the humanities and feminism; and so on. Perhaps yet another culprit is our collective impotence in the face of our family transgression: unable to solve this refractory problem, psychoanalysis just decided not to think about sex any more. Or, more kindly, maybe we merely took a little break; like artists, we looked away from our work to get a little perspective.

Psychoanalysis has, fortunately, now returned to the port from which it set sail.⁷ Much of the revived thinking about psychosexuality focuses on reconstruing sexual phenomenology, identity, and development. In my view, this renewal is also a first-rate opportunity to fine-tune our decryption of erotic countertransference, so as to make sexual infraction grist for the analytic mill before it happens. Until now, our way of forestalling sexual transgression has taken what we might call a super-ego form: "Don't." As with all top-down injunctions, however, this one, probably intensifies the problem it aims to solve by inciting guilt and shame, which oddly impel us to mime the perpetrator and act without thinking. To help engage sexual countertransference, it would be useful, in both clinical and supervisory settings, to have some ideas, to think about how desires that actually feel forbidden routinely emerge in treatment and how they inhere in subjective and intersubjective process. Lichtenberg (2008, pp. 9–15) suggests one might employ what I (Dimen, 2005b) have called "the Eew factor:" if you feel this mix of excitement, alarm, and disgust in response to a patient's sexual or other material, you might twig sexual countertransference and self-reflect accordingly.

The development of those ideas exceeds this article's needs and the reader's patience, so I will suggest only some key requirements: (1) locating sexual infraction and its refusal in a two-person psychology so that it can be part of clinical conversation between analyst and patient; (2) a relational theory of the subject as psychosexual, to help analysts keep sexuality systematically in mind as they work with their patients—and themselves; and (3) a three-dimensional relational theory of the incest prohibition that, as I have already begun to indicate in Part II, encompasses both children's desire for parents and adults' desire for children. A clinically pertinent theory would also show why analysts,

⁷ It has been moved to do so, I would assert but cannot here argue, by the multiperspectivalism of the contemporary cultural climate as informed by feminism, gay politics, queer activism and thought; the discovery of the ubiquity of child abuse (Rush, 1980; Masson, 1984); investigations into sexual transgressions in professional relationships; and a new psychoanalytic generosity toward other bodies of thought.

like parents and other caretakers, might want to sacrifice the inevitable urge to enact the forbidden. Analysts have called on each other to behave like (good) parents, to abstain from sexual action. But better than exhortation would be, in my view, a redefinition of abstinence as the pleasure one takes in another's desire, which would afford a way to appreciate the conflicts analysts inevitably undergo relative to patients'—and their own—desire.

Dr. O's lapse was a perfect storm, a disastrous meeting of technical error, intellectual vacuum, and moral failure. I hoped to tell of it without singing a song of victimization in the key of good and bad, and using my shame to tarnish him and burnish myself. I sought a voice to speak the unsayable, words that would help me think through the unthinkable. Now I see the problem inhabits an additional register: psychoanalysis deserves to be construed beyond idealization and demonization, a task to which a judicious skepticism (Harris 1996) is well suited. Let us acknowledge our collective lapse: psychoanalysis did not protect me, and it has not protected others, from an all too common betrayal, and this failure is very sad. In grieving, of course, I am also claiming psychoanalysis can do better. There *is* a worst, there *is* a best, and then there is the mundane middle, in which, despite our shame about our personal and collective errors and failings, we can and should maintain our self-critical stance and keep on thinking.

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Muriel Dimen, Ph.D., is Adjunct Clinical Professor of Psychology at New York University Postdoctoral Program in Psychotherapy and Psychoanalysis. A Fellow at the New York Institute for the Humanities, New York University, Muriel Dimen practices in Manhattan and supervises nationally.

3 East 10th Street, Suite 181
 New York, NY 10003
 murieldimen@nyu.edu