COLORING ACROSS THE LINES:

CLINICAL PRACTICE WITH GAY MALE COUPLES

by

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Abstract

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This qualitative study utilized structured interviews with psychotherapists who are experienced in work with male couples to examine how clinicians have addressed the societal, legal, multicultural, systemic, and psychodynamic forces that create and impact upon contemporary gay relationships. The concept of practice wisdom was employed to explore how these forces affect direct practice experiences and to generate practice trends, common stylistic adjustments, and necessary knowledge for clinical interactions with this population.

Through grounded theory methodology, the data revealed potential problems with the generic application of available theories of clinical practice to psychotherapy with male couples. Many of the respondents struggled to reconcile the values inherent in their clinical theories and techniques with the here and now phenomenology of the treatment process. A number of therapists reflexively engaged queer theory in their practice via the deconstruction of heteronormative presumptions that they formerly utilized to understand the developmental aspects of relational attachments. This process created space for the diverse patterns of dyadic intimacy that they witnessed in this population. In a parallel

process to that of the therapists, the researcher's data analysis revealed the need for an epistemological pluralism: an amalgam of both essentialist and social constructionist frameworks.

In addition, the data revealed how gay and non-gay clinicians emphasized different needs, pathways and patterns of clinical work, and as a result challenged prevailing beliefs about cultural competency. Obvious differences in sexual orientation, development and experience gave some of the non-gay therapists and their gay clients the intersubjective freedom to explore expectations of and differences with each other. The data from some of the gay therapists revealed the influence of their socially constructed gay identities on their choice of theoretical frameworks, their use of self and their desire for legitimacy among their professional peers. Borrowing from a metaphor supplied by one of the respondents, the data illuminated the impact of couple work with gay men on when to work inside, outside or across the lines of dominant clinical theories, common therapeutic processes and socially constructed beliefs that prescribe healthy relationships and effective couples work.

Acknowledgments

This study, first and foremost, is dedicated to those who came before me and those who will come after me who strive to enlighten others about the gay male experience and to create more encompassing conceptualizations of committed coupling. This includes the 20 therapists who willingly participated as respondents by offering their time, their perceptions and their personal as well as professional vulnerabilities in the quest to make it more acceptable for male couples to seek guidance in negotiating life, love and compatibility.

I still encounter a world that remains ignorant and fearful of the reality of gay men and lesbians. At Hunter's Doctoral Program, I not only learned the language to express my concerns, but also the methods necessary to conduct my inquiry into this social problem. I first think of Dr. Irwin Epstein, who offered unwavering intellectual and emotional support, as he inspired me to pursue every pathway and think inside, outside and "across" the box. He has shown me that success as an educator, as with every relationship, involves nurturing, trust, support and authenticity. In addition, this document could never have taken shape without the ongoing support of Dr. Gary Mallon, who encouraged me to apply to the Doctoral Program so many years ago, and inspired me to persevere through each step of the way. Also, Dr. Roberta Graziano, who, as a fellow clinician, embraced me as a clinical colleague even as she offered me her editorial expertise and taught me the necessity to dot my "i" and cross my "t's." And to Dr. Michel Fabricant, who introduced me to the world of qualitative research. He demonstrated through his intellectual rigor that expressing each tradeoff along the way

leads to a product that keeps on giving. I also want to thank Dr Harold Weissman, who, beginning with the first class that I had in the Program, helped me to question the disjunction between what I knew theoretically and how I both practiced psychotherapy and lived my life.

And lastly— the primary reason behind my fascination with the complexity of male relationships—I want to thank my partner Ben. In our ten years together, not only has he encouraged me to be more honest about myself, and in the process to confront conflict, disappointment and dissociation, but he also has continued to teach me the meaning of connection and empathy. As he became my ongoing editor and sounding board, I once again felt my own possibilities expand and grow beyond anything I could have ever dreamed of alone. I am grateful for his strong views, his love of language and his daily inspiration to examine life with all its immensely rich complications and joys. With his largeness of spirit encouraging me, I feel continually motivated to continue to examine how to make love last and grow.

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Chapter 1-

INTRODUCTION

Section 1-The Scope of the Problem

Over the last thirty years, gay men and lesbians have become increasingly active participants in the sociological transformation of long- term relationships and the institutions of marriage and the family. Paradoxically, the increased acceptance and visibility of gays and lesbians has complicated and challenged their already confusing choices about how to be in and sustain a healthy relationship (Advocate, 1997; Champagne, 1993; Goransson, 1998; Green, 2000; Marcus, 1998; Signorile, 1997). Fortunately, as part of an ongoing process of social and psychological liberation, more and more gay men are feeling entitled to seek couples therapy in order to resolve their intimacy concerns and receive guidance in a world that more than ever debates their recognition and rights to equal protection under the law (LaSala, 2001; Modrcin & Wyer, 1990; Morin, 1999; "Excerpts," 2004).

In the face of these changes, the millennial legacy of heterosexist oppression continues to impact not only the psychic and social life of male couples, but also the theories and values of the psychotherapists who attempt to help them (Green, 2000, Morin, 1999). In the absence of any clear parameters or specific theoretical paradigms about how to deal with these deeply embedded biases and the many new challenges of contemporary male coupling, both potential clients and the practitioners who attempt to serve them seem to be in need of developing a fuller understanding of how to work with the unique dynamics and concerns that confront these men.

Despite the growth and attention paid to gay affirmative mental health practice over the last thirty years, many clinicians still lack the training and experience necessary to address the variety of psychosocial and psychosexual problems of male couples (Doherty & Simmons, 1996; Green, 2000). Not only is an examination of same-sex couples still given little priority in social work, psychology, psychiatry or psychotherapy training and research, but also many clinicians overlook, or are unaware of the many ways in which they utilize heterosexually informed treatment approaches or interventions that are not always useful for, or applicable to, gay male couples (Green, 2000; Murphy, 1994; Shernoff, 1995; Ussher, 1991). As of 1996, nearly half of the members of the American Association of Marriage and Family Therapy (AAMFT) reported that they do not feel competent to treat gay men or lesbians, while 72 % reported that at least one out of every 10 cases in their practices involved lesbians or gay men (Green, 2000).

Need for Couple Research

Still denied the right to legal marriage, co-habitating gays and lesbians, like their fellow unmarried, cohabitating heterosexual counterparts, are more likely to report less relational satisfaction and to separate than those who marry (Kurdek, 1998). Rather than receiving social recognition, legal rights, and economic benefits that serve to promote and preserve heterosexual marriage, gay couples still become targets of cultural devaluation and institutionalized discrimination (Wood, 2002). It is not surprising, then, that relationship distress is the most common presenting problem in psychotherapy for gay men (Johnson & Lebow, 2000).

Given the enormous challenges that face all people who risk joining a committed relationship, couple therapy's popularity has risen over the last two decades (Donovan, 1999). However, as compared to individual, group, and family therapy, it is the youngest and least developed modality both conceptually and technically (Doherty & Simmons, 1996; Jacobson & Gurman, 1995; Johnson & Lebow, 2000). Most of the standard clinical literature disseminated about couples therapy is based on idiosyncratic personal interpretations by one or several practitioners informed by a variety of theoretical orientations; yet very little of the theory is based on systematic research (Bergin and Garfiled, 1994; Donavan, 1998; Johnson & Lebow; 2000; Karpel, 1994). Much has to be learned about psychotherapeutic interventions for all couples in distress.

Until recently, outside of the gay affirmative research and practice literature, in which gays and lesbians themselves have written about theoretical and didactic issues that pertain to their experience, nearly all the other articles published in the field of family and couple therapy remain focused on heterosexual coupling (Fornstein, 1994; Fraenkel, 1982; Frommer, 1995; Johnson & Lebow, 2000; Karpel; 1994; Laird & Green, 1996; Peplau, 1991). Therefore, very little of the theory base utilized by therapists who are not exposed to the gay affirmative literature is informed by empirical research on same-sex couples (Bergin and Garfiled, 1994; Solomon & Siegel, 1997; Witkin, 1989). For that reason, rather than treating gay couples as part of the larger homogeneous group of all couples, what propelled this investigation was a desire to uncover theory and clinical practices that better meet contemporary male couples' unique emotional, psychological, and therapeutic needs.

In essence, this study is an attempt not only to disentangle whether and how psychotherapists have dealt with the different societal, legal, political, multicultural, systemic, sexual and psychodynamic forces that create and impact male relationships, but also to explore how these forces impact their direct practice experiences. The plan was to locate seasoned practitioners chosen for their experience in working with male couples and use the reflections of these informants to dispel myths and expose the complexity of this work (Klein & Bloom, 1995; Olson, et. al. 1982). The result was that through systematic interviewing, these clinicians revealed not only adjustments to their style of working, but also specific therapeutic stances and thinking that came directly out of their varied practices. Consequently, this study became an attempt to continue the journey started by prior researchers and clinicians to not only "come out" of the heterosexist context of couples work, but also to further "come out" into the mainstream world of clinical practice with synthesized wisdom and practical advice about how to work with this population.

Research Methodology

In the tradition of social work's dialectical struggle between theoretical knowledge and practice application, this study was based on the precedent that skilled practitioners recognized for their expertise can reveal an in-depth picture of their work, while reflecting on clinically- derived heuristics and practice wisdom (Schon, 1995; Zeira and Rosen, 2000). Accordingly, it was assumed that their practice wisdom could reveal how therapeutic impasses and obstacles have stimulated creative solutions and relevant knowledge advantageous for working with male couples (De Roos, 1990; Imre, 1984;

Klein and Bloom, 1995; Mitchell, 1997; Payne, 1997). As argued by Rein and White (1981), bridging the space between theory and practice requires "knowledge that is developed in living situations that are confronted by the contemporary episodes in the field" (p. 37). For this investigation, this knowledge was best defined as practice wisdom developed from working with male couples that translates the intersection of theoretical knowledge and practice experiences into present and future professional behaviors (Klein & Bloom, 1995).

A qualitative methodology informed by grounded theory was most compatible with this inductive approach to mining practice wisdom from practitioners confronted with the socio- cultural evolution of male coupling (Gilgun, 1994; Glasser & Strauss, 1967; Rein & White: 1981). With a 'grounded theory' methodology (Glaser & Strauss, 1967; Strauss & Corbin, 1990) it became possible to link some of the realities of direct practice to parts of established theories and intellectual frameworks and to generate practice trends that are useful for clinical interactions (Gilgun, 1994; Klein & Bloom, 1990).

Clearly, contemporary male couples and their service providers have come a long way since the pioneering days of gay affirmative counseling in the 1970s. Nevertheless, earlier research and clinical theory provided a necessary background and foundation from which to build new perspectives, insights and practice knowledge. This investigation attempts to enhance, interweave and corroborate the body of knowledge gained through earlier research on practice with male couples with the data gathered from this study (Reid, 1994). By employing the method of data analysis core to the concept of grounded theory called constant comparison (Glaser and Strauss, 1977; Strauss & Corbin, 1990;

Gilgun, 1994), an in-depth and systematic exploration of the collective challenges, themes, and priorities extracted from the new data was inductively tested not only against each other, but against their fit to prior research and theory.

The Cultural and Theoretical Legacy

Despite changes in public law and public policy that include the Supreme Court's decision in 2003 to de-criminalize sodomy between consenting adults, the prevailing American culture continues to devalue gays and lesbians, leaving gay men and gay couples at risk for stigma, shame, violence, discrimination, homophobia and heterosexism (Bumiller, 2003). This legacy is well documented in dominant theories of psychological development over the past century that historically have defined homosexuality as a mental illness (Freud, 1951; Gonsiorek, 1982; Isay, 1988; Nicolosi & Freeman, 1995; Socarides, 1995). It follows then, that some psychotherapists, products of their culture and training, may retain negative biases regarding both the single and coupled gay experience (Mc Goldrick, 1996). When the insidious effects of this cultural and theoretical milieu combine with a lack of knowledge of the diversity and complexity of contemporary gay couples, the practitioner may construct a therapeutic process that inadvertently leaves the same sex couple lacking a sense of entitlement for the integrity of their relationship.

If a clinician harbors unconscious negative biases about any aspects of a client's life, it has been demonstrated to impact upon both the therapeutic relationship and psychotherapeutic outcomes in negative ways (Bowman, 1982; Lehman & Salovey, 1990; Norcross & Wogan, 1987; Young 1985). For instance, studies that looked at

effects of clinicians' preconceived notions toward African -American clients demonstrated that many clinicians either over or under pathologized this population, as compared to similar cases of white clients (Lopez, 1989; Ridley, 1984). These biased assessments clearly impacted the clients' ability to stay engaged in the therapy, resulting in early terminations. This is not to say that all clinicians who agree to help male couples necessarily espouse blatant homophobia or malicious intent. Rather, potential therapeutic difficulties result from incomplete and/or outdated knowledge bases for the treatment of male couples, a lack of awareness of the interrelationship between alternative relationship styles, gender roles and sexual orientation, and for some clinicians, subtle heterosexism produced during a therapeutic encounter (Bebko & Johnson, 2000; Dresher, 1998; Green, 2000; Laird & Green, 1996).

Because training experiences focused on same-sex couples are often limited to one-hour workshops at specialized conferences or electives in a relatively small number of educational settings (Levy & Koff, 2001; Sears & Williams, 1997), many therapists, gay or non-gay, have not yet had a forum for examining their concerns about working with male couples (Laird & Green, 1996). These clinicians, even if they are aware enough to recognize their own internalized homophobia and heterosexism, are often left to navigate these issues on their own. Despite growing awareness among clinicians with regard to cultural diversity, homophobia and the need to adopt theoretical positions and interventions that are appropriate to their clients' needs, the literature questions whether providers who work with male couples still universally apply heterosexually informed theoretical generalizations that imply that relationships are intrinsically similar and

follow similar rules regardless of sexual orientation and gender pairing (Gurman, 1986; Kniskern & Pinsof, 1986; Laird, 1993; Levy & Koff, 2001; Murphy, 1994).

In summary, the gay male couple is often examined through the lenses of couple and family theories developed for working with heterosexual couples, with potentially deleterious effects. In contrast, this exploration of how practitioners are presently working with male couples clarifies some of the difficulties in applying available theoretical models to the unique concerns of male couples and shares the differences and similarities between the work with non-gay couples and gay male couples.

Distinctive Concerns of Male Couples

The norms for many couples, gay or non-gay, have changed in the last thirty years as more people are facing increased social choices and pressures. The social upheaval has impacted same-sex couples with some of the same pressures as heterosexual couples, but often without the social and family supports, legal and moral frameworks, and general social guidelines that help heterosexuals to navigate these confusing times (Eskridge, 2002; Marcus, 1998). In addition, assumptions promulgated by a dominant gay urban sub-culture about male coupling and the role of sexual freedom that have been held since the liberating days of the Stonewall Riots are being actively questioned (Sadownick, 1996). Never before have there existed so many options nor as many decisions to make about how much or how little to conform to, or deviate from, what most gay men have been taught in their heterosexual upbringings about what defines healthy relationships.

While more and more gay couples may outwardly appear increasingly similar to their heterosexual counterparts: buying homes together, having ceremonies about relational commitment, raising children, etc., many have learned that they do not have to adhere to the norms of traditional heterosexual relationships in order to feel fulfilled and committed to one another (Ayers & Brown, 1999; Butler, 1997; Cabaj & Purcell, 1998). For example, while most gay men grow up exposed to the same traditional romantic beliefs and models as heterosexual men, substantial data has accumulated over the past thirty years which suggests that male couples have accepted a wide diversity of sexual and romantic arrangements within their relationships (Berzon, 1996; Browning, 1993; Johnson & Keren, 1996; Kurdek & Schmitt, 1986; Odets, 1997; Shernoff, 1995). More specifically, as compared to heterosexual couples, many male couples allow at least some extra-relational sex (Harry & DeVall, 1978; Herek, 1991; McWhirter & Mattison, 1984; Peplau, Cochran & Mays, 1998; Signorile, 1997). Thus, gay men often present in therapy with concerns related to how to manage the conflicts between their primary relationship and their sexual lives outside while maintaining their primary relationship (Blasband & Peplau, 1985; Isay, 1989; Marcus, 1998).

There are many less striking, but equally significant areas of concern that male couples often find themselves exploring in and out of therapeutic settings. Like the practice of nonmonogamy, these concerns may leave some therapists questioning how to utilize their clinical training and dominant theories and objectives of couple therapy (Browning, 1993; Mc Goldrick, 1996; Morin, 1999). Other noteworthy areas of gay male

relationship construction that prior research present as deviating from heterosexual norms and requiring a distinct gay-sensitive perspective include: accepting often ambivalent social and family supports; accommodating and working through of each others internalized homophobia and resulting developmental difficulties; illuminating the divisions of labor within and without gender stereotypes; showing of public affection; and gay parenting (Bebko & Johnson, 2000; Green, 2000; Marcus, 1998; Murphy, 1994; Peplau, 1991). Although some of these concerns manifest similarly to heterosexual couples, it was the contention of this study that this partial list needs continued updating and clarification, to reflect the numerous possibilities for structural variations and interpersonal accommodation that impact male coupling in this time of sociopolitical struggle and cultural change.

Integrating Varied Intellectual Frameworks

This project was originally conceived with an overarching commitment to the integration of clinical research, theory and practice, as well as the blending of diverse elements of effective practice into an integrative model of psychotherapy (Goldfried & Newman, 1992; Kottler, 1991; Saleeby, 1989). Finding broader, more encompassing frameworks that strive to identify unifying principles of helping that bring together sometimes competing concepts and theories, these integrative systems attempt to draw on a broad range of interventions, processes, theories and methods to guide the practitioner even when validated knowledge is not available (Bergin & Garfiled, 1994; Kottler, 1991; Laird & Green, 1996).

While the data analysis revealed generic metaphors by which to integrate material, common stylistic adjustments, and aggregated ideas about working with contemporary male couples, it became equally important to capture the varied creative, theoretical and personal processes. An incorporation of the post-modern, deconstructive inclinations inherent in the application of queer theory and social constructionism (Foucault, 1976; Sedgwick, 1990), offered the paradigm that privileged divergent narratives and processes over standardized products and homogenous truths (Butler, 1990; Sedgwick, 1990).

It seemed the ever shifting, diverse and sometimes anti-assimilationist culture of male couples can be more easily understood from the accommodating, more inclusive perspective of queer theory. Queer theorists focus on the historical and social progressions that created many of the essentialist "truths" behind sexual identity and gender formation (Butler, 1990; Foucault, 1976). And since the history of sexuality and sexual orientation is fundamental to understanding contemporary concepts of gays and lesbians, which in turn are integral to the conception of gay and lesbian love relationships, queer theory's perspective seemed necessary when examining the impact of social and cultural forces on many of the described couples. In fact, throughout the interviews many therapists revealed that understanding how each member in the couple came to know and "perform" his sexual orientation and gender reflected intrinsic and extrinsic factors that bear on how each feels and acts about himself as a coupled individual.

As Fuss (1991) argues, keeping subjects related to homosexuality inside the prevailing discourse of simply a "different" sexual identity fails to acknowledge the

impact of the asymmetrical heterosexist status quo, and how much of the framing of our understandings and realities of gay related studies (and gay affirmative psychotherapy) has been couched in terms of categories defined by the dominant culture that keeps everything gay relegated to the outside. In line with the postmodern standpoint of Hartmann (1992), who argues that those in power marginalize the knowledge of subordinate groups by keeping knowledge subjugated, queer theory subverts or rejects the tremendous power inherent in both the hetero/homo and the inside/outside binaries (Fuss, 1991). Thus, challenging and discarding the fixed meanings inherent in the categories of "couples", "committed relationships" and/or "couples work" created possibilities for an investigation into the construction of these categories with an awareness of the heteronormative shadow lurking in almost every related behavior, construct, and theory.

Queer perspectives' independence from social sanctions not only enables an exploration into many of the presumptions of healthfulness about sustaining love, sex and romance within a single relationship, but also honors the ongoing fluidity of many male relationships. Though its ongoing questioning of assumptions can be potentially disruptive to many of the structures utilized to understand couples and psychotherapy, it often provided the most thorough manner in which to understand the often subjugated knowledge described by the therapists who participated in this study. And even though the differences between conventional coupling and male coupling are not so clear cut and dichotomous as this discussion might suggest, an acceptance of the endless possibilities of ways to be a couple seems to be the phenomenon that most often complicates couple therapy with male couples.

Since the intent of this study was to investigate the ways therapists think about the "subject" of male couples, it was necessary to negotiate back and forth between the essentialism inherent in the psychodynamic, gay affirmative and systems formulations used by many of the respondents with the often unconscious constructionist leanings implied by other respondents. In the evolving politics of the queer/gay studies movement (Sedgwick, 1990), it has become clear how it is dangerous to embrace unambiguously either a constructivist/queer or essentialist position. Therefore, the subsequent section and later chapters will explore the epistemological tension between these frameworks and how both frameworks were useful at various times in the unfolding of the data.

This comprehensive process of ongoing examination, deconstruction and balance attempts to describe how the reflections of a diverse collection of clinicians can be used to construct a distinct body of clinical wisdom that helps male couples develop their own explanations of commitment, intimacy and longevity. Concordant with the values of the social work profession that include "regard for individual worth and dignity (and) honesty and respect for and acceptance of the unique characteristics of diverse populations" (Hepworth, Rooney, & Larsen, 1997, pp. 8-1I), this study describes a journey that cuts across sexual and theoretical orientations, a journey of clinicians stimulated and challenged to sharpen their sensitivity to difference while utilizing diverse, personal and flexible understanding to find ever more effective practice knowledge when working with male couples.

Section 2-Theoretical Struggles and Key Definitions

Gay and lesbian studies has spent the last 20 years engaging in a discourse over essentialist versus constructionist/queer thinking, which in turn has created debates over terminology which have impacted the definitions utilizedfor this study (Bohan & Russell, 1999; Gonsiorek, 1988; Sedgwick, 1990). Therefore, further background clarification about opposing epistemological domains seems necessary to explicate some key terms that have and will vary in meaning and intent throughout the study.

Sexual Orientation as seen through Essentialism and Constructionism

The twenty-first century still often adheres to values rooted in the Middle Ages that permit the moral and legal censure of same-sex behaviors (Wood, 2002). Foucault (1976) tackled a historical analysis that asserts theories of sexuality do not reflect objective facts so much as cultural biases and power interests. He believes that knowledge or systems of thought do not describe "reality," but rather construct it in order to legitimate social and scientific institutions and reinforce bureaucratic ideas of race, class, gender and sexual identify.

Proponents of this perspective, often called social constructionists have engaged in academic debate with those who embrace an essentialist perspective throughout almost the last thirty years (Mitchell, 1996; Stein, 1996; Wood, 2002). Constructionists have challenged traditional assumptions about the natural status and universality of virtually every sexual category, highlighting instead their historical contingencies, social contexts, and political functions. Like Foucault (1976) who has become known as one of the earliest voices of queer theory, a radically anti-assimilationist stance rooted in social constructionism, social constructionists have argued that "the homosexual" is a product

of the pathologizing discourse of medical science in the late nineteenth century, created for the purpose of social control (Appleby & Anastas, 1998). In addition, constructionists, feminists and queer psychotherapists challenged the power dynamics rigorously established in traditional American psychoanalysis, questioning its knowledge base while demonstrating the cultural-historical contingency of sexuality and how sexual and gender ideologies serve the specific power interests of those in control (Goldner, 2003; Mitchell, 1996; Stein, 1996).

However, constructionism does not readily explain or deal with the common experience of many gay, lesbian and bi-sexual (GLB) people who experience their sexual orientation as body-based and fixed (Drescher, 1998; Wood, 2002). It seems that the essentialist inspired gay affirmative stance evolved to mirror, supportand theorize about this innate, felt-sense of sexual orientation, as well as to counteract and neutralize the essentialist pathologizing that was rampant among mental health providers (Silverstein, 1991).

In response to the oppressive political and social climate after World War 11, GLB (gay, lesbian and bisexual) professionals fought back the historical tide of patholgizing with the development and assertion of their own essential knowledge base, which charted and advocated for the normative developmental lines and universal life concerns of GLBpeople (Gonsiorek, 1988; Mar mour, 1980; Silverstein, 1991). The most basic belief of this perspective is that sexual orientation is a fundamental and unchanging construct, something over which the person has no choice and little control (Stein, 1996). And since sexual orientation is a core aspect of a person's identity that affects all aspects of how s/he lives his/her life, it is not only crucial that people get clear about which

category they fit in, but that they positively adapt to what it means to them and their life process in order to develop satisfying relationships (Coleman, 1985).

Therefore, much of the gay affirmative knowledge base, until recently, could be described as essentialist in nature. However, even the limited examples encountered in this research will demonstrate that not all questions about sexual orientation, or problems in psychotherapy, or for that matter, couple work with male couples, are best understood through an essentialist perspective and its ensuing practice applications. Nevertheless, there are times, particularly when helping an individual come out and consolidate a fragile gay identify, that an essentialist inspired intervention would be more helpful then one informed by a potentially threatening social constructionist approach that challenges identity.

Applying social constructionism or queer theory to sexual orientation suggests that being "gay" is understood to be a socially constructed concept that creates particular meanings around such manifestations as same-sex attachments that are not necessarily taken as expressions of an intrinsic identity grounded in the core nature of one's erotic and affective attachments (Bohan & Russel; 1999; Butler, 1990). Utilizing this perspective enables the therapist to understand that certain phenomena are not only historically and culturally bound, such as healthy relationships, but also loosen the essentialist scripts that can get in the way of helping individuals and couples find their own dynamic and constructed reality. As will be demonstrated throughout this study, having constructionist/queer perspectives to call upon enabled both a deconstruction of the therapists ideas, concepts and/or practice approaches rooted in essentialist dogma, and a clarification of alternative interpretations of the work.

Definitions

Gay- The term "gay" was adopted by essentialist thinkers to represent an unchosen state of same-sex, sexual orientation that (Sedgwick, 1990) is still the most commonly accepted shorthand for most "gay" men to self refer (Nimmons, 2002). The term "gay", according to the folklore of "gay" subculture, was first embraced by men who have sex with men as a code word to be used in public to refer to themselves without "nongay" people being aware of whom they were discussing (Chauncey, 1994). Even though the noun "homosexual" is often used interchangeably with the term "gay", it has not been utilized in this project, except when referring to research or literature that has previously used that term, making an essentialist point, or quoting from one of the respondents who were interviewed for the study. There are several reasons for this decision. Most importantly, "homosexual" is a descriptive term that derives from medicine and psychiatry and most often defined an adult male who is engaging in overt, repetitive homosexual activity (Bayer, 1987). Furthermore, as explained in the following chapters, the word "homosexual" not only has been linked historically to a pathologized description, but it also continues to be used in a pejorative, biased manner by those who want "homosexuality' to remain invisible, second class or criminal.

"Queer" with its' less identity-based meanings represen ts a more diverse group of men or women, including bisexuals, categorizing most anyone with nonconformist sexuality (Fuss, 1991). However, "gay" was the term consistently employed by the interviewed psychotherapists in this study and is still the more universally utilized affirmative descriptor that men most often use to self -identify their sexual orientation. So as long as "gay' is understood to be a contested word, whose underlying conceptual

roots are an unending work in progress, it remained the descriptor of choice for this study.

Gay-Affirmative Practice- The overarching therapeutic outlook by which the data in this study were compared and which formed the foundation for this research is "gay affirmative." The two core practice assumptions that inform this essentialist knowledge base are: being gay is a normal expression of human sexuality; and development of a non-heterosexually–oriented individual involves the working through of internalized homophobia and heterosexism as part of the ongoing "coming out" process that helps to create a positive gay identity (Coleman, 1985; Herek, 1984; Isay, 1989; Silverstein, 1991).

Labeling oneself gay begins the complex process of "coming out" into the world of other gay people and coming out of the dominant culture's assumed heterosexuality (the closet), because a non-traditional sexual orientation is most often hidden not only from the larger culture but also from the family of origin. Along the way it becomes necessary to develop strategies for coping with experiences of invisibility and isolation, as well as external oppression and its intrapsychic counterparts (Coleman, 1985). Along this potential progression, what actually happens for many gay people is that they enter into their local gay culture (Nimmons, 2002; Signorile, 1997). These challenges impact many aspects of gay male psychological development, including sexual experimentation, dating, relationship building and long-term relationship sustenance.

In is important to underscore that the literature of gay and lesbian affirmative perspectives addresses how and why different clinical issues and outcomes ensue from

the experiences of growing up and being gay. These specific concerns are often addressed through modifying more established psychodynamic frameworks to include gay development (Cass, 1979; Gonsiorek, 1985; Isay, 1989; Silverstein, 1991).

Male couple - A "male couple" as defined in this study is most often two gay men in a relationship who identify themselves as a couple and most often develop mutual loving and caring for one another (Mc Whirter & Mattison, 1984). That is not to say that there are not triads, and groups of men that "couple," but for the most part all the couples referred to by the clinicians in this study were in dyads, unless otherwise noted.

Sometimes what clearly defines a modern gay couple remains a mystery not only to members of broader society and clinicians, but also to gay men themselves (Marcus, 1998). Some men base their relationship on a replica of the traditional, heterosexual framework that includessexual exclusivity and a societally supported ceremony, with their same sex gender being one of the few differences (Signorile, 1997). Other men are in relationships that embrace multiple partners with differing levels of connection; arrangements that challenge the boundaries of gender, sexuality and commitment (Morin, 1999; Nimmons, 2002). And then there is everything in between; a diversity of arrangements that makes it hard to generalize about either commonalities or an essential male couple. Since there is still no legal or cultural institution or clear historical precedent that has outlined the parameters of a gay coupling, the data in this study supports how it is ultimately up to each pairing, sometimes with the help of a therapist, to define their relationship for themselves.

Practice Wisdom- A term most often used by social workers, "practice wisdom" is defined in the Social Work Dictionary (1999) as "the accumulation of information, assumptions, ideologies and judgments that have seemed practically useful in fulfilling the expectation of the job" (p. 370). Often debated and reconceptualized (Schon, 1995; Scott, 1990), Klein and Bloom (1995) clarify that practice wisdom is the knowledge that "emerges out of the transaction between the phenomenological experience of the client situation and the use of scientific information." (p. 803). They believe practice wisdom serves to translate both empirical and theoretical knowledge and previous practice experience into present and future professional behaviors.

As I continually explained the concept of "practice wisdom" to the various respondents interviewed in this study, the notion of "practice wisdom" struck me as useful for any kind of praxis that depends upon theoretical assumptions. One could say that the whole psychoanalytic enterprise arose initially from a Freudian "practice wisdom" – with Freud negotiating back and forth between his emerging theoretical formulations and the psychotherapeutic practice that he represents, especially through case studies.

When seen through the constructionist lens Butler (1990), the entire idea of practice wisdom turns away from the more essentialist goal of finding future practice behaviors or principles (Klein and Bloom, 1995) toward a recognition that practice is a forever- changing process contingent on the intersubjective context of the therapist and the client. In that sense, practice wisdom emphasizes the developmental route of applied practice. It will be described in the final chapter that respondents seemed to utilize both essentialist and constructionist inspired conceptions of practice wisdom in their work.

Chapter 2-

THE SOCIOCULTURAL CONTEXT

Because both male couples and the clinicians that try to help them have continually had to adjust and respond to the evolving sociocultural climate in which they have lived and practiced over the past half century, this chapter is designed to provide a historical context for the subsequent clinical literature review. Section 1 will chronologically examine the research literature on male couples written by researchers and clinicians in an effort to demonstrate how the couples have accommodated to increased visibility and acceptance, and conversely, have responded to subsequent backlashes and sociopolitical crises. The impact of these sociological changes on how, where and who studied gay male couples will also be examined, in order to set the stage for the application of this information to the clinical concerns discussed in the following chapter.

Section 2 will examine how a long chronology of homophobia and heterosexism has impacted both the knowledge base of today's mental health practice and what is studied, published and taught. In addition, it will be demonstrated how these prejudices have impeded the accumulation of research and theory development specifically geared toward gay male couples.

Section 1- Research on Gay Male Couples

Before the Stonewall Riots of 1969

Most historians of gay culture agree that the Stonewall Rebellion of 1969 marked the emergence of a public acknowledgment of both the existence and the viability of living openly as a gay person (Berube, 1990; Chauncey, 1994). This turning point in the history of gay men for the first time gave visibility and direction to a gay culture that included positive representations of gay relationships (D'Emilio & Freedman, 1998; Sadownick 1996). Prior to this time, there was an underground, "invisible" gay world, particularly in urban centers like New York City. In this world, the contemporary categories of homosexual and heterosexual were rarely used to describe sexual identity. Rather, the vernacular ascribed different labels to men, depending upon their sexual behaviors and presentation. One was either a "fairy" (effeminate), "wolf" (conventionally masculine), "queer" (men who identify primarily on the basis of their same-sex interest rather than gender status) or "normal" (supposedly straight men) (Chauncey, 1994). During and immediately following World War II, when the demands of war resulted in the lessening of societal restraints and the changing of gender norms, large numbers of men and women, many of whom had moved to large urban centers to escape restrictions of their families, created a social climate in which to explore same-sex affection (Berube, 1990).

The repression of the post-war years brought a retrenchment to pre-war social conventions and heightened a growing consciousness among gay people of belonging to an outside group. One component of cold war politics was the drive to reconstruct traditional gender roles and patterns of sexual behavior that had been disrupted during the

war effort (Berube, 1990). Gays and lesbians found themselves under virulent attacks from all quarters: purges from the armed forces; congressional investigations into government employment of "perverts'; disbarment from federal jobs; widespread FBI surveillance; and inflammatory headlines warning readers of sex 'deviates' in their midst (D'Emilio & Freedman, 1998). Paradoxically, the heightened oppression in the McCarthy era ultimately helped to describe, create and make the public even more aware of a minority it was intent on destroying. During this time, same sex relationships, when it was believed by those other than the gay subculture that is was possible for them to exist at all, were often considered to be sad, miserable affairs. Writing in the 1940s, psychoanalyst B. S. Robbins (Marmor, 1980), for example, believed that sadism might be the distinguishing dominant drive in the homosexual personality and the one common denominator in the homosexual relationships.

During the same time period, some of the first empirical research on homosexuality was gaining public attention. In particular, in 1948, Kinsey's (1948) ground-breaking study, *Sexual Behavior in the Human Male* reported that over a third of the adult males interviewed had engaged in a homosexual experience, pointing to a world of sexual possibilities vastly at odds with public norms (Sadownick, 1996). Then in 1956, in a meeting of the American Psychological Association, Evelyn Hooker (1957) presented her paper on the male overt homosexual, arguing, "that gay men can be as well adjusted as straight men and that some are even better adjusted than some straight men" (p. 30).

But even in the 1960s as the activism of the civil rights movement moved into the gay subculture, psychoanalysis' pathological analysis of homosexuality upheld and

supported the general public's continued negative viewpoints. For instance, Socarides (1968), a frequently published and prominent spokesperson for psychoanalysis, was particularly clear in his beliefs about male couples:

> A pair of homosexuals can sometimes succeed in living together in lasting fashion, but it is a kind of association that is founded more or less consciously on the fear of solitude in which each leads his own sex life with the radical and irresolvable instability of an infantile and emotional state, in an atmosphere of petty quarreling, compromises, and sterility that is barely tolerable (p. 7).

Other psychoanalytic writers in the 1960s, like Harper (1963) and Bieber (1962), also advocated a pathological stance by implying that the core of gay relationships is a futile search for some sexual fantasy, or the basic neurosis involved in homosexuality. Both of these prominent analysts described homosexuals as egocentric, satirical, lonely, tormented, alienated, sadistic, empty, bored and repressed. Those few psychotherapists who published outside of traditional psychoanalysis who did not pathologize homosexuality believed the most serious problem for those who lived in the gay world was the great difficulty they had in establishing stable relationships with each other (Blair, 1975; Dank, 1973; Hoffman, 1968). Hoffman (1968) was one of the first to reason that the social prohibition against homosexual expression prevented the participation of many individuals in stable relationships, since involvement requires a rejection of one of society's basic norms, a feat not within the capacity of all.

While literature that confirms homophobic traditions about gays and lesbians and their partnerships continues to be published (Nicolosi & Freeman, 1995; Socarides, 1995), research that began to confront and contradict homophobic culture, to deconstruct myths about gays and lesbians, and to appreciate same-sex partnerships started to get published by the late 1960s (Hooker, 1965; Hoffman, 1968). Clearly, the response of

these early researchers and writers, like the ones that followed, reflects a historical progression that influenced what people studied, and how they asked their questions. In addition, as is often true today, what results got popularized often depended on the social and political forces in power.

The Birth of Gay Affirmative Studies

By the 1970s, as urban centers in all the major cities witnessed a growing gay presence, it became clear not only that gay couples were thriving but also that many of these men were taking part in a gay subculture that was campaigning for social, sexual and psychological emancipation (Katz, 1983). In response, a new movement of gay affirmative studies emerged that mirrored this end to repression by first and foremost attempting to prove that gay men could lead healthy and satisfying lives (Gonsiorek, 1982). Initially, most of the gay affirmative research focused on the individual as the unit of analysis (Bell & Weinberg, 1978; Blair, 1975; Cass 1979; Harry & DeVall 1978; Weinberg, 1972).

The few empirical studies and books that focused on relationships devoted attention to relationship models (e.g., Harry & Devall, 1978; Peplau, 1981), relationship values and goals (e.g., Bell & Weinberg, 1978) and the quality of partnership (e.g., Bell & Weinberg, 1978; Mendola, 1980). All of them helped refute the myth that long term male relationships don't exist, that sex is the sole basis for gay relationships and that relationships must develop with heterosexual partnering patterns (Bell & Weinberg, 1978; Harry & DeVall, 1978; Lee, 1976; Mendola, 1980; Silverstein, 1978). It was this early gay affirmative research, conducted in the 1970s, that started to analyze gay and

lesbian couples through a non-deficit paradigm, and tried to create a less heterocentric context.

For instance, Lee (1976) originally published a description of different styles of gay loving from his analysis of advertisements for partners in the popular magazine the *Advocate*. His styles of loving were (1) "eros," an attraction based primarily on an ideal image of a lover at a visceral level; (2) "ludus," a playful and noncommittal relationship; (3) "storage," an affectionate companionship arising out of gradual acquaintance; (4) "mania" the style characterized by jealous possessiveness, demands for assurance of love and obsession with the chosen partner; and finally (5) "prama,' where social and personal compatibility is primary. Lee creatively illustrated that gay men had multiple internal and external reasons for coupling.

Contradicting popular conservative and therapeutic thinking that "infidelity" or sex outside the couple is a sign of serious problems in a relationship, many of the early gay affirmative studies on relationships documented the varied causes and consequences of sexual openness in same-sex couples (Harry & DeVall, 1978; Mendalo, 1980; Silverstein, 1981). Explicitly agreed- upon sexual arrangements became the most understandable difference between gay and "straight" relationships, and the recognizable lens that many subsequent researchers in the next two decades used to compare these differences (Green, Bettinger & Zacks, 1996; Johnson & Keren, 1996; Mann, 1997). It is an obvious and powerful distinction that will be repeatedly utilized in the discussion that follows to compare the similarities and differences in the last twenty years of research and clinical thinking about gay and non-gay relationships.

Despite this acknowledgment of sexual plurality in many male couples, it seems that in an effort to legitimize their studies and use variables common to all couples, gay and non-gay, sometimes the early researchers used language in their methodology and data analysis that still described gay partnerships through a heterosexual framework (Morin, 1977). For example, in their book, *The Social Organization of Gay Males,* Harry & DeVall's (1978) study was stated to be about gay "marriages." It seemed to be an attempt to capture patterns unique to gay or lesbian relationships while at the same time using explanatory metaphors and analogs common to heterosexual marriage. In exploring the most common form of male coupling, Harry and De Vall (1978) explained that relationships were patterned "after best-friend rather than husband-wife models which tolerated sexual infidelity" (p.85). Simply using the value laden, heterosexually constructed term "sexual infidelity" framed their findings on the basis of what was common to heterosexual tradition. This study, like others that followed, often described their sample based on the degree to which they conformed to patterns and values of heterosexual couples. Harry and De Vall did make clear, however, that especially for the gay men, a desire for sexual exclusivity might actually inhibit the development of long-term relationships, a finding that radically contradicted a common conviction of heterosexual culture.

In the same year, Alan Bell and Martin Weinberg's *Homosexualities: A Study of Diversity Among Men* (1978) used "satisfaction" as a dependent variable in their development of a typology for the gay men they investigated in the Bay Area in the late 1960s. First they described the "Close-Coupled" relationship, which referred to relationships in which partners looked to each other exclusively for both companionship

and sexual gratification. In the "Open-Coupled" relationships, partners were each other's chief companions but not exclusive sex partner. The men in either type of relationship were reported to be happier than the value-laden descriptor "Dysfunctionals", who were having sex with many outside partners and had no relationship, and the "Asexuals", who had neither a relationship nor sex. As per the dominant sociocultural beliefs of the time in which they did the study, Bell and Weinberg only grouped men in couples if they were living together. If not, they were described as in "an affair." Similar to Harry & De Vall (1978), Bell and Weinberg's study used the nomenclature of heterosexual relationships to describe any outside sexual liaisons. It is likely that this language, when used in the context of a questionnaire, might have influenced how the men answered specific items, particularly if the men did not routinely use these words or concepts, for instance "an affair," to describe their outside sex contacts.

By the early 1980's a shift occurred in the culture as more men were not only living openly as gay but also were outwardly coupling (Peplau & Gordon, 1982). In *American Couples,* Blumstein and Schwartz (1983) developed the largest comparative samples of lesbians, gays, cohabitating heterosexuals, and married couples to be studied at that time (12,000 respondents). Including male couples in this popular study not only helped to legitimize their existence, but also explained their dynamics in relation to other categories of couples.

Blumstein and Schwartz (1985) surveyed 120 heterosexual, 90 lesbian and 90 gay couples about a wide range of issues related to sex, finances, career and work. The use of the same survey instrument for all types of couples, in addition to in-depth interviews, surfaced compelling evidence that gay couples shared similar emotional needs, power

struggles, commitment, and longevity issues with heterosexual and lesbian couples. In addition, they reported differences, particularly that 82 percent of gay male partners, 28 percent of lesbian partners, 26 percent of husbands, and 21 percent of wives had been nonmonogamous at some point during the relationship. Irrespective of sexual orientation, most of these external relationships were not revealed to their partners.

They concluded that the experience of gay men illustrates that all men in the United States are able to enjoy sex that is primarily recreational, even when some of the properties of intimacy are missing, but they also need the intimate connectedness of a primary couple relationship. Therefore, they suggested, sexual plurality for gay men may be as much an outcome of two males partnering as it is a cultural choice. Blumstein and Schwartz (1983), as outsiders to the gay and lesbian community but respected researchers, helped not only to normalize the sexuality inherent when two men couple, but also to point out the need for varied guidelines throughout all areas of concern. Critical to their inquiry was the inclusion of questions that attempted to get beyond customary marriage values to include items that would gather information common to all types of couples.

Building on prior studies, McWhirter and Mattison (1984) posited a developmental stage model of gay relationships, clarifying potential guidelines and expectations specific to male couples. Their research in the 1970s on 156 couples drawn from San Diego was the first large-scale investigation to capture the attention of the gay community and gay affirmative therapists because of its clear presentation of evolving male relationships over the long term. McWhirter and Mattison's study supported various other researchers (Harry & Devall, 1978; Harry & Lovely, 1979) in their

conclusions about extra-relational sex being an accepted part of the male couples' progression. In their study, the seven couples that had a totally sexually exclusive relationship were together less than five years.

Most importantly, McWhirter and Mattison's (1984) developmental framework continues to be used as a measure of couple development and as a structure for other stage models (Clunis & Green, 1988). Their six stages, roughly linked to the length of the relationship, are blending (year one), nesting (years two and three), maintaining (years four and five), building (years six through ten), releasing (years eleven through twenty), and renewing (beyond twenty years). The temptation for gay- affirmative therapists, and gay men in general, to universalize from McWhirter and Mattison's findings was high. First, the study findings emerged after a period of many years when there was a paucity of studies on gay couples. Second, McWhirter and Mattison wrote a book about their investigation that was geared toward a general gay public and became for many men a guideline for examining milestones and expectations about their relationships. Not to take away from its ongoing usefulness as a potential road map for those without any clear direction, like any framework, if it gets rigidly applied, it might not only cut off exploration of the many other potential developmental pathways, but also could lead to possible pathologizing of those who do not fit in.

For many of these earlier researchers, finding a representative sample in a population that remained largely invisible and feared visibility was extremely difficult, if not impossible (Morin, 1995). Many of the studies readily acknowledged that their research included mostly white, middle class men, in a narrow geographic location, and therefore should not be generalized beyond the limited demographics and location of the

samples. For instance, Mc Whirter and Mattison's (1985) sampling strategy was based on a friendships network of men, most likely with related viewpoints about sex and relationships that represented the urban mentality at the height of the post-Stonewall sexual revolution (Signorile, 1997). Nevertheless, because of its historical importance in the short life span of gay affirmative studies, Mc Whirter and Mattison's research, along with the other early research studies completed before the impact of HIV, still informs many therapists' beliefs about gay male relationships.

While these early surveys identified gay men's tendency, prior to HIV, to recognize and accept their desire for coupling behavior, often outside traditional heterosexual and romantic norms (Silverstein, 1981), they still left an unclear statistical picture and many unsubstantiated theories as to why gay male couples' arrangements differ from other couples in other substantial ways. With many questions remaining unanswered, these earlier studies while inaugurating a knowledge base limited by the samples and the locations in which they were conducted are most distinctively depictions of the first male couples openly living with and declaring their love to each other.

The Early 1980s-Pre HIV

Researchers in the early 1980s started to became more interested in documenting how and why gay couples seemed to evolve so far outside of heterosexual norms (Easton, 1986; Herek, 1984; Peplau & Gordon, 1982). Several studies focused on investigating attitudes, values and satisfaction as related not only to sex outside the relationships, but also to the relationship in general (Kurdek & Schmitt, 1986; Peplau & Cochran, 1981;

Peplau & Gordon, 1982). Still, little of the literature spoke specifically to why, how and to what end to do psychotherapy with male couples.

In several of the empirical studies by Peplau and various associates (Peplau & Cochran, 1981; Peplau & Gordon, 1982) in Los Angeles, she started investigating how particular values impacted upon relationships of gay men and lesbians. Like previous researchers who focused on sexual arrangements as the most striking area of difference between heterosexual and gay couples, Peplau concluded that gay men incorporate outside sex with far more varied strategies than either heterosexual or lesbian couples. For example, in their study, "Values orientation in the intimate relationship of gay men," Peplau and Cochran (1981) drew upon research from 1976 that hypothesized that, for gay men in particular, the value placed on having an emotionally close and relatively secure love relationship competed with the need for personal autonomy. Like Blumstein & Schwartz (1983), they concluded that in contrast to male/female and female/ female relationships, in a gay male relationship there are two men, both at least partly the product of being acculturated as men who traditionally are taught to value autonomy more than women.

Peplau reorganized her concepts with Blasband (and Peplau) (1985) in a second study of 40 gay male couples, 17 of whom were in closed sexual relationships and 23 of whom were in open relationships where both partners were free to engage in sexual encounters with other people. In terms of psychological adjustment and relationship quality, the research indicated that these couples were more similar than different, regardless of sexual arrangements. Peplau and Blasband began to look at reasons for having an "open" or "closed" relationship and concluded that many couples strived for

monogamy but tolerated occasional lapses into openness. For men in closed relationships, 70 percent reported that the biggest influence on their decision to have a monogamous relationship was their own personal attitudes about sexual exclusivity and a belief that sexual exclusivity was essential to a successful relationship. Consequently, it appeared to Blasband and Peplau that among gay couples sexual exclusivity is actually a continuum rather than a dichotomy.

Following the lead of Blasband & Peplau (1985), Kurdek & Schmitt's (1986) descriptive study identified couples who agreed they were either sexually exclusive ("closed) or not ("open"), in order to compare relationship variables of "time living together", to "psychological adjustment", and "quality". In contrast to Harry & DeVall (1978), Blasband & Peplau (1985) and McWhirter & Mattison (1984), Kurdek & Smith used a geographically diverse, national sample of 98 men in closed relationships and 34 men in open relationships. Their results disputed earlier research by finding many acknowledged closed or monogamous long-term male couples. Moreover, after statistically controlling for differences between couple types in the length of time together, they found that "closed relationships" caused higher relationship satisfaction than "open relationships." Like Blasband & Peplau (1985), Kurdek & Smith's (1986) work not only asked different questions related to attitudes toward sex with others, but seemed to continue a trend that was less focused on validating a particular life style based on gay liberationist ideology and separation from heterosexual values, and more focused on objectively cataloging distinctive relational values of gay men in ongoing relationships.

However, even as late as 1990, Peplau and Cochran (1990) observed that the research into the objective components of interpersonal relationships of lesbians and gay men still represented a relatively new direction in the study of homosexuality. Then with their empirical hypothesis stated in their title, "Are Lesbian Couples Fused and Gay Male Couples Disengaged?" Green, Bettinger & Zacks (1996) not only refuted a popular vision of same –sex relationships utilizing family therapy's theories of fusion and disengagement, but also were published in what became a more popular compilation about gay and lesbian coupling embraced by non-gay clinicians (Shimmerlink, 1999).

Green, Bettinger & Zacks' (1996) data spanned several studies and utilized various highly reliable scales. The researchers gathered their data from two prior doctoral dissertations by the second and third authors, and a follow up study on lesbian couples, in addition to a comparison group based on two national studies of heterosexual couples (Olson et al., 1983; Spanier, 1976). They demonstrated that lesbian couples are not fused and male couples are not disengaged and both lesbian and gay male couples are more cohesive and more flexible than heterosexual married couples.

Although the article was written in the 1990s, the bulk of its research was gathered in the early 1980s, before the AIDS epidemic had taken a major toll. Gay male couples reported slightly less couple "satisfaction" than heterosexual married couples, only 5 points out of 151 on Spanier's (1976) Dyadic Adjustment Scale). The authors note that Kurdek (1995) reported that all men report lower satisfaction than women on the Dyadic Adjustment Scale; therefore, gay men and heterosexual husbands show no significant difference. The authors believe thatwith the exce ption of compulsively driven sex, recreational nonmonogamy of gay male couples should not be interpreted as a

sign of either disengagement or triangulation. Given that most gay partners are likely to have substantial experiences with recreational sex before becoming a couple and that they have in common a similar responsiveness to other males, there seems to be a greater mutual understanding and shared frame of reference regarding outside sex than is the case for most heterosexual married partners. Green et al. (1996) demonstrated that gay couples in the early 1980s appeared to be functioning at least as well as married couples and that they sometimes included very different criteria, like the amount of freedom, in their measurement of satisfaction than heterosexual couples.

David Griffith's (1984) doctoral research, entitled "The sexual relationships of gay male couples", completed at the same time as Blasban & Peplau (1985) and Kurdek & Smith (1986), marks one of the initial studies in which couples acknowledged their growing concern over the impact of HIV/AIDS on their decision to not only limit extra-relational sex, but also change the reasons for staying in a relationship. One quarter of the 12 couples he interviewed who were monogamous reported they chose this arrangement because they did not want to deal with the consequences of having sex with others, because they found monogamy natural for them, or because their lover wanted a monogamous relationship. Griffith's discussion includes references to the belief that AIDS was doing for male couples what the needs and psychology of many women may have done for heterosexual couples: put a powerful constraint on the male desire for a variety of sexual partners (Pelligrini, 1992). In other words, while gay men may desire sexual variety, they will curb or forgo the desire in the face of compelling threat to their own or possibly another's well being.

The AIDS Crisis

AIDS created a moral confusion that not only changed how gay men experienced their sexuality, but also left a generation struggling with how to incorporate the lessons of an ongoing physical, philosophical, and emotional trauma. In reality, no one could have predicted the extent to which AIDS would force gay men to scrutinize their culture, reorder priorities, and hunger for some new vision of hope. Correspondingly, the health crisis of AIDS necessitated an immediate shift in research money and manpower to HIV prevention and frontline human and social services for those who were infected or affected by AIDS/HIV. Consequently, many gay affirmative researchers added to their agenda dealing with ongoing catastrophic dying and multiple losses (Forstein, 1994; Kurdeck & Smith, 1987; Ramafedi, 1988; Stulberg & Smith, 1988). For couples, initial research focused on maintaining health (Finchman, 1993), modifying sexual behaviors (Forstein, 1994, Shernoff, 1994) and caretaking (Simerly, 1996; Turner, Hays & Coates, 1993; Wethington & Kessler, 1986). This research reflected an externally imposed reshaping of a generation of gay men's attitudes and ideologies about their community and gay life, in general.

Some researchers continued to focus on relational styles and how HIV has impacted them. In Easton's (1986) subjectively titled doctoral dissertation, "The Effect of Unrealistic Expectations on Satisfaction and Duration in Male Couples," the majority of her 47 subjects reported that, before the onset of AIDS, they believed casual sexual encounters outside their primary relationship couples were innocuous. Now AIDS had forced most of them to be sexually exclusive. In other words, these couples were now forced to reassess their views about relationships and the actual safety of having sex

outside of their relationship. She believed the high rate of monogamy in her couples was an "artificial stance, created out of necessity, rather than a philosophical belief" (p. 54). It is important to take into account that as the AIDS crisis intensified after the inception of her project, it necessarily became a major focus of her discussion. Most noticeably, many of Eaton's subjects dropped out because of multiple deaths or care-taking concerns.

Easton's experience was a powerful indication of the consequences of the pandemic not only for couples in her sample, but also for the entire gay community. Moreover, at the height of her information gathering, there was an intense political anti-homosexual backlash (D'Emilio & Freedman, 1988). In essence, those openly gay men who lived through the 80s not only were part of a cultural and sexual revolution, but also were confronted with a conservative backlash, in part, triggered by HIV and its force visibility of gay men, that questioned what it meant to be part of an American family (Browning, 1993). It seemed thatin reacti on to these forces, coupling became more desirable, male couples became more visible and the rights of these couples were beginning to be weighed by the courts, legislators, the media and the public (Berzon, 1996).

The 1990s

In the beginning of the 1990s research on serodiscordant couples (an HIV positive man coupled with an HIV negative man) took center stage along with more of a focus on the impact of AIDS and HIV on all gay men (Ball, 1998; Mattison & McWhirter, 1994; Ussher, 1990). This research was frequently informed by a public health perspective which tried to show gay men how to integrate sex into their lives in a more holistic

fashion, one that both minimized infection and, at the same time, promoted general well-being.

In one of the earlier reports about the state of gay relationships after the onset of the AIDS crisis, a striking 96.5 percent of Berger's (1990) sample labeled themselves as monogamous. The researcher infers thatthis statistic is due to the effect of the AIDS epidemic, since two thirds of the subjects acknowledged that concerns related to HIV/ AIDS had led to changes in their commitment to their relationship and their sexual behavior. Another reason for the clear increase in those reporting sexual exclusivity from earlier studies may be that the sample was drawn from members of a national voluntary association of gay couples who were, as the author stated, "likely to be more relationship-oriented and more traditional in their sexual patterns" (p. 46).

This study demonstrated a clear change of direction in gay male coupling habits. Before AIDS, the dominant gay community, which had always socially influenced relationships to conform to certain norms in order for couples to feel accepted, often prescribed sexual freedom. After the acknowledgment of AIDS, the community strongly adopted safer sex practices and began reevaluating its reliance on sexual freedom as a defining factor in gay identity, gay dating and gay relationships (Berger, 1990; Forstein, 1994). Perhaps, in reaction to this need for revaluation, the majority of the couples in Berger's sample emphasized the need for new and more effective communication skills as a needed resource to keep their relationships growing.

A subsequent representative sample survey of 1,749 respondents of male couples throughout the United States indicated that more than half of the sample was sexually exclusive (63.5 %) and only nine percent had broken their monogamous relationship

(Bryant & Demian, 1994). At the same time, many men still seemed to successfully negotiate an "open" relationship. What appeared to be of paramount importance for the couples in this study was that partners respect their sexual agreements. This can be most easily understood by the fact that in the 1990s all gay couples had added to their concerns negotiating HIV testing, safer sex behavior, variations in HIV status and most importantly, potentialHIV infection. Bryant and Demian's (1994) study was also significant in that it prioritized challenges to the relationship quality. Approximating Berger's study (1990), improved communication skills were the most reported priority, while the number two challenge was the general lack of support and even hostility many received from parents and other relatives.

Similar to Bryant and Demian's study (1994), where both members of the couples were interviewed, Alexander (1997) interviewed both members of 14 couples, terminated for at least 6 months, all of whom had been in treatment at a Northern California based mental health agency. Only 2 couples said breaking their sexual agreement or "affairs" was the reason for ending, with most claiming it was a lack of communication that caused them to grow apart. The study looked at fidelity along a relationship continuum from "closed monogamous", "open with outside connections permitted" and "negotiable", where outside sex is permitted as long as it falls within explicit or implicit couple's guidelines. Eight of the 14 subjects said their relationship was closed, 4 said they were open, and 2 negotiable. This study is significant, not because of its statistics, but because it draws a picture of how a clinical population has been transformed since AIDS and how, once again, the need for communication skills and negotiating the sexual ararngment became recognized priorities.

Although not entirely clear from the findings, the study sample was most likely men who had participated in couple therapy, and therefore their belief that communication was the most important reason for their breakups might have been a learned or conditioned response. It seems exposure to couple therapy had rarely been a factor that has been controlled for, even though it might have had an impact on results (Berzon, 1996). Since most prior research involved nonclinical samples, questions remain whether gay couples that are in therapy might be more or less monogamous, or more or less satisfied in their relationship, and how, over time, they may or may not differ from heterosexual couples.

The Present

Many varied and complex social and political factors clearly affected the many gay couples that were studied. In the first twenty years after Stonewall, research documented a process of reaction to these forces, but illustrated how these men continued to embrace alternative intimacy styles and therefore looked untraditional and unfamiliar. Then in the 1990s, as the issue of gay rights reached another zenith on state, national and public agendas, homosexuality was talked about more than at any other time in human history (Bawer, 1993). In addition, Signorile (1997) surmised that in the late 1990s, the urban "scene" was no longer setting the standard for what it was to be gay in America. With the "deghettoization" and "deurbanization' of homosexuality, gay men were challenging long-held assumptions about not only how to be in a relationship, but how to be gay (Signorile, 1997).

Even today there remains insufficient research to document the extent to which gay men are changing their coupling habits in response to AIDS and their increased visibility. However, in a more recent sex survey published in the popular national gay magazine, the *Advocate* (1997), 48 percent reported being in a committed relationship for more than a year. With a sample large enough (over13,000) to draw some basic conclusions, 71 percent of the respondents said they preferred long-term monogamous relationships to other arrangements. Of those who reported they were in a relationship, 52 percent reported that in "either their current or last relationship" they "are or were monogamous as far as they know." Even taking into account that some men might feel pressured not to tell the truth and that the sample was not demographically diverse, the percentages are large enough to document changes since the research of the 1970s. What can be generalized is that since the onset of the AIDS crisis, male couples in research studies are reporting more varied styles of arrangements. Additionally, some couples who had not been sexually exclusive started reporting becoming so. AIDS has also re-invented the non-sexual couple, whose sex life has ceased as direct result of AIDS, but who stay together for pragmatic reasons related to companionship and money (Shernoff, 1995).

Clearly, times have changed. America's gay male couples live in a world substantially changed from the one just a generation ago. Today, at the beginning of the twenty -first century, there are several visible generations of out gay men, many of whom are accepted by their family of origin, and integrated into their communities. These men see themselves reflected in the popular culture and are looking for new ways to experiment with intimacy in their relationships. It is very possible that some are less

impacted by gay liberationist ideology, some are happy to be able to assimilate and take their sexual orientation for granted and expect others to do so, and all are being shaped by the shifting political and social tides.

Some gay academics and activists, like Eric Rofes (1996), believe it is necessary to reorder priorities to move research beyond the last twenty years of the HIV trauma, by using its lessons of empowerment to support a regeneration of gay affirmative research that examines issues unrelated to HIV. By not blindly accepting the previous gay affirmative research conclusions or long- held assumptions of the 1970s, 80s and 90s, attempts can be made to study the fundamental changes in both contemporary gay culture and dominant heterosexual culture, in order to understand its impact on male relationships. In the spirit of this challenge, this study endeavored to blend the empirical core of prior studies with updated practice wisdom, in order to both extract ongoing commonalties and to elicit any differences necessary to work with the psychosocial needs of today's male couples.

Ethnographic Limitations of Research

Peplau, Cocharn & Mays (1998) did the first national survey of "Intimate relationships of African American lesbians and gay men", and found many similarities to coupled white lesbians and gays. For instance, white and African American gays are more alike than heterosexuals in rating of attributes regarding partner selection. Approximately 50 percent of African American gay men indicated that their current agreement was that sex with others was prohibited; however, only 19 % of the men had discussed their outside sexual connections with their partners. Since this is one of the

larger and more inclusive recent surveys of all couples, it remains to be seen if these findings are that different from contemporary white couples.

It is important to note that most of the current knowledge about personal relationships, gay or heterosexual, is still based on research that is largely focused on couples who are urban, white and middle class. Little systematic research is available about the intimate relationships of ethnic minority, rural and working class lesbians and gay men (Cochran & Mays, 1994; Appleby, 2001). This is consistent with their heterosexual counterparts. In general, ethnic minorities are understood to be less likely to seek therapy as a solution to problems in coupling (Appleby, 2001; Brown & Zimmer, 1986). Similarly, like many prior studies, the practice wisdom mobilized from this study will not necessarily reflect the particular challenges of working with either ethnic minorities or working class gay men, unless specific practitioners have reached out to and shared examples of men from these underserved populations. Future studies will need to explore the specific complexities of working –class and ethnic minority gay couples, and discover if they differ from other groups of couples.

Section 2-Homophobia and Heterosexism in Mental Health Services

Any overview of research on gay male couples must be understood not only within the larger social, political and historical context, but also within the more specific context of the field of mental health treatment, services and education. In the previous section, it was established that, even though the history of mental health services to gay men has experienced a dramatic shift from a pathological stance that once regarded homosexuals as mentally ill to an affirmative model that assists gay men in asserting their equal and healthy place in society, there still exists resistance to de-pathologizing gay life. It is the intent of this section not only to identify the deeply ingrained roots of this ongoing discrimination, oppression and ignorance, but also to demonstrate how these attitudes still permeate the knowledge base and theories of some mental heath professionals.

One of the major obstacles to attaining unbiased practice principles is the often unconscious homophobic and heterosexist beliefs and attitudes in the theories informing clinical practice and mental health education (Berzon, 1996; Decrescenzo, 1984, Gonsiorek, 1995; Marcus, 1998). Several authors have written about a universal heterosexist bias inherent in most psychotherapeutic perspectives (Brown, 1989; Goodrich, Rampage, Ellman & Halstead, 1988; Morin and Charles, 1983). Brown (1989), for instance, claims that along with sexism, racism and other exclusionary biases, heterosexism is pervasive in the language, theories and interventions of American psychology. She claims:

> Our knowledge base is heterosexist.... More precisely, white, middle class, North American, married, Christian... able-bodied heterosexuality is defined as the norm. All other forms of experience are viewed in contrast to the norm (p. 47).

The concept of homophobia has been explored in the social science literature for the last twenty-five years with varying definitions, but in this dissertation the term will be refined to refer to any anti-homosexual attitude or behavior that results in stigma, and active malicious intent (Gonsiorek, 1982; Herek, 1984; Herek, 1991; Pharr, 1988; Weinberg, 1972). Homophobia frequently manifests itself alongside heterosexism, the culturally conditioned bias that heterosexuality is superior to other sexual orientations (Gonsiorek, 1985). Blumenfeld and Raymond (1993) defined heterosexism as discrimination by neglect, omission and/or distortion, whereas homophobia is often discriminatory and hurtful by intent and design. Herek (1995) goes on to propose that along with racism, sexism and other ideologies of oppression, heterosexism is manifested in societal customs and institutions, such as religion and the legal system, as well as in individual attitudes, perceptions of reality and behaviors. Heterosexism may result in the exclusion, by unconscious omission or explicit design, of non- heterosexual persons in procedures, theories, research and practice (Herek, 1995; Morin, 1977; Pelligrini, 1992).

The following section will not only provide a historical overview of the evolution of heterosexist and homophobic belief systems and theories, but will also clarify how these concepts relate to the marginalization and stigmatization of gay people seeking mental health services.

Early History-Beliefs about Homosexuality

The historical struggle against homophobia and heterosexism harkens back not only to religious doctrine spelled out by a Judeo-Christian value system, but also to a resulting history of legal, cultural and medical discrimination (Weeks, 1977). Prior to

1973, when the American Psychiatric Association officially declassified homosexuality as pathological, gay men were not only considered to have an abnormal sexual object choice, but were also considered to be morally deviant citizens who were fair game for ostracism by parents, teachers, friends, employers and clinicians on whose support the gay person could have relied (Weeks, 1977; Vargo, 1998). By the late 1880s, a medical theory of physical causation explained that the newly named "homosexuality" was a congenital, hereditary degenerative state which in some cases was impacted by acquired influences (Katz, 1976). As queer theorist Michel Foucault (1978) observed: "The sodomite had been a temporary aberration; the homosexual was now a species" (p. 43).

The lead taken by the medical profession in the late 19th century to reconceptualize homosexuality as a condition that inheres in a person, rather than as a criminal, sinful act, was less a sign of scientific progress than an ideological response to a changing social reality: some men and women with same-sex erotic interests were structuring their lives in a new way (Chauncey, 1994). Concurrently, a medical specialty evolved, called neurology, which dealt with diseases of the brain and the peripheral nervous system. Taking over the treatment of mental conditions, psychiatry gradually emerged as a medical subspecialty of neurology (Gonsiorek, 1982). The laws and social mores of the time influenced the medical hierarchy, particularly psychiatry, which became the arbiter of what was "normal" sexuality and what conditions were in need of treatment.

As the "medicalization" of broad domains of social life occurred during the twentieth century, psychiatry sought to assume responsibility for the control of behaviors previously considered to be immoral: e.g., criminality, violence, alcohol and drug use,

juvenile delinquency, and sexual deviance (Foucault, 1978). In attempting to provide an understanding of aberrant behavior in an increasingly secular society, psychiatry assumed from the religious tradition the function of protector of the social order, "substituting the concept of illness for sin" (Bayer, 1987). Assuming that heterosexuality represented a medical norm to which they were obliged to help homosexuals conform, psychiatrists enforced an ideology that attempted to maintain order in the prevailing Western culture by maintaining the sexual status quo (Foucault, 1978; Walby, 1990).

Pathology, in this context, can be defined in two ways: 1) the science of study of the origin, nature, and course of disease and 2) any deviation from a healthy, normal or efficient condition (Paulsen, 1988). Rubin (1984) observes that acceptable sexuality under this ideology should be heterosexual, marital, monogamous, reproductive, and non-commercial. It should be coupled, relational, within the same generation, and occur at home. It should not involve pornography, fetish objects or roles other than male and female. Inherent in this belief is that human nature needs restraints and health is a commodity that is differentiated by role, status, sex, age and sexual orientation (Doyal, 1979). Because of this dominant ideology, many mental health practitioners came to believe that homosexuality was not only wrong, but was also a problem in need of a cure (Gonsiorek, 1982; Pharr, 1992). It is directly out of these ideological beliefs that the theories of psychoanalysis evolved and became a cornerstone of twentieth century clinical social work and psychotherapy (Bayer, 1987).

The Impact of Early Psychoanalytic Thinking

It was in this environment, in the years preceding World War II, that psychoanalysis provided the most prominent, illness-based explanation of the 20th century used to promote the heterosexist status quo and, in so doing, continued the homophobia associated with a same-sex orientation. Psychoanalysis popularized a developmental approach to causation of homosexuality, particularly as articulated by Freud and his followers. Freud (1905/1962) believed that humans are born bisexual, and either do or do not progress through stages of psychosexual development toward mature sexuality: sexual love for an opposite-sex love object. Homosexuality, then, was not to be considered a sickness in the strict sense, but rather incomplete or arrested development. Even though most of the psychoanalytic literature after Freud focused, until recently, on attempts to correct what was viewed as psychopathology by changing sexual orientation from homosexuality to heterosexuality (Dreshcer, 1988; Isay, 1988), Freud seemed to be pessimistic on the subject. In his later works Freud (1951) stated a belief that a psychoanalytic approach is inadequate in this area and needs to be supplemented by biological research. Toward the end of his career, he included a famous letter to a mother of a gay son in a case study that said: "Homosexuality is no degradation, it cannot be classified as an illness: we should consider it to be a variation of the sexual function produced by a certain arrest of sexual development" (Freud, 1905/1962).

Freud, like most clinicians, was a man who subscribed, explicitly and implicitly, to the cultural norms of his generation that claimed the pursuit of sexual pleasure served the function of reproduction, leaving homosexuality to be either perverse, abnormal or as

he popularized, an inverse reaction (Isay, 1988; Walby, 1990). Nevertheless, his original psychoanalytic ideals of understanding and compassion toward all patients seem to have been betrayed by his followers, particularly by American psychoanalysts (Bieber, 1962; Harper, 1963; Socarides. 1968). Like Freud, the difficulties that some Freudian psychoanalysts still have in treating gay patients derive from the confusion of professional and personal ideologies with moral values, so that subjective judgments are posited as if they were objective facts and accessible to empirical validation (Butler 1990). Like previous medical studies, classical psychoanalysis makes general assertions regarding an entire population based on a patient population which is unrepresentative of the majority, non-patient population. Freud based his theories on a small number of middle-class, Viennese patients he worked with at the turn of the century (Walby, 1994).

Nevertheless, psychoanalytically informed psychotherapy prevailed throughout the 1960s (Gonsiorek, 1982). Martin Duberman (1991), the founder of CUNY's Gay and Lesbian Studies Program, clearly illustrated this dominant homophobic view in his autobiography *Cures.* He tells of his plight of going to clinician after clinician trying to cure his homosexuality in a professional culture that saw his sexuality as pathological "narcissism." Duberman explains that being thought of as "sick" not only further entrenched his generation in their own internalized homophobia, but also clearly did not provide the needed support for sustaining meaningful intimate relationships of any kind. In summation, he believes many mainstream psychotherapists reinforced the negative stereotype that gay men were unable to form intimate relationships and were rampantly promiscuous and destructive to the dominant culture.

It is important to note that most psychoanalysts have dropped the pathology model, and have accepted new theories of homosexuality which appear to help clients understand and express their sexual preferences as normal variations in human sexual development (Drescher, 1998; Isay, 1988; Mitchell.1978; Mitchell, 1996). Unfortunately, even though these theories are gaining acceptance, the old, contradictory and confusing pathological concepts still get studied and not only provide a foundation for more traditional psychoanalytic training, but also are used to theoretically inform reparative models that focus on changing the sexual orientation of gay men and lesbians (Browning, 1993).

Early psychoanalysts clearly suggested what normative behavior is an is not, and in the case of gay men, blamed the stigmatized, ostracized, and traumatized for not conforming to the "norms" of human nature as dictated by the heteronormative culture (Cain, 1991). As a result of continued exposure to the bias and stigmatization promulgated by the authoritarian psychoanalytic establishment, many mental health researchers, theoreticians and clinicians from other traditions and frameworks ascribed to and projected the oppression and marginalization of homosexuality into their own theoretical foundations and research focus (Laird, 1993; Silverstein, 1991). If it were not for the persistent pressure of gay affirmative and queer activists, researchers and clinicians, this blatant discrimination and professional prejudice might still be the dominant force it was only thirty years ago.

The Influence of Gay Affirmative Psychotherapy

It was not until the publication of the Kinsey study (1948), the first to include homosexuality as a natural, nonpathological phenomenon (Ritter & Terndrup, 2002), that some gay men and women began to build a political movement to fight homophobia. The "homophile" movement of the 1950s and 1960s attempted an accommodationist spirit that saw its task as one of educating professionals who influenced public opinion (D'Emilio, 1986). Consequently, by the late 1960s some social psychologists, sociologists and anthropologists began to provide explanations for homosexual behavior that increasingly called into question the historically accepted illness model and instead looked at biological and constructionist origins (Gonsiorek, 1982).

By the early 1970s a growing number of gay and lesbian mental health practitioners, inspired by the mass civil rights movements of the 1960s, united with an increasingly vocal and organized gay community in leading the way toward dismantling homophobic myths and creating a psychosocial model of healthy homosexuality (Deyton & Lear, 1988). By openly challenging the models of pathology kept alive by American psychiatry and traditional psychoanalysis and exposing their lack of empirical support, these men and women paved the way toward developing an alternative, affirmative, practice base for working with gay and lesbian clients (Appleby & Anastas, 1998; Ball & Lipton, 1996; Freidman, 1988). Gay counseling services, staffed by openly gay and lesbian professionals, opened throughout the United States, enlarging the information on how to lead a life as a healthy, gay identified person and challenging the gay community's mistrust of mental health professionals (Silverstein, 1991).

In the late 70's and early 1980s, prior to the onset of AIDS, practitioners began developing a significant body of literature on the theory and practice of gay affirmative counseling and psychotherapy (Bell & Weinberg, 1978; Cass, 1979; Gonsiorek, 1982; Harry & Lovely, 1979). During the same period, responding to the needs of their clients, gay and lesbian practitioners began writing and speaking about couples therapy as well (Bell & Weinberg, 1978; Harry & DeVall, 1978; McWhirter & Mattison, 1984; Mendola, 1980; Peplau, 1981; Silverstein, 1981). Then, as detailed in the prior section, by 1985, the gay community, including most gay affirmative researchers and academics, became immersed in an encompassing transformation to address the impact of the HIV virus (Nichols, 1986; Sadownick, 1996).

As a result, since the early 1990s, AIDS has become the dominant hub from which most responses to psychosocial concerns of gay men radiate (Lipton, 2001). Significantly traumatized by the enduring epidemic, gay affirmative researchers and academics often lost sight of other concerns that were still affecting gay life. Paradoxically, the focus of HIV has helped make even the most homophobic practitioners aware that gay men and lesbians are part of every facet of American life and most desire support and help to live comfortably (La Sala, 2000). In addition, as the millennium approached and more and more gay people were living openly and making strides in politics, culture and family life, more gay couples were feeling entitled not only to seek mental health practitioners, but also to work with clinicians who have rigorously self-examined their own heteronormative beliefs and know the specific issues that they face (Bernstein, 2000; Johnson & Lebow, 2002; Laird & Green, 1996).

The Influence of the Family Therapy Literature

In the time before HIV, as more and more research on male couples was complete, in the journals and books focused on gay affirmative studies, there remained little that was published in more mainstream, heterosexually based, clinical literature (Morin & Charles, 1983). Undoubtedly, the insular nature of gay and lesbian focused research, coupled with the homophobia and homo-ignorance of many accepted clinical journals and books, was a factor in the lack of transfer of gay-affirmative knowledge to mainstream literature (Laird, 1993).

This lack is prevalent in the family therapy field, which is where the articles on heterosexual couples are mostly located. In an expansive evaluation of the foremost family research journals as well as journals from related fields during the years 1980 to 1993, Allen and Demo (1995) found that lesbian and gay families and couples were largely ignored in their books and compilations. Although the family therapies included more women as experts and generally focused on the here-and now versus individual pathology, continued marginalization of gays and lesbians mirrored not only the dominant sociocultural value system, but also the legacy of heterosexism and oppression left over from the psychoanalytic influence on many mental health professionals' core values (Horowitz, 2000; Laird & Green, 1996). It was not until Laird and Green (1996) edited a comprehensive and theoretically grounded volume titled *"Lesbians and Gays in Couples and Families"* that mainstream family therapy fully acknowledged in print not only its lack of attention to same sex couples, but also some of the myths and misconceptions about male couples propagated by the field (Shimerlink, 1999). Laird and Green (1996) claim that until 1996 there were less than 10 journal contributions on

gays and lesbian families and couples in the leading journal of the family therapy field, *Family Process*.

In the same compilation, Siegel (1996), an experienced family and couples therapist who practiced both as a closeted married man and as a gay man, captures one of the main concerns that initiated this dissertation: many caring, well meaning, competent non-gay and gay couples' therapists not only lack the training and opportunities to learn about male couples, but also are unaware of their ignorance:

> There is an absence of dialogue between gay and straight therapists about treating gay and lesbian clients and there are far too few training opportunities for straight family therapists to work with an experienced gay or lesbian therapist on the issues particular to gay and lesbian individuals, couples, and families with gay or lesbian members. Gay therapists have felt the need for empowerment and mutual support through meeting and collaborating with each other and have not sought ongoing dialogue with straight therapists. Similarly, straight therapists have assumed they can deal with the issues gay clients raise from the perspective of generalist training without being in dialogue with gay therapists. (p.29)

Siegel (1996) examines not only the need for ongoing dialogues between gay and non-gay therapists, but clarifies that all therapists, including gay and lesbian clinicians, should seek the specific knowledge and supervision necessary to be qualified to treat male couples. In fact, both Laird and Green's (1996) entire compilation and Johnson and Lebow's (2000) decade review of couples therapy with male clients supports the idea that it takes more than good intentions or "gay sensitivity " to do competent work with same-sex couples. In the spirit of their insights, this study's data analysis continually sifted through and noted any preconceived, heteronormative constructs or values that still infiltrated the work in an unconscious manner.

Ongoing Homophobia and Heterosexism in Clinicians

The dominant cultural script that pathologizes and stigmatizes all sexual orientations other than heterosexual remains evident in the traditions and institutions associated with religion, law, mass media, and family (Appleby & Anastas, 1998). Cultural heterosexism has not disappeared among clinicians, even as their professional organizations continually further develop gay affirmative platform statements (Isay, 1989; Sears & Williams, 1997). For example, in 1984, De Crescenzo's quantitative survey of homophobia among all types of mental health professionals revealed that anti-homosexual bias was still common within the mental health professions. At that time, social workers had the highest homophobia scores. Her explanation for their high scores was that gay and lesbian concerns had gained more visibility in the field of psychology because that field was influenced by an organized group of vocal activists prior to the time of the study. She concluded that all mental health professionals, particularly social workers, needed more course content on homosexuality that addressed, among many issues, a consideration of homophobia, "coming out" issues, and coupling in the lesbian and gay community (De Crescenzo, 1984.) The Council on Social Work Education accreditation standards, in 1992, not only started requiring social work programs to include sexual orientation in their nondiscrimination statements, but also mandated inclusion of content concerning lesbians and gay men in its curriculum policy reports (Council on Social Work Education, 1992).

Unfortunately, throughout the 1980s and beginning 1990s, there remained little non- heterosexist material available for training new practitioners. *An Annotated Bibliography of Gay and Lesbian Readings*, (Lee, 1991) commissioned by the Council on

Social Work Education, stated in the introduction, "it represents approximately a twenty year survey and review of the literature with an eye toward what is genuinely helpful to minorities of sexual orientation" (p. v.), noting that previous articles had been written in "medical language with words like 'deviance,' 'perversion,' 'ego-dystonic homosexuality,' 'developmental arrest,' and other pejorative terminology." Clearly, the paucity of gay affirmative and non- homophobic literature can be traced to the powerful effects of many years of ingrained heterosexism and homophobia and the dominance of pathology-focused theories discussed earlier (Silverstein, 1991).

In 1997, Cramer's (1997) report of "Strategies for Reducing Social Work Students Homophobia" reported that homophobia still abounds among students and professionals, despite more educational strategies being utilized to reduce different motivations for their homophobia. The attitudes of mental health professionals have historically paralleled those of the lay public (Sears & Williams, 1997), so despite ongoing changes in policy and education, it follows, then, that some psychotherapists, products of their culture and training, may still retain negative biases regarding both the single and coupled gay experience.

At the core of the heterosexism most often seen in psychotherapists are personal prejudice, religious taboos and ignorance which arise from the internalization of negative cultural stereotypes (Herek, 1991). A common stereotype about same-sex relationship, for instance, is that they are inherently dysfunctional and less satisfying than heterosexual relationships (Green, 2000). Another erroneous and exaggerated belief is that male partners mimic the traditional gender roles of heterosexual marriages, so that one partner plays the husband and the other the wife (Appleby & Anastas, 1998).

This ongoing heterosexism is profoundly disadvantageous to all same-sex-couples. For instance, for the male couples, the internalization of negative self images makes it necessary for the therapist to help them work through any shame and guilt for desiring a male partner. Without a foothold in the actual realties, legitimacy, and potential health of these relationships, it would be difficult for heterosexist therapists not to project their beliefs, and potential devaluation, into this already difficult work. In addition, if therapists do not understand that the fundamental benefits that heterosexual couples take for granted, including positive role models, social supports and validating rituals, are denied same-sex couples (Herek, 1995), then they cannot help respond to these omissions in their work.

Differences and Similarities among Gay and Non-gay Clinicians

Most clinicians, whether gay or non-gay (straight), receive the same formal training, particularly in regard to family and couple therapy (Morin, 1999). Therefore, no matter the sexual orientation of the clinician, many are ill equipped to fully understand or make room for the variations of intimacy and commitment in gay couples. Many male couples believe that seeking a gay –identified therapist eliminates the possibility of bias and homophobia that would make the therapeutic situation toxic (Mann, 1997). However, if gay clinicians have not continually examined their own homophobic and heterosexist biases, they too will have trouble navigating and managing their own homophobic biases and internalized stigmatization as it arises in treatment situations. This is particularly true when gay clinicians face the same unaddressed issues and/or homophobia as their clients.

In an effort to self educate, many gay clinicians report informal efforts to remedy their lack of effective education by utilizing gay focused journals, magazines, books, academic literature, and conferences, and eventually consulting with experienced gay supervisors (Siegel, 1996; Silverstein, 1991). Without this kind of ongoing inquiry, it would be difficult for even the most self-aware professionals to navigate the gap between their education and training and direct practice. If this is true for the out gay therapist who daily must confront the realities of homophobia and heterosexism in their personal life, it might be even more difficult for the non-gay therapist (Green, 2000). No matter how much the non-gay therapist believes that he or she is open to the gay experience and sympathetic to the issues of difference, putting aside the pull of socially constructed heterosexual norms, both clinically based and non-clinically based, which continually shape his/her views, takes conscientious self-education, case consultation and training (Bernstein, 2000).

As a result of the complexities of interacting social, cultural and educational factors, all clinicians work with male couples in an environment characterized by incomplete knowledge and potential heterosexism and homophobia. When validated knowledge is available, it should be brought to the therapeutic situation, not only to guide the practitioner, but also to offer the most effective interventions and treatment strategies (Klein & Bloom, 1995). Even though this study does not pretend to replace the specificity of training that effective supervision and education provides, this research hopefully adds to the professional developmental process by offering the best available practice wisdom that is culturally sensitive, recognizes the powerful stigmatizing effects

of homophobia and heterosexism, and reflects the impact of ongoing sociocultural changes.

Chapter 3-

CLINICAL LITERATURE REVIEW

In the spirit of clinical social work's challenge to bring together the influences of changing social, cultural and political forces with eclectic theories that best contribute to effective practice with specific populations (Epstein, 1992; Payne, 1997; Sibeon, 1990), the chapter that follows will review and classify prior theoretical and clinical thinking that relates to couple therapy with gay men. This examination will build on the research from the sociocultural chapter to demonstrate how varied practitioners and researchers have all developed ideas within their own fields and theoretical orientations that they apply to working therapeutically with male couples. In addition, this chapter will not only examine the varied contexts by which the literature has examined how the process of couple therapy with male couples differs from practice with heterosexual couples, but will also confront the specific developmental, social and existential issues that complicate the process of doing effective therapy with these men. Ultimately, the categories and subjects of this review were utilized as both a starting point and point of comparison for this dissertation's data analysis, in order to find out what remains relevant among particular areas of concern, what seems to be prioritized and what if anything is new.

Each section that follows will review the collective concepts, themes, and dominant theories that guide many clinicians' practice assumptions about male couples (Drescher, 1998; Forstein, 1986; Gonsiorek, 1988; Marcus, 1998; Odets, 1997; Silverstein, 1991). The first section discusses the actual and potential relevance of both essentialist and constructionist/queer frameworks to the clinical practice of couple therapy with two men. The issue of gender is utilized to demonstrate not only the

generative tension of these dissimilar epistemological forces, but also their influence on clinical manifestations in male couples (Karpel, 1994). The second section offers a distillation of what the literature based on gay affirmative perspectives clarifies as the distinct clinical characteristics that distinguish the therapy of male couples from heterosexual couples. These characteristics have been subdivided into the developmental impact of coming out, sociological factors, the pull of the gay community, erotic concerns and issues related to HIV.

Then, the multidisciplinary area of marital/couples therapy, with an integration of a general systems framework, will be critiqued to demonstrate how some of its major conceptual ideas have been applied and reworked to practice with male couples (Section 3). This section will expand the list of key content areas where male couples differ from heterosexual couples to include their unique dyadic interactions. In addition, this section will demonstrate how countertransferential awareness has been utilized as a catalyst for rethinking and bridging gay affirmative perspectives with family therapy.

In the final section (section 4), cultural competence and sensitivity will be clarified as not only another unifying paradigm that helps conventional clinical practice evolve toward more responsive and appropriate interventions for male couples, but also a potential force for theoretical change (Payne, 1997).

Section 1- Multifaceted Interplay of Perspectives

While examining the research literature on the specific distinguishing characteristics and issues that clinically set the concerns of male couples apart from heterosexual couples, it was the gay affirmative literature that provided the foremost resource. It also became apparent that the predominant task of most gay affirmative theorists and researchers in the first thirty years was to reduce the homophobic and heterosexist bias of the more traditional, psychoanalytically inspired theories (Gonsiorek, 1988). Many of their ideas were developed to enhance, reform and rethink the main body of psychoanalytic theories (Gonsiorek, 1988; Mitchell, 1978). And in that tradition, they assume thata male couple's distinctive characteristics are r elated to each member's psychodynamic history that often remains unconscious, and therefore, needs to be revealed in treatment in order to help the men act consciously (Drescher, 1998; Forstein, 1986; Sliverstein, 1991).

About the same time period, on the other side of the ocean and the theoretical divide, Foucault (1976) tackled conventional knowledge of sex and deployed a historical and discursive analysis of the ways sex and sexuality were constructed over time, from culture to culture, in order to begin deconstructing thinking about all sexed and gendered identities. Hence, queer theory emerged from a loose association of feminist, post-structuralist and psychoanalytic theories (Butler, 1990; Sedgwick, 1990). Unlike gay affirmative theorists who legitimized their ideas by incorporating them into the more traditional frameworks of psychoanalytic principles, "queer" theorists attempted to demonstrate the possibility of shifting the experience of identity away from essentialist ideology (Butler, 1990; Foucault, 1976; Sedgwick, 1990). As a result, sexual identity

gets conceptually removed from gay affirmatives' focus on an individual's psychodynamic forces, in favor of a socially constructed identity that allows for more indeterminacy and instability (Butler, 1990; Sedgwick, 1990). Thus, queer theory not only reveals the conditional foundations of all concepts of identity, but also clarifies the importance of deconstructing and destabilizing essentialist, normative assumptions about all things related to sex, sexual orientation, gender, and in the case of this study, relationships.

It was hoped that with this multifaceted interplay of perspectives, a fuller appreciation of the diverse interpersonal and social forces affecting male couples could be integrated into this review. However, queer theory remains more on the political and theoretical level, and has not yet been actively utilized to deconstruct what gay affirmative studies assert to be the more essential characteristics of male couples. Nevertheless, queer theory and its related postmodern ideology is continuing to filter into the literature on therapy, particularly when deconstructing gender and more recently when discussing sexuality (Bohan & Russell, 1999; Goldner, 2003; Mitchell, 1996). Therefore, it became clear that when looking at the data from this study, the lens of queer theory could provide a useful and innovative addition to not only this data analysis, but to the research of couple therapy with male couples. Particularly in the following section on gender, the frame of queer theory acts as a constant, critical reminder that any generalizations are not necessarily an always-accessible reality, but instead a construction validated by social and scientific research.

Applying Varied Perspectives to Gender

Theories of gender and gender oppression play an important role in conceptualization of the problems of same sex couples (Peplau, 1993), particularly because many researchers and theorists trace the roots of gay oppression to sexism (Appleby & Anastas, 1998). Same-sex sexuality is considered the ultimate gender transgression, and the psychosocial dimensions of this violation, teamed with other complexities of gender socialization and oppression, have a direct impact on the interpersonal dynamics in same sex relationships, which in turn affect psychotherapeutic treatment for these couples (Drescher, 1998; Green, Bettinger & Zacks, 1996; Johnson & Lebow, 2000; Ussher, 1990).

The evolution of critical themes in the development of gender and gender studies is vast and include psychoanalytic theories, feminist theories, biological theories, behavioral theories, cognitive theories, queer/ constructionist theories and many combinations of all of these different forces. Despite ongoing investigation and deconstruction of gender categories in all these fields, for many the biological is still the hub from which all thinking about gender radiates. Freud, despite his notion of innate bisexuality, shared the widespread assumption of his day that masculinity and femininity were by nature mutually exclusive; he accordingly regarded the manifest presence of both in the same person as a sign of serious disturbance (Mitchell, 1996). Although accepted for years by the medical and psychological communities, it was not until the 60s that Freudian gender theory was widely debated and discredited. This was most evident when Stoller (1968) conceptualized that "core gender identity" was a psychological development independent of biological sex and sexual orientation. Disconnecting gender

and sexual orientation broke with fifteen hundred years of Western tradition (Woods, 2002).

In the 80s, the term "gender" was interrogated by a new wave of feminist theorists who examined the social construction of gender, thereby further distinguishing feminist discourse from biological connections of sex and gender that are oppressive to women (Hare-Mustin & Marek, 1998). The social constructionist perspective argued that the focus on deep-seated differences in the "core self-structure" of men and women is unduly essentializing, since it represents them as dichotomous, intractable and virtually universal (Hare-Mustin & Marecek, 1988). In this way, "gender" became associated with social constructionism, and sex and sexual identity further linked to biological–essentialism.

Drawing on a blend of Foucauldianism, psychoanalysis and radical–constructivist feminism, Butler (1990) introduced her formulation of gender performativity. Butler contends there is no essential gender that is expressed in actions, gesture, or speech, but rather there is only the outer performance of gender that retroactively produces the illusion of an inner gender core. Therefore, gender is nothing more than the ritualized mimicry of cultural convention that is socially reproduced ad infinitum. Butler specifically identifies compulsory heterosexuality as a driving force behind the compulsive repetition of gender rituals, therefore displacing categories such as 'man', 'woman', 'male', 'female', by revealing how they are indirectly constructed within a heterosexual matrix of power (Butler, 1990).

The Pull of Gender in Male Couples

Despite the varied ways in which gender is theorized, gender's organizing pull is evident in all couples. In many gay relationships, both male partners acquire the advantages and disadvantages of essentially similar patterns of gender-role socialization (Herek, 1984; Pelligrini, 1992). Since both members of male couples are the same gender, the traditional or stereotypic couple roles, functions, tasks and balances of power that are commonly assumed and/or at least illuminated through differences in male and female gender socialization, often must be reorganized, and created through the reality that both men are impacted by their internalization of male socialization (Blumstein & Schwartz, 1983; Green, Bettinger & Zacks, 1996; Peplau & Cochran, 1981; Weingarten, 1991). Some theorists and researchers believe the predominant male script does not develop men along a relational model that helps men connect to others, but instead acculturates logical process, and competitive skills, leading to competition in such areas as earning money, occupational success and sexual attractiveness (Blumstein & Schwartz, 1983; Goldner, 1991; Real, 2001).

In male couples, this socialization can lead to a tendency toward disconnection and less balanced skills in negotiating conflict, since the empathic, often more relational, female voice is not present (Marcus, 1998; Odets, 1997). Unlike the heterosexual couple where gender socialization sets up what is called "complementarity" of roles and psychological needs (Bateson, 1958), such gender differences are often absent in same-sex couples. In stable relationships of any kind, both partners achieve stable complementarity by balancing each other's power through complementary actions and communications, where both partners balance power through equity or similarity (Karpel,

1994). Without the differences in gender role socialization, this already difficult balancing act between intimacy and individuation becomes a complex journey for most male couples (Brown & Zimmer, 1986; Forstein, 1986; Johnson and Kern, 1996; Odets, 1997).

In addition, because of the connection between gender and specific functions of coupling (Hendrix, 1992), the extent to which each member of the couple identifies and experiences himself with masculine or feminine traits will affect not only complementarity and symmetry, but also attachment in a long-term relationship (Forstein, 1986). The therapeutic process often addresses and makes conscious the connection of gender role identification, individual psychology and the partners' varied capacity for intimacy and, through this process, helps men find some measure of connection, stability and individuation while normalizing the inevitable power struggles of all relationships (Hendrix, 1992; Odets, 1997).

Section 2-Relational Challenges as seen from a Gay Affirmative Viewpoint

The Impact of the Coming out Process

One power struggle specific only to same –sex couples arises out of the members different levels of acceptance that reflect their particular stage in the ongoing coming out process. Both members of a male couple have had the burden of consolidating a gay identity that most often has been repressed, denied and shamed. Therefore "coming out" is a necessary developmental process that begins self and social acceptance (Brown & Zimmer, 1986, Isay, 1989). Since each individual is often at different stages of the

coming out process (Cass, 1979; Drescher, 1998; Forstein, 1994) each partner must find some way of accommodating the other's internalized and externalized homophobia. Different levels of self-acceptance and self disclosure can affect multiple concerns, including both partners' definitions and expectations about being a couple (Forstein, 1994; Gonsiorek, 1985), as well as how both men integrate their families of origin, friends, work, religion and various communities into their relationship. Ultimately, the stage of "outness" in the coming out journey can impact each partner's sense of entitlement to being in a relationship and the extent of commitment made to its longevity and fitness (Berzon, 1996; Kurdek & Smith, 1987; Peplau & Cochran, 1981).

The Sociologically Influenced Factors

The process of coming out involves not only undoing the intrapsychic impact of growing up in a homophobic and heterocentric society, but also an ongoing process of evaluation, practice and/or reformulation of what it means to be in a relationship (Forstein, 1986; Isay, 1989). Very few gay men grow up with role models of how to be gay, let alone how to be in a healthy male relationship. Adolescents with gay attractions or fantasies have few, if any, safe places to experiment or to learn to date, leaving them feeling alone, hopeless and often victimized by any hint of same-sex feelings (Drescher, 1998). Understanding how these external societal factors are internalized and impact the negative and positive aspects of being in a relationship has been an important focus of much of the literature on the psychodynamic therapy of coupled gay men (Drescher, 1998; Forstein, 1986, Isay, 1989; Marcus, 1998; Murphy, 1994; Ussher, 1991).

In addition, almost all male couples are at one point confronted with not only a lack of societal supports, family traditions, legal definitions, financial incentives, and religious validation, but also the absence of the civil and legal rights assumed in heterosexual couples (Berzon, 1996; Marcus, 1998; Mc Goldrick, 1996). The deficiencies of these supports and institutions impact all aspects of relationship construction and security, including: accepting and balancing often ambivalent, occupational and family supports, showing of public affections, and clarifying the inclusion of moral, spiritual, political, cultural and religious beliefs and attitudes into the social construction of the couple (Marcus, 1998; Murphy, 1994; Peplau, 1991).

The Impact of Perceived Norms in the Gay Community

There are those authors who make a case thataspects of dominant, gay, urban, community values could be destructive and counterproductive to the creation of committed partners (Bawer, 1993; Signorile, 1997). This often unconscious stigmatization of gay relationships was in part due to an increasingly commercialized gay culture that is more sexual and single-oriented than relationship focused (Bawer, 1993). Since this more vocal and highly visible part of gay culture still impacts most young gay men, particularly at the more adolescent phase of their coming out process, it necessitates a continued growth process that sometimes involves rethinking the dominant assumptions about relationships promulgated by popular gay culture (Alexander, 1997; Bawer, 1993; Marcus, 1998). In actuality, the history of gay culture has created few positive role models for male relationship that reflect the choices available to contemporary gay males (Sadownick, 1996), leaving many men feeling overwhelmed, confused and without

guidelines in their difficult search for relationships (Green, 2000; Marcus, 1998; Modrcin & Wyers, 1990).

Erotic Concerns

Many authors make clear that the history of the gay community reflects a support of gay male sexuality which includes an acceptance of diverse meanings of how sex and outside sexual arrangements fit within a committed relationship (Harry & DeVall, 1978; Herek, 1991; Mc Whirter & Mattison. 1984; Peplau, 1999; Signorile, 1997). More specifically, as examined in the prior sociocultural chapter, many male couples allow at least some extra-relational sex (Herek, 1991; Harry & DeVall, 1978; McWhirter & Mattison, 1984; Peplau, 1998, Signorile, 1997). This reality results in gay men often presenting in therapy with concerns related not necessarily with how to eliminate extra-relational sex, but with how to manage and communicate about the conflicts between their primary relationship and their sexual lives outside the relationship (Blasband & Peplau, 1985; Isay, 1989; Marcus; 1998). A common dynamic involves one partner wanting to 'open things up' to outside sexual encounters while the other partner gets further invested in monogamy. Similar negotiations are rare in couples treatment with heterosexual clients, where sex outside the relationship is most often seen as something that needs to end in order for the relationship to survive (Karpel, 1994; Moultrop, 1990; Pittman, 1989; Scharff & Scharff, 1995).

Even when attempts are made to communicate about their sexual arrangement, which is not always the case, these contracts are often difficult to negotiate, particularly

since the men within the relationship most likely have different erotic desires, interpersonal concerns and moral beliefs, all of which impact their visions of a committed relationship (Morin, 1995; Morin, 1999). In addition, the conscious discussion of these sexual arrangements can call into question many core values and self esteem issues. Depending on both partners' level of self-acceptance and ability to communicate, these negotiations can stimulate not only a range of concerns and feelings, but also, difficult power struggles (Alexander, 1997b: Hendrix, 1992; Isay, 1989; Modrcin & Wyers, 1990; Murphy, 1994). The key ingredient discussed by therapists who work with these arrangements is helping the couple to learn how to negotiate and feel comfortable enough to remain honest (Isay, 1989; Laird & Green, 1996; Murphy, 1994).

Loss of sexual desire

Some authors believe that gay men's erotic selves evolve quite differently than those of women and heterosexual men, with sex developing without the integration of intimacy, but with a feeling of freedom and independence that is core to the acceptance of being gay (Alexander, 1997b; Morin 1995; Odets, 1997). Sometimes this developmental path, along with the influence of the highly sexualized, gay culture they experience when coming out, contributes to a couple's loss of sexual interest in each other (Berzon, 1996; Blumstein & Schwartz, 1983; McWhirter & Mattison, 1984; Odets, 1997). Blumstein & Schwartz (1983) found that after ten years together, 33 percent of gay male couples had sex together less than once a month, compared to 15 percent of heterosexual married couples. McWhirter and Mattison (1984) normalize this waning of sexual desire in their

stage model of relationship, believing that is starts as early as the transition between stage one (blending) and stage two (nesting).

Therefore, two men often have sex without transitioning into experiencing it as a communication about deep feelings (Odets, 1997). This split between sex and intimacy is believed to be part of the gay developmental experience because, unlike heterosexual men who grow up anticipating that their sexual desires will culminate in a loving relationship, most gay men are devoid of this ultimate vision of putting together their sexual desire with a loving partner (Berzon, 1996; Isay, 1989; Odets, 1997). Drescher (1998) offers the perspective that boys get no affirming help in dealing with their homosexual feelings and consequently often dissociate from them with isolating shame. Berzon (1996) points out that without the complementarity of gender, some same sex couples might start to feel more like siblings than lovers, activating the incest taboo. Therefore, when some gay men attempt to shift their core erotic desire back toward their partner, it is an extremely difficult task, particularly since it is often linked to the complex intrapsychic events of gay sexual development (Gonsiorek, 1988; Morin, 1995).

Ultimately, male couples may seek therapy once they admit either that they are bothered by sexual boredom or that they have difficulty revitalizing their sex life (Alexander, 1997b; Berzon, 1996). This is a prime example of how applying the norms of more traditional heterosexual development of intimacy and sexuality to gay couples might not only fail to respect psychological and social differences, but also lead to further disillusionment, which could inhibit the couple's viability (Levy & Koff, 2001; Odets, 1997).

HIV

Though not the focus of this dissertation, any examination of therapy with male couples needs to factor in the profound and all encompassing transformation that the HIV virus has had on all gay men. As discussed in the prior sociocutural chapter, the complex impact of HIV on how, when and why gay men couple has been documented throughout the epidemic. Forstein (1994) explores how HIV has added new pressures for all gay couples, no matter their HIV statuses, that include: a) a pressure to define the romantic arrangements, sometimes leading to premature coupling to avoid the fear of contagion; b) a desire to define the sexual arrangement within the reality of HIV, with a push for exclusivity that becomes more complicated by longevity and each partner's individual fear of infection; and c) a spiritual and existential confusion complicated by the degree of loss and exposure sustained by the partners individually and together.

In the light of treatment advances introduced in the mid 1990s, HIV issues have become transformed, particularly as HIV has come to be thought of as more of a chronic illness than a fatal one. Due to these changes, men begarletting down their guard related to the continuation of safer sex practices, and have created new concerns due to the higher rates of unprotected anal sex (Ekstrand, Stall, Paul, Osmond & Coates, 1999; Halkitis & Wilton, 1999) combined with increased popularity of recreational drugs (National Institute of Drug Abuse, 1999). Though some men might suspect that they are protected from these concerns by coupling, these issues still impact many men who decide to get into relationships, since seroconversion within a committed relationship is one of the more common routes of transmission (Ball, 1996).

Utilizing these factors in treatment

While not exhaustive, all of the factors and content areas referred to in this section appear key to understanding and working effectively with male couples. Not considering each of these potentially significant factors in context of the whole of the relationship would seem to make it difficult for any therapist to apply his/her approach or theoretical orientation in a helpful way to the couple's social and personal situation (Alexander, 1997b; Levy & Koff, 2001; Odets, 1997). Some critics assert that context gives meaning to behavior and behavior must be understood within context, not generalized beyond that context (Rampage, 1989; Sedgwick, 1990; Witkin, 1989). Consequently, working with male couples without factoring in the meaning and impact of these fundamental contextual characteristics and factors would be like working with an interracial couple and not considering the context of race and culture. Of course, these factors are most beneficially viewed as being both an addition to and a reconstruction of the rest of the body of knowledge concerning relationships.

Section 3-Distinctive Factors of Family/Couples Therapy for Same Sex Couples

This section will utilize a diverse body of knowledge drawing from authors who have reinterpreted the more universal concepts of family/marital and systems theory not only to articulate how they have recast these perspectives to address gay relationships, but also to further articulate the unique dyadic concerns most often witnessed in the treatment of male couples.

Goodrich, Rampage, Ellman and Halstead (1988), self- identified lesbian family therapists, argue that it is only through recognizing the heterocentric context in which the dominant theories of family therapy developed that they can be reinterpreted for contextual issues relevant to therapy with same sex couples. In particular, Goodrich and her colleagues explore how such core family therapy concepts as triangles, fusion and boundaries, all created out of a practice base with heterosexual couples, are not only imbued with heterosexist bias, but fail to capture a comprehensive description of lesbian or same -sex couples. Often when these concepts are rigidly applied, they result in an assessment that pathologizes the behavior of same-sex couples. In a broader sense, they call into contention what makes any therapeutic concept "healthy"?

Because these concepts are not always interpreted as gender or same-sex sensitive, negative countertransferential reactions and heterosexist biases often result when applying these conceptions literally in couples work with same sex couples. The final segment of this section will consider how clinicians have used their counter-tranferential feelings to further understand how to more effectively utilize these concepts and themselves in the therapeutic process.

Even though Goodrich et al. (1988) focused on lesbian couples, their arguments help clarify roadblocks embedded in many of the core concepts of family therapy for all same-sex couples. Despite the literature which clarifies how many lesbian couples face different psychological issues than male couples, particularly because of different gender socialization (Berzon, 1996; Brown & Zimmer, 1986; Peplau, 1991), much can be applied from the literature on female couples when integrating family therapy tools into practice with male couples

Adapting Core Family Therapy Constructs

Triangulation

The first core concept of family therapy that Goodrich et. al. (1988) reinterpret in their work with same-sex couples is that of "triangles," one of the four major interlocking concepts of the Bowen family systems model. This model, the cornerstone of the work in most family and couple treatment, focuses on multigenerational patterns of transmission, emotional systems, differentiation and emotional triangles to understand how the family of origin sets the stage for ways in which couples connect and relate emotionally to each other (Friedman, 1991). According to Bowen (1978), triangulation often involves pulling a third party into a dyad in order to diffuse or deflect anxiety related to intimacy. Ultimately, he believes this form of adaptation to fusion between partners (lack of differentiation) may serve to exacerbate the partners' inability to differentiate themselves and achieve mutuality (Bowen, 1978; Friedman, 1991).

Triangulation as a concept might have different meanings and manifestations for male couples, lesbian couples and heterosexual couples. For instance, Goodrich and her

co-authors (1988) attempt to depathologize a classic analysis of triangles by making a case for women pulling in a third party in a relationship as a potentially healthy way to dilute the intensity of a conflict in order to make it more manageable. They support this interpretation by generalizing that because of the socialization process, two women are more likely to choose a problem solving style based on empathy as compared to a couple with at least one male, who is culturally supported to be more aggressive and conflictual.

According to Green, Bettinger and Zacks (1996), some family therapists invoke a pathologized interpretation of "triangulation" when trying to make sense of the varied sexual arrangements in male couples. For example, a pathology -based analysis would suggest that male couples pull in third parties because they are unable to deal with the intimacy and closeness in the dyad. However accurate this interpretation might be for some male couples, for others, there may be no dysfunctional consequences. Using a third party for sexual gratification outside a primary relationship might have all to do with the men's casual association to sex as recreation. It is also possible that such triangulation might have positive effects on the commitment of the couple and their capacity for intimacy, by potentially assuring the partners that their relationship goes beyond the heterosexually informed norms of monogamy and/or involves more of a focus on emotional then sexual fidelity (Green, et. al., 1996).

Fusion

Goodrich, et al. (1988) also attempted to reformulate Bowen's (1978) concept of fusion, particularly the idea that people who suffer from fusion are not only dependent but also undifferentiated, by which he means symbiotically connected to each other.

They challenge this concept, explaining that in terms of lesbian relationships, what might be interpreted as fusion could better be described as ongoing mirroring or twinning, a necessary developmental step that involves strong identification with each other. They further pull apart the construction of fusion as homophobic and profoundly patriarchal, when fusion suggests the absence of the more independent, more in control, more differentiated masculine member.

Many similar interpretations are possible with male couples, particularly when one or both men involved have developed with what is sometimes referred to as an atypical gender socialization that leaves them with some gender characteristics more identified with females (Green, et. al., 1996). In addition, sometimes with the lack of societal sanction, family involvement, legal and civil definitions, and defined milestones, some tendency toward fusion can be an adaptive way in which to establish closeness and empathy in a world that has been resistant to validating and viewing the members as a committed dyad.

Boundaries

Another central component of family systems theory utilized by many practitioners doing couples work (Fraenkel, 1982) is Minuchin's (1974) concept of boundaries or "the rules defining who participates and how" (p. 51). Boundaries are thought to exist on a continuum ranging from diffuse boundaries (enmeshed), to clear boundaries (normal range), to inappropriately rigid boundaries (disengaged). Minuchin (1974) claims that boundaries serve the protective function of maintaining a system's unique identity and viability. He further asserts that clarity of boundaries in a system is a

measure of functional effectiveness, since boundaries are crucial in modulating the effects of the external, larger system.

Goodrich and her colleagues (1988) believe the concept of boundaries is often interpreted so as to protect patriarchal hierarchy in families. Consequently, they see the use of boundaries as restrictive and based on power politics, leaving out the possibility of relational metaphors based on intimacy, mutuality, interdependence and equality. Instead of universally applying these concepts in a traditionally heterosexual manner, their case examples clarify how it is helpful for therapists to assist same-sex couples in negotiating their own unique and explicit "boundaries" regarding the patterns of their interactions, especially with respect to defining the nature of the expectations about, money, sex, and closeness.

Green, Bettinger and Zacks (1996) who used Bowen's and Minuchin's theories in an effort to answer the question "Are lesbian couples fused and gay male couples disengaged?" consider the concept of boundaries essential to an understanding of the norms of male couples. On the one hand, they argue that for male couples, the creation and maintenance of boundaries is made complicated by the lack of rules, models and cultural legitimacy of their relationships. On the other hand, the absence of convention leaves the men freer to create boundaries that are unique to the two partners' individual needs and values. Ultimately, their findings suggest that both lesbian and gay male couples are often more functional and less fused or disengaged than many heterosexual couples.

Johnson and Kern (1996) directly apply the idea of boundaries to male couples, as well. For all couples, they claim, boundary making involves two important tasks: (1)

developing intracouple boundaries, including the establishment of patterns of closeness and distance, and (2) developing boundaries between the couple and the outside world. Like Goodrich et. al(1988), they imply that especially for gay couples, it is important for therapists to remember that boundaries should be defined in the sociocultural context of the couple and not in a restrictive heterocentric context.

Similar to Green, Bettinger and Zacks (1996), Johnson and Kern (1996) came to related conclusions in their findings, once again using the lens of nonmonogamy as their most profound example of the context specific nature of boundaries, this time to demonstrate the flexibility of the concept of boundaries. These authors believe that the concept of boundaries can be helpful in interpreting and normalizing the sexual plurality espoused by male couples. They suggest that because of the drive for procreation and creating families, monogamy is biologically and culturally "hardwired" into the core boundary that makes two people a couple for most heterosexual relationships. As a result, because of gay men's varied developmental pathways and cultural expectations, it becomes probable that nonomonogamy might not necessarily disturb the boundaries in male couples.

Johnson and Kern (1996) conclude that boundaries related to sexual norms from one male couple to the next are clearly so diverse as to not be generalizable. They make a point that boundaries, like sexual exclusivity, exist on a continuum for male couples and thatin long -term male relationships they often vary throughout the years. Some couples set down rules such as no outside sex, only one-night stands, no disclosure about outside sex, full disclosure about outside sex, and/or mutual participation in the outside sex as a threesome or foursome. These boundaries, particularly if the two individuals in

the couple helped create them, are usually quite important, but nevertheless, for many are open for revision and further clarification.

In the clinical examples presented by Johnson and Kern (1996), it appears that male couples are most likely to seek counseling at times when existing boundaries are breached or a couple has a difficult time coming to a consensus. This is often where the therapist steps in and helps the couple either negotiate boundaries for the first time or re-negotiate them, as the individuals' and the couple's needs change over time. These studies clearly point to the need for clinicians who work with same sex couples to become acquainted not only with the different relationship styles of male couples (Shernoff, 1995), but also with the complications that arise from these concerns, so as to be able to assess where strains or dysfunctions are occurring without unnecessarily pathologizing or applying heterosexually defined family therapy theories.

The Lessons of Countertransference

Goodrich et. al. (1988), Green, Bettinger & Zacks (1996), and Johnson & Kern (1996), all described how at one point they utilized their countertransferential reactions to propel them down the path of reinterpreting the core concepts of family therapy and applying them to gay coupling. In fact, one of the most common ways that both systems and gay affirmative literatures describe how clinicians can identify and address their own homophobic and heterosexist assumptions is through monitoring their counter-tranferential reactions (Berzoff, Melano Flanagan & Hertz, 1996; Cabaj, 1991; Decker, 1988; Forstein, 1991; Frommer, 1995; Goodrich, et. al., 1988; Horowitz, 2000; Payne, 1997; Perez- Foster, 1998; Silverstein, 1991). Certainly, many contemporary clinicians

of varied theoretical backgrounds are taught to access their subjective experience and apply their knowledge to the specifics of a client's situation by becoming aware of and sometimes utilizing their own countertransferential reactions (Greenson, 1974; Perez-Foster, 1998). Ideally, the therapist who remains aware of his or her countertransferential reactions is able to more easily understand not only the influence of his or her values and beliefs on the treatment, but also the impact of his or her theoretical traditions (Solomon & Siegel, 1997).

It is important to remember, that countertransference has had various definitions, and remains a construct around which much clinical literature and theoretical debate have focused in the last half-century (Berzoff, Melano Flanagan & Hertz, 1996; De Simone, 2000; Greenson, 1974; Reich, 1952; Tower, 1956). Presently, countertranference is often considered to be the most informative source of data about the interaction between the client and the therapist (Berzoff, Melano Flanagan, & Hertz, 1996; Solomon & Siegel, 1997) with the countertransference experience being used by most psychodynamically informed therapists to make a positive contribution to treatment (De Simone, 2000; Racker, 1957; Winnicott, 1949).

Given the challenges in understanding countertransference with a single client, the level of complexity increases exponentially when working with a couple ((Brown & Zimmer, 1986). And add conflicting theories, potential homophobia, heterosexism and the therapist's current reality into the mix, and the continuum of countertran ferential reactions with male couples can be extremely complex. The following example will demonstrate how some clinicians have not only bridged gay affirmative perspectives and concepts from family therapy by examining the impact of their countertransferential

reactions, but also, and more importantly, used this knowledge to elucidate a common challenge that impacts the therapy of same-sex couples.

Mann (1997), an openly gay therapist, who utilizes an eclectic systems approach, makes the case with a lesbian couple that when he utilized an awareness of his countertransference he was able to more easily identify his own biases, making the multiple challenges more manageable and more enriching. He clarifies how in this case he started out more excited about working with a couple with his own sexual orientation, "his people"(p. 157) with whom he believed he was on similar ground and could act as a role model.

Mann acknowledges how his narcissistic identification not only hindered his ability to recognize the couple's pathology, but also elicited his homophobia when dealing with his disappointment. He found himself generalizing this couple's difficulties to all same –sex couples, even his own, asking if all same sex couples are destined for failure. His countertransferential wish, he alleged, was to collude with the intricacy of the task of staying together, even as he reluctantly agreed with the couple to terminate therapy and the relationship. This awareness of his countertranferential wish ultimately helped him to contain his own anxiety, access his own disappointments about witnessing the end of a gay relationship, and let the therapy unfold without his unconscious demands for an idealized outcome.

Goodrich, Rampage, Ellman, & Halstead (1988) in their discussion about working with lesbian couples through a feminist perspective address how a countertransferential reaction that idealizes the dynamics that bind same sex partners to one another is no more useful for therapeutic work than a pathologized reaction. Similar to Mann's (1997) case

study, this idealization could result in an over attachment by the therapist to maintaining the longevity of a relationship, making it difficult for the therapist to aid in a healthy termination of a same-sex couple relationship that is lacking in mutual satisfaction and incapable of change. In their discussion, Goodrich and her colleagues (1988) highlight not only how heterosexist biases can be easily projected into work with lesbian couples, but also how fear of reacting with a heterosexist bias often leads to clinical paralysis. In other words, just as clinicians have to be aware of their inevitable heterosexist bias, so they should exercise diligence in not *de facto* idealizing of all gay relationships.

Like many of the therapeutic questions raised in the last two sections, the risk of a therapist to over- idealize, make excuses, or even hold same –sex couples to a higher or lower standard because of their same –sex coupled status, is one that needs to be further explored and collaborated. It is important to note that many of the authors referred to in the last two sections based their analyses on cases from their collective practices, without any acknowledged collaboration with clinicians outside of their study. This project, on the other hand, aggregated countertransferential knowledge from social workers and psychologists, with different theoretical backgrounds and experiences, to generate data from various clinicians' accumulated practice knowledge

Implications for this Research

It seems that no matter the theoretical and conceptual underpinnings, the clinical literature supports the idea that one of the most important attributes of an effective therapist is the degree to which he or she has acknowledged, worked through and continues to remain conscious of any personal issues and theoretical biases that would

negatively impact the therapeutic relationship (Decker, 1988; Garfield, 1980; Kottler, 1991; Lopez, 1989; Nocross & Wogan, 1987; Schon, 1990). And since the concept of countertransferential reactions has become an integrative, almost universally accepted term that many clinicians of varied theoretical backgrounds utilize to identify and work with their values, attitudes, reactions and theoretical limitations (De Simone, 2000; Solomon & Siegel, 1997), the descriptions of therapists' countertransference were an important source of knowledge for this project.

This brief review of the usage and reinterpretations of countertransference over time, along with the extensive examples provided by the therapists interviewed, actually help demonstrate the reality that all clinical wisdom resides within a historical, linguistic, political and cultural context. Therefore, it was important to discover if the psychotherapists interviewed in this research utilized this contextual lesson, and if not, what frameworks or constructs they did utilize to become more clinically sensitive, attuned and knowledgeable. In the next section, the "cultural frame" will be clarified as another unifying paradigm that helps varied knowledge bases become more responsive and appropriate, as well as a force for sensitizing some of the basic paradigms inherent in conventional clinical practice.

Section 4-The Overarching Lens of Cultural Competence

Development of a culturally competent knowledge base has been an important focus in contemporary clinical practice, where providing more effective services to people of diverse genders, cultures, religions, classes and races has led to related research and educational changes (Cramer, 1997; Lefley, 1985; Mays & Albee, 1992). Social workers have been in the forefront of stressing both the social and cultural, when it comes to the interplay of these factors in treatment (Cramer, 1997; Lefley, 1985; Mays & Albee, 1992), and recently created standards of cultural competence specific to social work practice (Vallianatos, 2001). Historically, "culture" within a clinical context most often referred to shared history, customs, practices, beliefs and values of a racial, regional or religious group (Lefley, 1985). This framework often omitted the realities of gay men and lesbians whose psychosocial stressors must also be understood within a cultural framework and are also influenced by race, ethnicity, religion, etc. In fact, it was only recently that the NASW board of directors started creating standards of cultural competence that clearly stated that "there is a growing recognition that the concept of cultural competence is broader than culture defined by race and ethnicity, but also is relevant to cultures defined by sexual orientation, physical ability and religion" (Vallianatos, 2001, p.1).

When working with clients whose backgrounds differ from one's own, it is especially important that a therapist becomes culturally competent, developing familiarity with the clients' heritage, cultural milieu and developmental expectations (Bernstein, 2000; Lefley, 1985). When a clinician fails to educate

himself about a client's culture and harbors unconscious biases, it has been demonstrated to impact upon both the therapeutic relationship and treatment outcomes in negative ways (Bowman, 1982; Lehman & Salovey, 1990; Norcross & Wogan, 1987; Young, 1985). Problems result, in part, from the clinicians' lack of knowledge of cultural differences, particularly related to how power differentials in society not only impact the clients' day to day lives, but also the therapeutic relationship (Greene, 1995; Lopez, 1989).

Cross-cultural consciousness that includes an awareness of power differentials is equally important when differences involve sexual orientation (Greene, 1995; Pharr, 1988). Culture is a critical lens that many gay affirmative practitioners and researchers have utilized to help create clinical sensitivity (Green, 1995; Kanuha, 2000). However, as demonstrated in prior chapters, with regard to sociocultural influences on practice, until recently, social work and other professions concerned with psychotherapy have been reluctant to question their stances on sexual minorities, letting a legacy of homophobia and ignorance define their cross- cultural efforts.

When graduate or training programs in mental health do address the needs of gay or lesbian clients, they are usually relegated to a special elective, or left up to the openly gay or lesbian student to highlight and discuss (Lipton, 1996; Sears &Williams, 1997). Because of this marginalization, an ongoing lack of knowledge still leaves some clinicians unaware that they are defining the cultural context of male couples through the lens of heterosexual culture and traditions. As explored in the last three sections, this perspective fails to acknowledge considerable developmental and social differences,

potential variations in sexual practices, alternative motivations for getting and staying in relationships, and the influences of heterosexual and gay culture.

Clinician's Cultural Biases

Abramowitz and Murray (1983) assume that biases are ever present, and believe that cultural competence in counseling of any kind requires providers to be aware of the effects of these biases on the therapeutic relationship. In response, providers need to work toward resolving their prejudices and take active steps toward learning about and understanding the experience of the other. Lack of cross-cultural knowledge often creates misinterpretations which might lead not only to alienation, but also to an inability to develop trust, credibility and rapport with one's client (Lefley, 1985).

Pinderhughes (1989) suggests that culture permeates perception on every level and impels one to categorize people as "we" or "they." If a practitioner is unaware of this profoundly ingrained, often-unconscious categorization, the therapeutic process could be in jeopardy. For a practitioner to assess a client appropriately, Pinderhughes believes the clinician must have the following capacities:

*The ability to be comfortable with difference in others,

*The ability to control and even change false beliefs, assumptions and stereotypes,

*The ability to respect and appreciate the values, beliefs and practices of people who are culturally different,

*The ability to think and behave flexibly (Pinderhughes, 1989, p. 147).

As further suggested by Kanuha (2000) in her article on ''being" native versus "going native," clinicians and researchers require particular skills not only to work with different cultures but also to work within their own cultural identities. She claims social work needs more research about the challenges facing professionals who work within their own communities, particularly if, as with gays and lesbians, there are intrapsychic and interpersonal challenges that have resulted from centuries of internalized oppression. Similar to Abramovitz and Murray (1983) and Pinderhughes(1989), Kanuha (2000) asserts that clinicians must be more than just aware of multiple traditions and cultures, but must also engage in an ongoing process of confronting their own fundamental cultural biases. Thus, the data and discussion chapters address Kanuha's assertions by clarifying and expanding upon what it means to be a culturally competent practitioner when working with male couples, from both an outsider and insider perspective.

Multi-cultural Realities

Through their practice-based research as psychotherapists, Johnson and Kern (1996) believe that core relationship issues for gay men can be defined by the couples' bicultural experiences, the ever–present conflict and conversation between dominant culture (heterosexual culture as defined by popular, mostly white, Judeo-Christian influences) and the gay male culture. In addition, there is the potential that the individual partners also have different racial, ethnic and religious identities that shape the unique ways each person digests and uses his

bicultural experiences, integrates them into personal history, and brings them into the relationship (Fraenkel, 1982).

So whether gay men are defined as part of a sub-culture whose beliefs, values and norms differ from the dominant culture or as bi-or even tri-cultural, there is the strong potential for ongoing social, cultural and interpersonal tension. If the practitioner who works therapeutically with these men systematically understands the impact of these differences, in addition to the process necessary to adapt to the effects of stigmatization, potential discrimination and power differentials, s/he can more effectively intervene and asses the wide array of psychological and social concerns presented by gay clients (Appleby, 2001; Bernstein, 2000).

Influences of the Feminist Perspective

Research that addresses racial, gender and cultural considerations in both psychodiagnosis and treatment has broadened the framework of clinical practice and continues to be incorporated into social work education and training (Hare-Mustin, 1987; Lopez, 1989; Mays & Albee, 1982; Payne, 1997; Weingarten, 1991; Witkin, 1989; Zane and Young, 1994). However, it is important to note that, even among ethnic minority clients (i. e. African Americans, Latino-Americans, etc.), most research has been focused on concrete recommendations, often working within and borrowing from current theories of psychotherapy, developed from working with white, middle class clients (Sue, Zane & Young, 1994). More recently, however, clinical social work along with other mental health disciplines, is not only examining the historical and cultural roots of its

theories and clinical experiences, but also asking what might be ethno-psychologically bounded, rather than universal, phenomena (Kaplan, 2000).

Culture is now being viewed not only as an external force, but also as a key factor in the construction and conceptualization of clinical theory (Lopez, 1989; Perez-Foster, 1996; Roland, 1996; Walby, 1990). In particular, the literature directly influenced by feminist thinking (Payne, 1997; Rubin, 1984: Thompson, 1993; Weingarten, 1991) has managed to examine both direct practice and new theory development when it comes to working with women. Despite many competing factions, ranging from liberal feminism to radical Marxist traditions to queer theory, the last century saw many efforts toward creating practice knowledge based on feminist perspectives that took into account the evolving social, cultural and political realties of women (Gilligan, 1982, Horney, 1967; Keller, 1989; Walby; 1990).

Therefore, just as feminist therapists, regardless of their epistemological framework, developed theoretical constructs that took into account how the wider cultural context influences clinical practice while outlining the ability to act consciously in regard to gender, (Goldner, 1985; Hare-Mustin, 1987; Solomon & Siegel, 1997), it remains imperative that all therapists working with male couples create a groundwork for practice specific to the different experiential, cultural and psychological realities that confront gay men in couples.

The Widening Lens: The Summation of Objectives

The prior research literatures from which the distinguishing factors and characteristics of gay relationships have been extracted were developed mostly through clinical observation and interpretation by established clinicians (Gonsiorek, 1988). In a parallel fashion, this study was designed, in part, to discover how applicable and global these core factors remain in the clinical population discussed by the clinicians interviewed.

Despite the addition of this knowledge, it seems each therapist still has to actively sort through not only their personal biases, but also through their own theoretical and conceptual choices as to how to best work with these men. It has been posited that even when their clinical awareness is wide enough to include constructs like counter-transference and cultural competence and such varied perspectives such as family systems, gay affirmative psychotherapy and feminist theory, many clinicians still struggle with just how to work with the particular kinds of challenges that face contemporary gay males in committed relationships (Green, 2000; Levy & Koff, 2001; Mc Goldrick, 1996: Morin, 1999).

In addition, because these existing theoretical frameworks sometimes offer very different purposes, knowledge bases, units of attention and strategies for helping, they often lead to competing and confusing clinical choices that are difficult to balance (Payne, 1997). In response, this study presents the ways the therapists interviewed sorted through these choices and shaped their own clinical experiences through the addition of their personal practice wisdom. The next chapter will explain how this task was operationalized.

Chapter 4-

METHODOLOGY

Anecdotal accounts by published practitioner- researchers (Johnson & Lebow, 2000; Sherman & Reid, 1994) who rethink and reapply conventional psychotherapeutic practice principles to male couples are numerous. However, because many of these therapists not only have varied allegiances to different theories and training, but also are most focused on predominantly revealing the understandings gained from their own practice experiences, their knowledge base remains uncorroborated externally, underdeveloped and limited in generalizability.

Therefore, this research endeavored to build upon the body of knowledge gained through earlier investigations on treatment with gay couples so that the cumulative knowledge contributed to an updated and corroborated practice perspective. Rather than searching for comparisons or finding discrete variables defined by specific theoretical constructs, what was most important in this study was to extract from clinicians the essential nature of their methods of working with male couples, in other words, their clinical practice wisdom.

This research supports the idea that skilled practitioners have developed a practice wisdom that is task specific, grows directly out of practice experience, and captures elusive phenomena with complexities and context intact (Imre, 1984; De Roos, 1990; Reid, 1994). In this case, rather than applying theoretically informed knowledge from related situations-- specifically, heterosexually informed family and psychodynamic theory applied to male couples--this research was driven by practice experiences that

derived knowledge from the work of experienced practitioners who regularly interact with and have access to the experiences of male couples (Saleebey, 1989). In addition, based on more current descriptions of a "grounded theory" approach to qualitative research (Gilgun, 1994), this knowledge was inductively synthesized for either specific competency unique to this population and/or possible theory evolution. This chapter will discuss how the research methodology and study design were originally conceived and the connection between the plan and what actually occurred throughout this investigation.

Section 1- Rationale for a Qualitative Design

Scott (1990) believes practice wisdom is initially registered as intuition that eventually accumulates into loose cognitive associations and schema that get clinically validated over time. Identifying the generalizations and loosely organized frameworks and principles of practice that are hidden in these sometimes-unconscious associations took finding a methodology that could make this knowledge accessible. It was probable that in order to most cleanly access and bring meaning to this knowledge, the group of therapists that comprised the basic unit of analysis for the project would have to be engaged in a multi-layered conversation about their training, their theoretical backgrounds, their practice experiences, their implicit and explicit hypotheses about work with male couples and perhaps, for illustrative purposes, various case examples. The context of their thinking was of equal importance to the content of their clinical experience, each component adding to continued redefinitions of how they came to know and understand their way of working with these men. This required an inductive, flexible method of inquiry that could allow the researcher to explore and probe unexpected

material, anecdotal data, case illustrations and espoused theories into a comparative analysis that gets revised and redirected throughout the data collection process. Only a qualitative design can accommodate such an improvisational structure, clarify the implicit nature of the thoughts on practice choices and theories, utilize trade-offs that reverberate throughout data collection and analyses, and yet still remain clear in technique and form (Janesick, 1994).

Unlike more quantitative designs that attempt to verify specific hypotheses that tend to posit linear relationships, or describe single moments in time, this inquiry was envisioned as a dynamic, fluid discovery process that would mirror the dynamics of ongoing, direct practice in an ever changing world (Guba & Lincoln, 1994; Patton 1990; Payne, 1997). Attempts to name and measure all the interacting clinical variables that are embedded in theoretical contexts that contain even more variables might have led to findings that miss the explanatory and holistic scope of this project and fail to describe general trends of commn experiences (Wood, 1990). Since the goal of this study was not to measure or find causal connections between variables, but rather to describe, in as rich and detailed a manner as possible, methods of working, experiencing and thinking, quantitative methods were not employed.

As discussed earlier in relation to culturally competent knowledge development, this methodology was designed to follow the path blazed by those feminists who questioned the entrenched oppression of the dominant culture in clinical dynamics and set the example for accumulating and producing an evolving- less gender biased- knowledge base (Clunis & Green, 1988; Du Bois, 1983; Goldner, 1985; Walby, 1990; Witkin, 1989). These researchers continually emphasized the importance of a qualitative inquiry that

seeks not only "thick" description of the special needs of women but also reaffirms the validity of theory being grounded in the experiences of the group studied. Thus, this qualitative inquiry incorporates many of the methodological assumptions made by feminist therapists' work with gender, but applies them to clinical work with male couples.

A Phenomenological Approach Utilizing Grounded Theory

The choice of a phenomenological style that utilized the research procedures of grounded theory was based primarily on the nature of the material to be explored. An exploration of a therapist's practice wisdom is an intersubjective phenomenon which is not easily quantified, since it starts with asking therapists directly about both their work and their interpretations of work that evolved between multiple clients and their ongoing inductive experiences over time (Scott, 1990). Only a phenomenological investigation that is both descriptive and interpretive can attempt to extract the diversity of these dynamic experiences as well as their related core essences through probing interviews of the participants and ongoing comparison to the already accumulated data (Bogdon & Biklen, 1982; Patton, 1990; Sherman & Reid, 1994). Therefore, in the phenomenological tradition, it was the categorizing of these seemingly numerous ways of explaining the multiple processes and intuitive factors that contributed to these therapists' experiences that guided this researcher's search for practice experiences that led to translatable practice wisdom (Cole, 1992; Guba & Lincoln, 1994).

A number of other qualitative research orientations were considered but eventually ruled out, particularly because they did not fit as well with the objective to

generate potential theories and practice principles that emerge out of the data (Patton, 1990). An orientational approach (Patton, 1990) informed by "queer theory" was considered (Sedgwick, 1990), but seemed inconsistent with the exploratory nature of the research, since queer theory, or for that matter, any other single theoretical lens, would filter all the data on the basis of one, preconceived perspective. Consequently, a phenomenological focus represented a better fit for surfacing and framing practice, no matter the varied intellectual frameworks or predominant theoretical orientation of the practitioners.

A heuristic approach was also considered, because I had not only had extensive experience in counseling male couples, but also had contact, supervision and training with some of the experts in the field. However, the challenge to develop enough detachment to effectively interview with openness to multiple interests, perspectives and realities and then analyze without funneling the data through my personal experiences, would have proven to be even more complex then it already was (Patton, 1994). A phenomenological approach that utilized my conceptual familiarity without sharing my direct experiences seemed more bias resistant, more focused on "how other people experience what they experience" (Patton, 1990, p. 71), and seemed more commensurate with a grounded theory approach (Sherman & Reid, 1994). Needless to say, clarifying my role as a participant-observer who shared many of the same experiences as the participants (Bogdan & Bilken, 1982) required a peer review, and ongoing self-monitoring, which called upon my skills of being impartial acquired through years of practicing as a psychotherapist.(Guba & Lincoln, 1994; Lofland & Lofland, 1984).

Ultimately, the lens of social constructionism contained not only the intellectual key to my attempted impartiality throughout the interviewing, but also the frame for the entire conceptual construction of the methodology. First, the epistemological foundations of constructionism, with its core understanding that all truths are subjective, time- bound and shaped by informed constructors, best lent itself to creating the guide and proposed data collection process (Guba & Lincoln1994; Payne, 1997). In addition, the social constructionist framework worked as a distancing mechanism that helped me interact with the varied realties of the respondents, by my accepting that all their thoughts, and beliefs, even when presented as unitary facts, were socially constructed. In addition, through the lens of social constructionism, not only would the therapists' beliefs and practice skills be viewed within the context of social convention, but also their impact on their clients would be seen as part of the social construction.

The theory of social constructionism recognizes that arriving at knowledge that guides behavior only occurs after views and ideas are contextually shaped and develop coherence through time (Payne, 1997). Similarly, the concept of practice wisdom is recognized to be about a process oriented by contexts in transition and bounded by time, place and person (Klein & Bloom, 1995; Rein & White, 1981). With these common conceptual filters in place, the actual interviewing of the clinicians in this project was envisioned as helping the participants deconstruct the social realities inherent in their clinical values, knowledge and skill. Even when the data eventually revealed a struggle between essentialist and constructionist ideologies among the participants, the expansive social constructionist frame helped inform the final discussion of this theoretical tension. Simply put, social constructionism helped me remain conscious that any emerging

assumptions that emanated from the data were value-bound, and based on the consensus of a clinical subculture in collaborative social interaction with clients and reflective of this time in history (Bogdon & Biklen, 1983).

Grounded Theory

Some phenomenological researchers in their search for the essence of an experience stop at the point of general descriptions and do not strive for any theoretical conclusions (Miles & Huberman, 1994). Others use more diversified techniques that transcend philosophical differences and approaches and lend themselves to taking these descriptive accounts and, utilizing the grounded theory approach, interpreting them for their meanings, patterns and links to possible theory (Glaser & Strauss, 1967; Wolcott, 1994). Strauss and Corbin (1990) went even further, claiming that besides generating theories that account for the hows and whys of a phenomenon, theories could be then be validated through qualitative, grounded theory methodology.

Gilgun (1994) makes a strong argument that research utilizing a grounded theory approach is especially compatible with the development of practice knowledge because there are comparable skills and conceptions. She focuses on such parallels as:

> *The focus on the perspective of the informants is congruent with the social work idea to start where the client is.
> *The data collection methods are similar; both use a natural setting, field notes, tentative hypotheses, a form of constant comparison and are open to modifications (pp. 123-124).

Most significantly, the grounded theory approach seems consistent not only with practice but also with practice wisdom. Klein and Bloom (1995) clarify that practice

wisdom is incomplete information and/or knowledge at the fringes of experiences that emerges out of an inquiry process that gets shaped and tested by consecutive transactions between the phenomenological experience of the client situation and the inductive experience of the practitioner. It remains important to note once again that, unlike Klein & Bloom's (1990) ultimate striving for "scientific knowledge" through quantitative hypothesis testing, the data in this study demonstrate that weaving data through an inductive analysis process that translates it into conceptual themes and functional theories (Sherman & Reid, 1994) is valuable in and of itself. Parallel to the interwoven experiences between the client and the clinician for which practice wisdom evolves, grounded theory interweaves data collected from subjects through a constant comparison process. In essence, the development of practice wisdom has an analytic analog in the qualitative methodology of grounded theory, and therefore can be most efficiently and effectively gathered by these means.

The Data Source as seen through Practice Wisdom

The concept of practice wisdom as a personal system of knowledge development most often does not include the step of packaging the knowledge for general consumption (Klein & Bloom, 1995; Scott, 1990). Klein and Bloom (1995) suggest that the translation of value-driven practice experiences should be linked into communicable terms as naturally as the intuitive process that created the wisdom in the first place. In their conceptual model for the creation of practice wisdom, they believe hunches that get tested in client interaction are funneled and reshaped through a personal system of knowledge. This dynamic process can be traced to both practice experiences and prior

accumulated scientific knowledge and is most fully developed when these principles are openly articulated with other professionals.

Sometimes this process is observed or talked through with a clinical supervisor. However, most supervisors clarify or teach existing theories and knowledge, funneled through their own experiences, and do not think in terms of building emergent practice wisdom (Lipton, 1996; Scott, 1990; Zeria & Rosen, 2000). Even if a supervisor or colleague consciously strives to make practice wisdom explicit, it is the practitioner who not only registers the experience and awareness, but also, often goes back to test and develop new knowledge in practice situations (Klein & Bloom, 1990). In addition, this ongoing intuitive process is not always conscious to the supervisor or the clinician. A supervisor can only speak to what the clinician reports and then only what has been revealed and/or observed at the moment. Consequently, even though supervisors can potentially be the source of data for practice wisdom generated by their work with supervisees, the more immediate and proximate source would be the clinician immersed in the treatment process. So while, supervision represents one potential pathway in the surfacing of new knowledge, this study focused on clinicians as the source of data, those closest to the practice situations described earlier.

Section 2-Data Collection Choices and Tradeoffs

The Use of an Interview Guide

Similar to the extraction of practice wisdom that focuses on the clinicians' observations and experiences sifted through available clinical information, a grounded theory approach uses a combination of interviewing, observation, document analysis and sometimes even quantitative techniques in the collection of data (Strauss & Corbin, 1990). As described in the rationale for qualitative research, capturing the subtle, sometimes unconscious, inner process of a therapist's understanding of his/her experience is difficult to observe or describe and therefore requires a retrospective analysis, whose complexity can only be captured in an ongoing interview process (Patton, 1990). The drawback with this sort of interviewing was that some therapists found it hard to explain what they actually did and to retrieve useful examples from their recollections. However, as will be demonstrated in the data chapters, in instances such as these, through a progression of discussing specific cases and exploring their impact on their practice, insights and previously unconscious process were often revealed.

To counteract difficulties with recall, triangulating an observation of the therapists in action, as part of the data collection process, was considered. Some subjects were questioned as to the possibility of such observation, and all responded negatively regarding its practicality and potential disruption of therapy. Unfortunately, outside of clinics and training institutes that possess one-way mirrors or video-taping for observation, the possibility of receiving permission from enough experienced clinicians was at best very modest.

Ultimately, similar to other grounded theory projects (Gilgun, 1994; Sherman & Reid, 1994), it was believed that a cumulative, face-to-face, guided interview would best surface the research relevant experiences and points of view of the informants. In addition, it allowed focused, detailed and consistent information to be captured from often subtle and complex clinical practice situations. Furthermore, because this study contained elements that were both exploratory in regard to practice wisdom and potentially confirmatory, in terms of prior knowledge about male couples, a well-structured interview guide was the logical choice (Miles and Huberman, 1994). Although not as flexible as a loosely structured instrument coupled with conversational style of interviewing, fixed questions provided assurance the same material would be covered in each interview (Shatzman & Strauss, 1973; Strauss, & Corbin, 1990). Even with its limitations, it allowed a range of individual differences among participants to be explored in depth while providing a systematic framework to ensure initial reliability, to aid in comparisons among participants and to best identify emerging trends (Miles and Huberman, 1994; Patton, 1990). Another drawback of this approach, however, was that some therapists, despite prompts, could not surface their internal experiences, making some of them unable to respond effectively to certain questions and making other reminiscences seem "second hand."

The Mechanics of Data Collection

Since this study sought experienced clinicians who usually work with appointments scheduled every hour, initial interviews lasted 50- 60 minutes, in order to fit within most therapists's scheduling protocol. The time frame proved to be within the

natural confines of the therapist's hour and proved sufficient to capture core material, engage subjects and build rapport for potential follow-up interviewing. In addition, psychotherapists who met the sampling criteria (see the next section) were already trained to be introspective. Therefore, since they had a chance to review aspects of the guide prior to the interview, most were able to answer the guide questions within this time frame. It was anticipated, as well, that in order to get the widest geographic range, and the most accessibility, interviews would be conducted both face to face, and by phone. However, it proved close to impossible to get firm commitments over the phone for those potential subjects outside of New York. Interestingly, the one and only subject interviewed over the phone, someone I had known from his prior work in New York, had a follow-up interview, face to face, when he visited New York.

Each subject received in the initial mailing a request to collect anecdotes about particular cases that seemed relevant to the purposes of the guide (see, Appendix 3). In addition to making potential respondents aware of the initial 50-60 minute interview, the initial phone contact discussed the possibility that potential follow –up interviews would be requested when elaboration on specific points was required. When subjects agreed to participate, a consent form was mailed out (see, Appendix 4) along with a demographic face sheet (see, Appendix 2) that was utilized for gathering basic demographic statistics and served to further orient the subjects to the upcoming interview.

All interviewees gave their permission to be audiotaped. In addition to the tape recordings, handwritten interview notes included observations of the communication process (including nonverbal communication). After the interviews were transcribed, and memoing helped emerging themes develop, four respondents, chosen because they were

such productive informants, participated in a second interview. Three of these interviews were given over the phone, and one was in person.

Section 3- Sampling Procedures

In order to mine shared practice wisdom and potential theories, it was necessary to select a sample of clinicians to interview who would provide entrée to the unique practice wisdom that clinicians utilize and thatnaturally emerges when working with male couples. This section discusses the rationale for various aspects of the sampling procedure, including: sampling criteria and rationale, the procedures for subject selection, the sample size, and limitations that occurred throughout the procedures.

Criteria and Procedures for Selection of Sample

Miles and Huberman (1994) assert that through focusing and bounding the collection of data, decisions can be made about the size and the characteristics of the sample. The most obvious boundary concern was finding access to therapists known to have mastery in working with male couples. Experienced clinicians would have had more time not only to shape their practice knowledge, but also to refine their thoughts into a comprehensive stance that applies this knowledge (Klein & Bloom, 1995). Therefore, the focus was on explicitly selecting a sample that would elicit the fullest possible development of this area of practice wisdom.

In addition, consistent with Gilgun (1994) and Glaser and Strauss (1967), it was essential to select a sample that created enough of a range of experiences to fully develop each category. Therefore, a smaller number of therapists possessing a depth of clinical

experience with ample variability in the number of male couples they have worked with, was preferred over a larger number of clinicians with minimal experience, in order to access participants who could be rich sources of information and who had the potential to articulate the subtleties of their practice experiences. Consequently, the sample of therapists was selected with the following criteria in mind:

1) All subjects were licensed mental health providers, of any relevant academic background or discipline, who have been working primarily as psychotherapists for a minimum of five years.
2) Subjects were either gay or "straight", but must have identified themselves as highly experienced in doing couples therapy with gay men.
3) All subjects had practice that evidenced a gay affirmative position and yet incorporated any variety of clinical theories and traditions.
4) All subjects were clinicians who have developed reputations in the mental health community as competent in working with male couples.

The Plan for Sample Selection

In this study, probability sampling was clearly ruled out in favor of nonprobability sampling that attempted to be both purposeful in its richness and flexible in its unearthing of appropriate participants (Weiss, 1994). Specifically, the most general description for the initial sampling strategy was criterion sampling that would locate potentially information rich respondents with the pre-determined criteria cited above (Patton, 1990). Since these criteria restricted the pool of possible respondents to a rather specific segment of the population of psychotherapists, I started with several key people, whom I knew

already met the foregoing criteria. The plan was to start with a convenience sample and then proceed to a "snowball strategy" that asks respondents to identify other potential respondents. To ensure that clinicians with the stated criteria will be recruited, identified subjects were asked specifically if they knew appropriate candidates who would qualify based on the fit between their practice experience and the criteria. The challenge was to search for a diverse sample of clinicians that still fit the criteria, but represented a cross section of backgrounds, disciplines, training, theoretical orientations, sexual orientations, etc.

All potential respondents were contacted by phone. After revealing the referral source and the nature of the study, the subject's experience and willingness to provide information was discussed. Potential interviewees were assured confidentiality in the interview process (see, Appendix 4) and anonymity for any published material for themselves and their clients and then, if they agreed to participate, were sent a copy of the interview guide and the demographic face sheet. At that time, names of other potential respondents were solicited, particularly from those who were known to possess some variations from the pool of clinicians already participating.

Potential respondents included colleagues and acquaintances, but not teachers, supervisors or any colleagues who conferred in the creation of the present project. The main reason for including colleagues is that I had been involved in the field of gay and lesbian psychotherapy and research for a number of years and had contacts with many of the more established members of the New York community. To have excluded known respondents would mean excluding subjects who would not only be interested in being included in this research, but who had the most to contribute. Naturally, however, there

were concerns about objectivity, particularly if the subjects attempted to please the researcher by revealing what they assumed the researcher wanted to hear.

This was such an important consideration that it was addressed in the opening statements of the interview, not only with subjects the researcher had prior contact with, but also with all potential subjects (See the Guide- Appendix 1). However, since "practice wisdom" was not a concept any of the respondents said they were familiar with, it seemed to level the field and created enough of an evenhanded discussion to generate data in unfamiliar ways, for everyone involved.

Trade-offs Associated With Each of the Sample Criteria

1). *All subjects were licensed mental health providers, of any academic background or discipline, who have been working primarily as psychotherapists for a minimum of five years.*

This restriction was designed to assure that the subjects had acquired some experience to back up their basic training in psychotherapy. More experienced clinicians have demonstrated some competency, have had more time to experience gaps in their basic knowledge base of working with male couples and potentially have developed their own ways of working (practice knowledge). This limited drawing on less experienced therapists, who might not have had enough years in practice to think independently of their training or theoretical traditions and develop the degree of self-awareness necessary to describe their own brand of practice.

Ultimately, the sample included social workers and psychologists, all with a minimum of seven years experience. Five psychiatrists, identified by word of mouth

contacts, claimed their ongoing experience with male couples was not sufficient enough because they get less opportunity to work with couples then other disciplines. However, several of them were excellent resources for potential referrals. Perhaps, if I had taken more time to keep networking, I would have located psychiatrists who consented. Nevertheless, in the final sample, there was considerable diversity of experience, training, and theoretical orientations, but no psychiatrists and almost no geographic diversity (see, Table One).

The lack of geographic diversity was a result of the more general difficulty in getting appropriate subjects who saw themselves as experienced to commit to an hour, along with the difficulties of arranging a phone interview, already discussed. The inclusion of an advertisement in the national magazine, "*In the Family*," a magazine for gays and lesbians and their therapists, did not net not one qualified respondent, despite asking the editor in chief,for her assistance. The entire process of seeking respondents demonstrated that there are many couple experts and many experts who work with gay men, but few who satisfy both criteria. I was most effective in getting a commitment from respondents who knew somebody I knew or had contacted, or had met me face-to face at some conference or training experience

Once saturation was reached with the 20 who participated, there was only one participant from outside New York, from the Mid-West City. Consequently, the skewing of this sample to the New York City area reflects an unanticipated limitation. Of course, this data, because it is a relatively small purposive sample, cannot be generalized to any other populations, and has even more limitations when applying its insights to couples and therapists outside of urban, liberal environments like New York City. On the other

hand, the diversity of opinions reflected in this sample and the depth of experience might only be found in a city like New York, where many people value and utilize therapy and there also exists a high concentration of gay males and male couples.

2.) Subjects were either gay or "straight", but must identify as highly experienced in doing couples therapy with gay men.

This was not intended as a comparative study between gay and "straight" clinicians. Even though the literature suggests thatthere are different issues that arise in practice for gay versus straight clinicians (McGoldrick, 1996; Morin, 1977; Seigel & Walker, 1996), the focus of this study was to surface experiences independent of the sexual orientation of the practitioner.

Getting qualified gay clinicians was far easier than getting "straight" or non-gay-identified clinicians. The first 12 respondents interviewed comprised 10 gay men and 2 lesbians. Identification of these participants was achieved mostly through word of mouth or referrals based on reputation. It was difficult finding lesbian clinicians who had seen more than two male couples and wanted to participate. Several lesbian therapists claimed that the male couples they had seen tended to show up for an initial assessment, but ultimately did not choose to work with them. Most potential lesbian respondents reported that gay men were more likely to see them on an individual basis, than as a couple. Gay male couples, they said, tend to want gay male therapists. The two lesbian women interviewed corroborated this generalization.

After interviewing the 12 gay identified clinicians, there was enough replication of themes to develop an emerging sense of saturation (Strauss & Corbin, 1990). I felt that at

that point I could fully express the views of these subjects, but was concerned that a potential source of valuable experience was left out, with not only the limited range of location, but also the exclusively gay sexual orientation.

When the magazine advertisement for research subjects placed in, "*In the Family*" failed to locate non-gay clinicians, or clinicians outside of New York, I called the Ackerman Institute for Family Therapy in New York City, known as an agency that at one point had a special training program for clinicians working with same-sex couples. I was able to get two heterosexual referrals through them, but despite their prominence in couple therapy, could not locate other straight clinicians like themselves. Other avenues were utilized, such as flyers that sought both gay and straight clinicians who worked at London Terrace Psychotherapy and The Institute for Human Identity, two well-known gay and lesbian focused psychotherapy centers. There, I did acquire gay and lesbian clinicians, two of whom I interviewed, but no more non-gay respondents. I then attended the 2003 National conference in New York for "Psychotherapy Integration" whose theme that year was "Similarities and Differences" among clients and clinicians. I handed out flyers and spoke at many of the workshops that might relate to this study. It was ultimately through contacts that I made face to face at this conference, along with referrals from the gay clinicians, thatI was able to obtain the 8 heterosexual respondents.

I believe thatsome of the non -gay therapists I telephoned, at the beginning of my search, did not feel comfortable labeling themselves as "experienced," and therefore passed. At that point, I was still hopeful enough to get others and did not work very hard to convince them otherwise. In retrospect, I suspect it also felt threatening to identify as "experienced" to an out, gay male therapist who wanted to question these non-gay

therapists about an aspect of their practice that they might not have spoken to anyone about except their supervisors. As time went on, I de-emphasized this criterion, because it seemed to create unnecessary apprehension and therefore, self selection out of the study. Nevertheless, most of the non-gay respondents who *agreed* to be interviewed, even after I stopped highlighting the need to be highly experienced, started out apologetically about the extent of their practice knowledge with male couples. Eventually, however, almost all of them relaxed enough to provide a wealth of data and case illustrations.

3.) All subjects must have practice that evidences a gay affirmative position and yet might incorporate any variety of clinical theories and traditions.

As stated earlier in the nominal definitions section of this proposal, gay affirmative refers not only to a respect for sexual diversity, but also to an ideological stance that puts homosexuality on par with heterosexuality as a normal variation of human sexuality (Gonsiorek, 1985). All clinicians may have different ways of demonstrating this perspective, but all respondents were questioned as to this gay affirmative principle in the initial phone contact. From the start, this project was not intended to reveal how clinicians who have an ambivalent or a knowingly pathologized perspective on gay male sexuality and coupling attempt to work with clients who seek their counsel. In addition, even though differences in clinical orientations are described, these distinctions are not the major focus of this study (see Table 1). However, the differences that yielded distinct patterns of practice are discussed in the data analysis.

4.) All subjects will be clinicians who have developed a reputation in the mental health community as competent when working with male couples.

Seeking clinicians with a reputation was not only another way to help verify experience, but was practical since the most common source for informants was recommendations from other practitioners who recognize their expertise in this regard. Despite the fact that there was an abundance of gay –identified psychotherapists who fit all criteria, as just discussed in criterion # 2, there were few non-gay therapists who felt they qualified as experienced in working with male couples. Even the subjects who eventually were interviewed had not seen nearly the number of male couples that the self- identified gay therapists had seen.

These unanticipated circumstances led to the inclusion of some non-gay respondents without reputations for working with male couples. However, what they lacked in breadth of gay-couple experience and reputation, they more than made up for in depth of experience with couple work, in general. Where they could not describe how male couples might have changed over time, they were able to add valuable content about working outside their area of clinical and cultural expertise. Similar to the reports of the lesbian therapists, it seems when the few male couples who choose to go to a non-gay or female therapist actuallyget engaged, a different therapeutic agenda and dynamic surfaces. Examples of these will be shown in the subsequent data analysis and discussion.

The Final Sample Size

The sample strategy most often used in qualitative research involves interviewing an expansive pool of respondents to the point of redundancy or the point at which continued inquiry reveals no new ideas, meanings, experiences and descriptions (Glaser and Strauss, 1967). At the outset, it seemed unlikely that a study that explores something as subtle as practice wisdom and as complex as male coupling would reach a point when no new generalizations would emerge.

Even though the problem of accessibility to clinicians outside of New York was unanticipated along with the difficulty in finding non-gay therapists, I eventually felt I could accurately represent the synthesized views of the varied types of respondents. Arrival at the final sample, like all aspects of the design, involved making significant judgments. Over a single year, out of 41 people contacted, 20 therapists were interviewed once, with unknown others exposed to the flyers, word of mouth and the advertisements placed in "*In the Family*" and clinical settings. Ultimately, three of the respondents had follow-up phone interviews, and one follow-up was conducted face to face. All of these second meetings involved unscripted conversations that focused on nuances of their previous responses, more details about specific styles of working and discussions about the differences experienced in the two major subsets of clinicians.

Similar to most aspects of qualitative research, decisions about sample size are complex and ambiguous because they emerge in the process of pursuing the study and in the ongoing analysis (Patton, 1990). In this case, after the 12 gay respondents were interviewed, specific trends were identified that were redundant and no longer led to new options in the preliminary coding (Glaser and Strauss (1967). Then, the non-gay

therapists not only added new insights to existing categories, but also raised new concerns not previously encountered within the subset of gay therapists. Thus, sampling continued until no new ideas or significant variations were being obtained from both sets of interviews.

Clearly, even though the respondents revealed an array of experiences, there were many who refused to participate for varied reasons. Therefore, this sample represents a subset of clinicians, with certain types of experiences, limited further by the interview, and its one-hour time period.

Section 4- Guide Construction and Evolution

Based on the objectives of this study, the main focus of the interview guide was to reveal the subjects' practice challenges, experiences and developing practice principles in the context of their work with male couples. The two most serious challenges in constructing the guide were: 1) finding a way to systematically help the subjects uncover and share the relevant data and knowledge that represented their practice wisdom; 2) formulating questions and probes that support the articulation of sometimes unconscious or latent thought processes (Scott, 1990). Utilizing the "typology of questions matrix" offered by the Loflands (1984), the "trace-back starting point" time-line offered an organization whereby the point of origin would be the subjects' pre-existing theoretical and subjective knowledge in regard to their training, theoretical orientations and practice experiences. Subsequently, it was anticipated, they might be gently steered into revealing how they encountered impasses in treatment that potentially represented gaps in their practice knowledge that led to their present state of practice with male couples.

The Loflands' (1984) suggestions were a referral point for the initial structure of the interview guide. It must be noted, however, that in order to discover how best to elicit questions about a developing knowledge base, the guide evolved through successive drafts based on test runs and conversations involving several clinicians. The original draft started with clinicians fleshing out the straightforward self-descriptions outlined in the demographic face sheet (see, Appendix 2). The plan was to gradually prepare informants to start thinking about themselves in relation to the subject matter before asking them about their opinions regarding "how" or "if" they had deviated from their training, original theoretical underpinnings, and beliefs about effective couple treatment. It was not until the probes, in the later questions about process, that specific details of cases, and/or critical therapeutic moments, were requested. Parenthetically, at that point in the pilot interviewing, most clinicians had difficulty linking cases back to their stated ideas about direct practice.

Through pre- testing the guide it was discovered that clinicians had great difficulty in being spontaneously reflective when linking general challenges to particular case examples that supported their thoughts and generalizations. What participants offered were descriptions and general ideas about male couples. This became problematic, when asked to flesh out the cross case comparison requested throughout the guide.

Butler, Davis and Kukkonen (1979) and Scott (1990) propose that it is up to the researcher to help identify the hidden generalizations and principles of practice in anecdotes and case illustrations when seeking practice wisdom. Similar to Klein and Bloom (1995), they advocate starting with practice problems that build into the

practitioners discovering previously unarticulated commonalties across experiences. Consequently, the guide needed to be redesigned so as to most effectively link specific experiences with evolving practice knowledge.

Ultimately, it was revealed through using the revised version of the interview guide that when clinicians were asked to focus initially on specific case examples, rather than general questions about practice, they more easily reflected on their evolving practice approaches. Perhaps this can be attributed to the fact that many clinicians in both supervision and training are taught how to present a case and then reflect on their work. Mirroring this sequence in the guide, a specific clinical case context is established before requesting self-reflection. For the subjects, this not only seemed familiar, but also helped them clarify the direct impact of theses cases on their practice wisdom.

In retrospect, mailing out the guide preparation sheet with the initial documents (see, Appendix 3) not only gave the clinicians time to pick out specifically rich case examples prior to the interviews, but also gave them more time to flesh out the details and reach for reflections and comparisons between cases and types of couples. The potential drawback in pre-picking cases was that some subjects' responses could have seemed pre-planned, polished and 'tamed.' Being aware of this limitation, I introduced probes improvisationally, based on the contents of the respondents' presentations. This seemed to lead participants to not spend time on thinking about which cases to present, and instead disclose unanticipated, tangential and often fresh material, most useful to the process of unearthing previously unarticulated ideas and insights.

Surfacing Practice Wisdom

Through experimentation it became apparent that in order to focus on cumulative practice knowledge based on direct practice experiences, the guide would need to map effectively how practice experiences lead to practice wisdom. Klein and Bloom (1995) provided their framework in the chart, "Translation of value –driven practice experiences into communicable terms" (p. 802). This schematic is based on their conception that experiences from the practice realm are linked with ideas in the theoretical realm to build practice wisdom. In Klein and Bloom's framework, practice wisdom is the bridge between pre-existing scientific knowledge that gets fed through subjective knowledge and practice challenges that emerge out of mini- hypotheses that develop into new concepts and practice guidelines.

In conceptualizing a framework that develops practice wisdom, this guide combines Klein and Bloom's (1995) schema with the need for specific case dilemmas supported by Butler, Davis and Kukkonen (1979) and Scott (1990). In essence, this guide attempted to capture the specific impasses and moments that forced clinicians to recognize if gaps in their knowledge base and then reveal how these have been addressed, applied and potentially utilized with future cases. Therefore, the core of the final version of the guide was structured with sequential questions that were constructed to best capture the complexity of practice wisdom mined from comparing multiple subjects and case examples. In other words, the underlying assumption was thatpractice wis dom surfaces once therapists not only focus on dilemmas and contradictions in their practice experiences, but also proceed to share how they are experienced, understood, resolved and applied.

Section 5- The Final Guide

Even though the body of the guide remained consistent, the significance of certain areas and particular questions were highlighted and changed throughout the data collection process. This process of emphasizing different sections enabled me to sharpen the process of information gathering, to surface new information and move into areas that had not already been saturated or fleshed out. The guide was as follows:

TOPIC: Pre-existing knowledge

1). What most prepared you for your work with male couples? (How did this help?)

PROMPTS: your graduate education, post graduate training, workshops, supervision, your own therapy, influence of your sexual orientation, your own experiences of being single and coupled, influence of generational issues or your age, gender, ethnicity

2). If a colleague asked you to describe your theoretical orientation in regard to male couples, how would you describe it? What are its strengths and limitations?

PROMPTS: Integrative, systems, Gay affirmative, etc., other approaches, expectations, most useful aspects

3.) When you first started working with male couples, what, if anything, got in the way of treating these couple as effectively as you could have?

PROMPTS: own experience, your practice approach, over or under identification, value judgments, theories that informed your work and how you utilized them, conflicts with your clinical education, ideals versus reality, rigidity, examples

These experience questions (Patton, 1990) warmed the participants to the purposes of the guide by asking them to clarify and assess a range of factors (graduate education, other training, workshops, their sexual orientation, their relationship experiences, their theoretical orientation etc.) that might have influenced their knowledge base, both positively and negatively. Question 2 asks for a characterization of their present theoretical orientation, as well as the pros and cons of applying their "espoused theories." This introductory section is an attempt to understand the participants' pre-existing knowledge, and pre-existing biases with their own evaluation as to their relevant knowledge.

TOPIC: Discovering gaps in the knowledge base

4). Think of a couple, or a particular moment in your work, when a therapeutic impasse related to the couple being gay men forced you to discover a new way of working or apply different knowledge. Describe the circumstances and what happened.

PROMPTS: was there a failure or gap in knowledge base, countertransferential obstacles, limited beliefs, preparation, training, supervision, personal experience, theoretical gaps and modifications, specific interventions

5). Over time, how did you correct this?

PROMPTS: specific interventions, new thought process, imagination, trial and error, other theories, mini- hypotheses, value shifts finding similarities, differences with other couples, types of couples, stages of couples, value shifts

6). As you reflect on this case, what did you learn that might have translated into intervention strategies or beliefs about male couples that you utilized or generalized in future cases?

PROMPTS: structuring sessions, use of theory, ideas about male couples, types of couples, stages about couples, specific needs based on ages or stages of life, power differentials

This set of questions focuses on the subjects' efforts to understand an encounter with a practice situation that made them potentially aware of an incomplete knowledge base or challenged their techniques of working. The more specific intent was to enable the subjects to search for how they combined already existing knowledge with the specifics of this practice dilemma, to give meaning to this experience as well as to similar, future experiences (Klein and Bloom, 1995). The last question attempts to find

out if this experience has contributed to their interaction with other clients and in what ways it may have become part of their cumulative and continuing knowledge base, their interventions and/or style of working.

TOPIC: Bridging subjective experiences with objective knowledge

7). Choose another couple, or a particular moment in your work, when your knowledge or experience related to the couple being gay men felt insufficient for effective work. Again, describe the circumstances and what felt ineffective?

8). Over time, what did you learn from this gap in your knowledge base and how are you applying it now?

PROMPTS: specific interventions, new thought process, imagination, trial and error, other theories, mini- hypotheses, value shifts, finding similarities, differences with other couples, types of couples, stages of coupling

9). Utilizing these two cases, or any others you believe are relevant examples from your practice, identify other aspects of your knowledge base or practice principles that you have learned through direct clinical experience and not necessarily through your education or training.

PROMPTS: hypotheses about male couples, interventions, style of working, countertransferential obstacles, cultural needs, revision in concepts, practice principles, ideas about relationships in general

This section's questions were intended to further elicit patterns of accumulated ideas and strategies developed through recurring case experiences (Scott, 1990). After asking the participants to choose another case example (question 7), question 8 again attempts to clarify how this experience impacted their ongoing work. Question 9 directly approaches the core research question. It asks, what has been learned from ongoing challenges in their practice that they utilize as knowledge and/or practice principles and/or ways of working in their present work with male couples? All the questions in this section help the participants to address gaps they discovered in their pre-existing knowledge base and how they have began to adapt and fill in with their own intuitive ideas, theories and methods. Additionally, attempts were made to distinguish past and present knowledge, and between what they were taught and what they discovered through practice experience.

TOPIC: Beliefs about male coupling

10.) Based on your practice experiences, what do you believe are some of the essential common characteristics of male couples?

PROMPTS: impact of homophobia, lack of social, political and familial supports, impact of gay community, gender norms erotic concerns, loss of sexual desire, HIV, others

11). Again, based on your practice experience, what are the most challenging issues facing today's male couples?

PROMPTS: How long has this been true? All or some couples? Details

12.) What are your observations about the way male couples have changed since you started to practice?

PROMPTS: sexual arrangements, social and/or political climate, visibility, AIDS epidemics, HIV status, the increased possibilities of children, etc,

13) How have these changes affected how your work?

The next section of the guide provides a slight respite from the more intense personal introspection of prior questions. The questions in this section presupposed that the participants had something important to report about the characteristics and common experiences of male couples. Their general intention was to discover whether the issues facing male couples have changed in the last thirty years and how these changes have influenced practice and the knowledge base needed to work with these men. Prompts fleshed out the details, containing the basic "who," "what," "where," "when," and "for how long" particulars (Patton, 1990). The questions in this section were structured to reveal "if" and "how" these responses paralleled those discussed in the literature review, aiding in creating a set of cumulative inferences (Gilgun, 1994) and enabling the data analysis to more easily code and contrast this new material with prior research.

In the course of these interviews, question 9 and question 10 yielded similar responses and blended into each other. Therefore, question 10, became a time for respondents to focus on a particular area of interest that most intrigued them or that they struggled with in their work with male couples. Questions 11 and 12 eventually morphed into one question, more focused on changes in their practice experiencestha n about generic changes among couples.

TOPIC: Differences between working with male couples and straight couples

14). Based on your practice experiences, how are male couples similar to and different from straight couples?

PROMPTS: sexual arrangements, children, family, stigma, inter-cultural needs, rituals, assimilation, legal, financial

15). What do you believe are some of the significant differences between working with gay male couples and straight couples?

The next set of questions focused on the differences between working with male couples and other (non-gay) couples. This section was planned to be another pathway to examine the distinct characteristics of male couples. In particular; questions 14 and 15 sought out a snapshot of comparisons, clarifying "how" their work with male couples was different from their work with non-gay couples. Similar to the last section, the questions and probes were constructed to help link and compare the data gathered in these sections to the information gathered in the literature review, potentially enabling more reliable comparison during data analysis (Gilgun, 1994).

In general, this was the section that became less important, some time during the first several interviews. Initially, it felt like a matter of time constraints when this section did not get fully addressed, but as the interviewing progressed, it became clearer that this study was less about comparisons between sub-categories of couples and more about the uniqueness of executing this work. In addition, it became apparent that clinicians who wanted to compare would do so spontaneously throughout the interviews with material that came out of case examples. By interview ten, this section remained more in the background and was an alternative direction utilized to flesh out specific thinking of the clinicians who brought it up. Interestingly, many of the respondents shared how their work with male couples has positively impacted their work with other couples by helping them expand their vision of what factors lead to a healthier relationship.

TOPIC: Self- Reflection: Emerging theories

16). What have you learned from the male couples you have worked with?

17). What advice would you give to other clinicians working with male couples?

The questions in this "self- reflection" section served as a final summation and a chance to pick up any loose ends. The questions offered another chance to elaborate on unexplored ideas, and provide suggestions as to emerging theories and ways of working. In essence, in removing the necessity to link their ideas to direct practice experiences, it was hoped that the participants would feel freer to theorize broadly in a manner that might challenge or support their practice experiences. Question 16 was another

opportunity to discover the shifts and compromises participants made in both their subjective knowledge and their practice experiences. The last question was the final attempt to explain any new norms they have discovered in their practice as they clarified, by talking about an imaginary less experienced clinician, how they might work in the future. Many subjects gave a list of ideas that became an important source of distilled practice wisdom that is presented in the final chapter. In addition, the final question indirectly seemed to uphold Klein and Bloom's (1995) conviction that practice wisdom could translate ongoing practice experiences and professional judgments into future professional behaviors. However, in this case, what most clearly surfaced was generalizable advice.

Section 5- The Process of Data Analysis

Analysis of the data of all qualitative research requires multiple simultaneous actions that evolve into a systematic strategy (Glaser & Strauss, 1967; Patton, 1990). For that reason in this study I employed a blend of methods to help capture the data, which included not only the tape-recorded interviews, but also field notes and analytic memos. Field notes were written during and after each interview. They included major points emphasized by the respondents and burgeoning thoughts that helped create some order for remembering each interview. Memoing started after the third interview and continued during the entire process of interviewing. Initially, the memos focused on ways to re-direct and sharpen the wording of the interview guide, which led me, for example, to the helpful concept of "therapeutic impasses" as an alternative to "a gap in your knowledge base" and also clarified "how" and "how much" I would talk about

practice wisdom to the respondents. By the sixth interview, memos focused more on fitting together themes, selecting out metaphors and clustering stylistic choices, types of cases, therapists' challenges and categories of couples' problems. These initial journeys into coding were then documented in newer memos, as subcategories came into view through a method of constant comparison of the different interviews (Strauss & Corbin, 1990).

In addition, having transcribed all the interviews myself, from the beginning I started inserting ideas from my field notes along with a listing of themes that were appearing to be common among respondents. In a general way, the coding, categorizing and hypothesis building were all done concurrently throughout the yearlong interview process. This procedure proved extremely helpful when the first 12 interviews consisted of 10 gay male therapists and 2 lesbian therapists. Even though this sample strategy had not been pre-planned, grouping this sub-category of gay therapists, along with ongoing analysis, facilitated my realization that by the twelfth interview, I could almost predict the various responses. I was getting enough replication of patterns, issues and concerns that it became clear that it was time to move on to the less accessible, non-gay therapists.

By this point, I was extremely curious as to how and whether the responses would remain the same or different with the subset of non-gay clinicians. What occurred were interviews that were not only different in context, but were also different in tone and in some thematic content about how to approach the work. Although there were no respondents who challenged emerging hypotheses about the couples themselves, their deep struggles to empathize with the couples, their active questioning of their biases and their acknowledged lack of familiarity with aspects of gay development and life, stood in

contrast to the position of the gay therapists, who generally seemed more self- assured in their application of a gay affirmative stance.

Prior to conducting the interviews and while developing the guide, I struggled to keep out my own assumptions that gay therapists could more effectively treat male couple than non-gay therapists. Conversely, close to theend of interviewing the gay and lesbian therapists, I felt an initial disillusionment as I went about comparing new interviews with older ones. Even though there was a large amount of exciting material, I could have predicted many of the themes based on prior interviews and my own ongoing work with male couples. However, with the introduction of the 4 heterosexual women and 4 heterosexual men, not only were my own biases confronted, but many new issues were raised. As a group, the gay-identified therapists seem to utilize both their personal and clinical experiences to focus more readily on the presenting problem, whereas many of the heterosexual therapists seemed to move more slowly by first fleshing out how both clients' histories, connected to their being gay, impacted their present coupling experience. In other words, gay therapists sometimes take the commonalities in the relationship as a given, while the non-gay therapists, in their effort to counteract their lack of cultural awareness, seem to spend more time understanding the context that brought the couples together.

Among many other questions about countertransference and the complexities of working within and outside one's own minority status that will be explored inthe final discussion chapter, the differences in approach destabilized the dichotomy of being inside the know/versus outside the know (Fuss, 1991) of how to treat gay clients. Building on impressions that began emerging in the interviews with the gay clinicians, unexpected

factors became apparent that revealed how similarities and differences between the client and the therapist's sexual orientation impact aspects of practice wisdom and the therapists' therapeutic style.

At that point near the end of the interviewing and the beginning of the more focused data analysis, I utilized an English professor I was working with in an interdisciplinary class in gay and lesbian studies as a sort of peer reviewer (Ely, et. al, 1991). Although he was not a clinician, he had a discursive interest in psychotherapy and had deconstructed psychoanalytic texts, including works by Freud. With no prior connection to this study, he read and discussed some of my impressions of the interviews completed at that point and allowed me to utilize the class and his interest as an objective sounding board to explore what I was extracting from the interviews. At this point, both students in the class and the professor helped me root out what they saw as my prior essentialist bias. In addition, the professor's ability to dissect text helped me realize that my easygoing style, though building rapport, potentially impacted the types of responses I received from some of the respondents who seemed quite eager to please. I finished the interview process with these insights intact, and utilized this feedback during the unstructured interactions of the follow-up interviews.

Constant Comparison

Since this project was concerned with building knowledge inductively and revealing current practice wisdom concerning therapy with male couples, the processing of this data entailed integrating new findings with previous knowledge. As described throughout the literature and clinical review chapters, other clinicians, theorists and

researchers have been questioning the links between various theoretical frames and practice principles (Mitchell, 1996), setting the stage for, and shaping, this project. At this point in the analysis, pairing queer theory with impressions expressed by the group of therapists not only became an unexpected journey toward deconstructing many other essentialist concepts embedded in this study, but also brought out new categories and foci.

Contrasting the lens of queer/constructionist thinking with more essentialist thinking stimulated re-thinking of categories. Typically, this integration occurs at the end of the data processing cycle as part of the conceptualizing step, when new findings are compared with prior research (Stern, 1994). However, according to Gilgun (1994), prior conceptualizations can also be utilized earlier, to help in organizing data for the final coding. In this case, it became clear that the final stage of analysis could not begin until the new data was linked back to the prior state of theoretical knowledge. Given the tension involved in coordinating this new data with prior data, both sets of information needed to be examined closely, particularly when there was no convergence with prior research.

First, however, four key respondents, two gay therapists and two non-gay therapists, participated in follow-up interviews, in an abbreviated version of member—checking (Ely, et.al, 1991, pp. 165-167). The gay clinicians were selected because they had published in gay affirmative literature and seemed open to further interaction. Likewise, the non-gay clinicians were known for publications concerning either couple work and/or integrative psychotherapy and seemed to take pleasure in the subject matter. I conferred with the subjects about the direction I was going in analyzing the data and if it

captured their work. First, I sent these four respondents an early draft of some of my categories that included quotes that I felt were meaningful, but had not fit into already constructed categories. Then, in theinterview s that lasted around 45 minutes, I asked for feedback and recommendations, particularly as related to the clarity of the main points. Two of the four interviewed commented on clarifying theoretical categories related to couples work and therapy with gay men as seen through the essentialist lens of gay affirmative psychotherapy, and/or the constructionist leanings of family therapy. Another recommended utilizing additional quotations, in the context of "the technique" section. These interviews helped me check in with third parties as to the logic of the analysis, even as they validated the different theoretical, stylistic and countertransferential challenges for gay therapists and non-gay therapists in working with male couples.

Only then did I go back to the interviews and re-read each one. Without imposing categories, I tried to think more descriptively, as compared to theoretically (Glaser & Strauss, 1967). Not utilizing the preexisting concepts, the content analysis went line- by line, as categories clustered together, in what felt like separate structures, designed piece by piece. As this ongoing process moved to higher levels of cohesion and comprehension, codes were redefined and verified by returning not only back to all the data at hand, but also through the scrutiny of prior memos and the data included from second interviews (Miles and Huberman, 1994). I tried to complement and/or confirm or disconfirm the importance of these emerging categories, struggling most with organizing the clinical vignettes into core categories.

However, as findings did seem to converge with each other, the integration of cases helped reinforce explanatory theories, as well as to create more refined practice

wisdom. Throughout this process, the data will demonstrate how some larger, more inclusive groupings emerged that were invigorated by inclusion of information from the literature and clinical review, and how some groupings seemed best categorized as having little connection to prior research.

Additional Limitations, Trade-offs and the Importance of Context

As data analysis continued, I became more aware of additional limitations inherent in both the planned methodology and the manner in which all the related events and interactions transpired to affect the course of this study. The most obvious methodological constraints, previously cited, remained the type and size of the sample, based on accessibility of possible subjects. I am sure some of the potential respondents who felt like they were not "experienced" enough, and/or all those I never made contact with, would have brought in many other factors and points of view that I could have utilized. Consequently, as with all the limitations encountered, the moral of this qualitative journey was that the knowledge revealed by the data not only must be generalized with caution, but also is always significantly related to contextual variables, whether they are generated by the respondents, the couples or the researcher.

For instance, because of limited time and resources, I not only had restricted member checking, but also had veritably no triangulation. I suppose I could have read original case notes, for example, but instead I chose to focus on the remembrances of the therapists, because their very subjectivity, with its flaws intact, was an important part of establishing common therapist struggles and concerns. In addition, utilizing case notes or observation would have involved including clients, raising issues of confidentiality and

informed consent that I decided were not necessary to gather the desired data. However, the limited options in terms of data gathering encouraged me to contend with ongoing accountability and to utilize varied and different intellectual frameworks in interpreting the data at hand.

My final usage of the guide and its resulting data was also, ultimately, defined by personal restrictions and contextual trade-offs. For instance, the task asked for in the interview guide that caused the most apprehension in many of the therapists was how to talk about what they extracted as utilizable practice knowledge from complex, personal and idiosyncratic cases that at first glance appeared to have no connection with each other. In addition, some therapists did not think in the terms of the language utilized in the guide questions, such as 'gaps' or 'impasses.' Others seemed to have difficulty revealing in more vulnerable moments. By sensitizing myself to the respondent's conceptual biases and strengths, I often found myself aligning with the respondents' language or interpersonal style in order to elicit responses that made it easier for these therapists to answer and conceptualize these important questions. The tradeoff in reliability was not exactly replicating the guide throughout each interview. In that sense, I faced both the therapists and my own social theoretical and personal constructions and let them impact how we talked about the work and what got reported as data.

As the interviewing progressed, I further appreciated that just as researchers who formulate questions and address the real concerns of gays and lesbians should be aware of heterosexist bias, I had to exercise diligence in not projecting my "homo-sexist" bias into the interviewing. The more adept I became at keeping my preconceptions out of each step of the way, and allowed myself to vary how I presented the questions and

concepts, the more the inventive thinking of the respondents surfaced. As they contrasted cases, and made tentative conceptual leaps from one case to another, I assured them it was the major task of this investigation, and not them alone, to aggregate their clinical experiences into the best examples of translatable practice wisdom, with an awareness that these understandings are always in flux and limited. Nevertheless, there remained an ongoing concern to strive to remain objective and maintain reliability, even as I delved into the resulting data analysis.

Despite being aware of my preconceptions, limitations from the sample, ongoing tradeoffs during the entire data collection process, and trying to scrutinize data as it emerged directly from the interviews, my own conceptual filters were invariably utilized and led me to emphasize certain themes and conceptions over others. Building on the therapists who gave me their detailed, personal experiences to synthesize, my process was like that of a sculptor who within the context of current aesthetic principles and his own individual filter molds his specific medium, as thoughtfully and artistically as he can, all the while remaining aware of the strengths and limitations of his material. What follows, in the next chapters are the intersubjective results of these efforts.

Chapter 5-

THE COUPLES: RECURRING THEMES

This chapter will examine and highlight the common clinical challenges and core areas of distress that the interviewed therapists believe most impact the male couples they have worked with in their practice. The findings are described with attention to the clinical and systemic characteristics that distinguish the therapy of male couples from heterosexual couples, as emphasized in the clinical review chapter (chapter 3).

Section 1- Reasons for Entering Therapy and Couples' Distress

Generic Starting Points: Coloring In and/or Outside the Outlines

I will start where the clients and the therapists begin their journey together, and report on why the therapists believe the male couples they have seen choose to enter couple therapy. It is important to note that there were only a few times when the interviewed therapists referred to those presenting problems that appear the same as those of heterosexual couples (Bebko & Johnson, 2000; Forstein, 1986; Hendrix, 1992; Johnson & Lebow, 2000). Karpel (1994) categorized these more universal complaints as unresolved conflicts, failing out of love, conflicts over withholding and/or receiving intimacy, devitalized relationships, difficulties with third parties and sexual difficulties.

Rather than focusing on these universal or overarching themes, most often the interviewed clinicians reported on the contextual and specific reasons why male couples benefit from interventions with a psychotherapist and the therapeutic impasses that differ from their experiences with non-gay couples. It would be appropriate to conclude that these clinicians described the more specific manifestations because the centerpiece of the

guided interview was to discover the knowledge gained explicitly from working with male couples and not the more general reasons. In other words, if the guided interview were conceptualized differently, it is possible that more respondents would have focused on universalizing the presenting problems and concerns, actively comparing them to other categories of couples.

Nevertheless, while attempting to respond to what was distinguishing about male couples, most of the clinicians concomitantly wrestled with and volunteered unique reasons why male couples enter therapy. Several clinicians posited creative metaphors that characterized the interrelationship between the difficulties faced by male couples and how these difficulties brought them to therapy. For instance, Robert, a gay social worker in practice 9 years, explained:

> I do not think my mind is consciously wrapped around what is different about why male couples enter therapy. I just know enough from the gay affirmative literature and having been in several versions of male couples, myself, to have a sense of the developmental and relational areas that they often overlook and might need to be filled in. So often, it's like a coloring book with several pages missing, pages about commitment and potential support that need to be first sketched with a generic black outline, before they can be colored in and shaded with the specific dynamics of the two men. Because there can be such confusion regarding their possibilities as a couple, often they lack any clear outlines how to move forward as a couple. My job is helping them bring shape and clarity to their experience, while, to push the coloring book idea a little further, I decide what knowledge I need to "draw from" in order to be most effective.

Robert believes that male couples, who often live on the margins of definitions about what makes them a couple in the eyes of the world, their family or even their friends, enter treatment in need of guidance that helps the men "color in" various developmental or relational areas that are often overlooked. Coloring in these areas not only offers the therapist a place to begin, but also provides the men a sense of permission to draw on these various sketches to form their own personal parameters regarding how

they want to be a couple. As clarified in his second interview, Robert believes many male couples' lack of clarity about "healthy relational values, potential levels of commitment, expectable supports and paths to follow in their day to day existence," profoundly impact their behaviors, problems, and relational expectancy.

Heterosexual couples have many frameworks (developmental and relational outlines) that they readily utilize, all of which are influenced by the predominant institution of marriage, that guide everything from ways to be sexual and celebrate their relationship, to ways to separate and end the relationship (Karpel, 1994). Whether positive or negative, the internalized legacy of heterosexual coupling often helps both the heterosexual couple and the couple's therapist socio-culturally share a map that at least helps them begin their work together with commonly understood gender, relational and cultural expectations. Bill, a gay psychologist, experienced with both straight and gay couples, clarified this point when he said:

> I had this couple that in certain ways have problems that typify gay couples with age differences, but these guys didn't even know how or where to initiate the work on feeling better about their future. After three years they were stuck, and had no idea how to blend finances or for that matter their lives, even as the older one is rolling in dough and the other is still a poor student. They thought they were alone with this type of stalemate. With my more conventional hetero couples, it could be so much clearer for them, because of common guidelines prescribed by gender and societal traditions that inform them how to couple.

So in contrast to non-gay couples, same –sex couples live with the task of creating a life together without assumed outlines or frameworks, but nonetheless, like all couples, need security and relational-definition in order to survive (Bebko & Johnson, 2000; Bryant & Demian, 1994).

Harkening back to "coloring in the lines," Robert believes, in a metaphoric sense, that men enter therapy to fill in and define their relationship in areas that remain diffuse or ignored, which in the process may fortify already established areas of stability. Henry, a gay social worker, argues, however, that gay men are more confused then ever about how to define their relationships:

> What is the proper prototype- is a relationship one with commitment ceremonies and/or adopting children, or one based on a free-spirited sexuality, where the possibility exists to have even three people being intimately involved. This confusion is reflecting a present dilemma in same-sex relationships and the gay community.

Also referring to this confusion, Jill, a 44 year old, heterosexualtherapist, trained in family systems, and interviewed because she works with many male couples, suggested:

> Many gay couples enter therapy to create a safe bubble around their relationship, in order to get clear who they are outside of all the many influences: their family, their friends, their past, the culture. Some have bubbled themselves off, in an opaque bubble that does not let anything else in, which isolates and eventfully could be the downfall of the relationship. Others have a layer that is too porous and needs to be less diffuse, in order to protect the integrity of the unit, before someone floats right outside it or someone floats inside the thin layer of protection, I often give couples this image, in order to help them see what kind of bubble they have and what they might like to have.

Unlike filling in the "lines in a coloring book" which underscores areas of relationship building that need further information and development, Jill's image of the protective "bubble" serves as a container, or in the language of family-systems work, a boundary that starts to delineate what in the infinite array of cultural, sexual, psychological and relational choices they include and discard. This bubble expands and contracts,

sometimes separating out and enclosing, and sometimes becoming permeable, like a cell wall that lets in what it needs to survive and thrive.

Like Robert, but with a different emphasis, Jill asserts thatmale couples often arrive at therapy when they need some version of defining or re-defining boundaries for themselves:

> The question is how to help them find their own 'brand' of coupling. For some, the idea is to break down boundaries, that are established out of defensiveness and fear, and for others it is to create boundaries where things have gotten so diffuse that usually one member no longer feels like he is in a couple. That's actually quite common.

Directly mirroring the boundary conceptualizations of Johnson and Kern (1996), together Jill's and Robert's metaphors suggest that the men who come to their therapy rooms generally struggle with the task of clarifying boundaries, which includes the establishment of patterns of intimacy and separateness within the couple (Robert), and developing safe margins between the couple and the outside world (Jill).

In a related point, several of the therapists proposed that male couples enter therapy because of the perceived and actual pressure that they are more likely and more ready to dissolve their relationship than married heterosexual couples. Bill, Robert, Paul and Frank, clinicians whose quotations will follow, added credence to the ideas expressed in the aforementioned literature (Kurdek, 1998; Peplau, 1991) that without the political, legal, societal and familial institutions creating support systems and frameworks to rely on when a couple is in distress, same–sex couples tend to lack the same perception as heterosexual couples that there are institutional barriers to ending their relationship. Hence these couples enter therapy because the possibility of "breaking up" makes it more

difficult to problem solve while feeling insecure, threatened and/or already anticipating the painful loss of the partnership.

Paul, a heterosexual psychologist, academic and researcher known to be a specialist in family therapy, elucidated:

> I think the legality of marriage, binds heterosexuals together more powerfully, and therefore, keeps them involved in a relationship longer then a male couple. My experience is that when a straight couple comes to me, and the niceness has worn off, they realize they do not have the smooth relationship they fantasized having. And when gay couples go through the same process of 'oh my god, this is difficult look at what we are dealing with, look at who we are, we have more challenges the we realized,' they break up, or they do not leave together holding hands, like the straight couple who has the world to lean on. And I do not think that comes for either type of couple from a place of examining. It's different types of relational denial, one a collusive deal that is about mutual investment reinforced by the culture, and the other is a more individual denial, informed by homophobia, saying you are not the one for me, also reinforced by various cultural and gender forces.

Frank, the only heterosexual male social worker interviewed, explained that it is not unusual in his practice experience for male couples to enter therapy because either breaking up has been threatened by one member and/ or at least one member has already decided to leave. He clarified:

> I've seen several couples where one man already gave up on the relationship, without the other one even knowing. I saw these guys; one was an academic, the other a professional caterer, who had been a couple 12 years. They had the support of both families and a wide circle of friends who looked up to them. The present-ing issue was a sexual breach. They had established the option of openness in terms of their sexual outings. The academic presented he took advantage of that openness, the other partner had not. In session 2 the caterer said he did not really want openness because it had led to no sex within the couple, and his stated goal was to see if they could be more sexual. By session three, the academic admitted he had taken up with the third person and even had had weekends away with this new guy and he had come into this therapy to make sure his partner was taken care of as he left him

Robert reflected on a related trend among several of the male couples that have called for appointments.

> The supposedly more invested member of the couple calls for a referral, as a last ditch effort before breaking up, and then in negotiating the appointment together, they end up breaking up, as sort of the final demonstration of their inability to get along. Sometimes they even call again, and might come in, but they often do not last much longer.

Assumptions about the impermanence of gay relationships can become an unconscious stressor that gets laid over already existing problems. Bill, who has worked with almost equal numbers of male couples and heterosexual couples, believes this occurs because:

> There is still a lack of equal status. Equality that impacts the individual first and then the couples they are in. I think it brings two, rightly paranoid and wounded individuals together to work out the impact of that, to work it out, sometimes in a vacuum, and that is difficult. Unlike married couples, there are few social and no legal supports to intervene in ending the relationship.

Since multiple support systems tend to be a major correlate of satisfaction for all types of couples (Kurdek, 1995), and these support areas remain unclear areas in male relationships, it would follow that they need to be compensated for in other ways. Hence, it seems the men come into therapy seeking a space to confront the anxiety and confusion created because of the absence of these supports, hoping to manage the ever lurking possibility of breaking up.

For some, the possibility of breaking up can be exploited by one of the members to awaken relational atrophy. Arthur, a gay social worker, told of a couple where one member's threatened exit was used not only to get the attention of his partner, but also to begin a process of communication building that led to a temporary rebalancing of power and invigorated their coupling.

> One was passive-aggressively bored and was acting out by bad mouthing his partner at work, and with every friend, as the other, extremely self-involved one, faced retirement and kept defining their life with only *his* desires for their future.

> This had gone on through their 22 years, but the 'bored' one, who had been in individual and group therapy with other gay men for two years, was finally voicing his disappointment and threatened to leave. The self-involved one finally consented to therapy and it only took several sessions to get him to contain himself long enough so the passive one could voice his disappointment and then give input into a joint plan for the next phase of their journey. The dominant one claimed he had never known how upset the other one was, since they never talked about their coupling together with friends or family, and so it remained a growing concern for the passive one who for so many years felt they existed in a void. After several sessions they were both more satisfied since they came up with a future plan *together* that involved leaving New York City.

Stabilizing Hybrid Frameworks

In an often-unconscious effort to define themselves, it seems some of the male couples referred to by the interviewed therapists mirror traditional relational frameworks, some blend both the traditional and the unconventional, and some widely deviate from all heterosexual traditions. Frank, a heterosexual social worker with a large gay practice believes:

> Since these men have license to create what they want, they do that, but then end up looking for some source of guidance. It is confusing how to get grounded, particularly with the pull between the alternative pressures of the gay community and their families of origin.

It seems that frameworks that contain heteronormative customs, beliefs, and behaviors can become problematic when the couple consists of two men. Paul, the heterosexual psychologist, already quoted in regard to his view of the different societal forces impacting non-gay and gay couples, commented:

> This one couple I saw might as well have been straight. They met in college 19 years ago, virtually came out together, are monogamous, one having sex with only one other person in his life. They make cookies every X-mas, and had become the source of connection that holds their families together. On the other hand, they are often angry at each other, isolated, sexless, have few gay friends and do not let their gayness impact their life. After exploring how they were still both pleasing their families, they were able to somewhat break out of this hetero

> model, by joining gay organizations like the Gay Man's Chorus, where one began to socialize independently. And they even opened the relationship to outside sexual encounters. I guess it was all too late. I just heard they broke up and one had already moved in with a new boyfriend.

It seems this more traditionally leaning couple commenced therapy either to unconsciously stabilize their already existing framework and/or to attempt to design their own more satisfying and updated guidelines.

The more common type of male couple referred to in this study seems to have pieced together a hybrid model that blends elements of traditional heterosexual relationships, such as more or less equal ownership of property, with aspects of unconventional relationships, like nonmonogamous sexual arrangements. Some of these men enter into therapy, at least in part, when they become uncertain about how to navigate some of the contradictions inherent in this blended model. Mark, a gay social worker who advertises that his specialty is couples work with same-sex couples, shared just such an example:

> These guys, together ten years in a relationship thatseemed strong and fairly conventional in their sharing of money, time, and domesticity, admitted to feeling dissatisfied. Their sex life together, which was minimal, proved to be the major area of disappointment. Interestingly, they were the only couple among their couple friends who did not state they were monogamous. As we struggled how to improve their sex lives, they made clear they did not want to mirror hetero couples and enforce monogamy like their friends. Ultimately, we were able to explore how they both did not want to be like their friends or parents who remained in unexamined relationships, but did want the security and support offered by relationships recognized as being committed. The challenge was a balancing act of not only their individual defenses but also relational paradigms. They stopped having outside sex, as they attempted to enliven their sex life, but kept the arrangement open to possible encounters.

Combining Robert's "coloring in lines" and Jill's"bubble " metaphors in the context of this male couple, their therapy with Mark helped define and normalize their hybrid

relational paradigm (filling in aspects that utilize conventional and unconventional relational standards) and make changes to their relational strategies that arouse conflict (re-clarifying what relationally and sexually remained inside, what remained outside and what reached across the lines of their specific relational needs).

Beyond the Honeymoon- A Lack of Milestones

Arthur remarked, after his prior description of the couple together 22 years where one threatened to leave (see, p. 142-3), that:

> They had not only *not* fantasized together about the future, but also had kept many other areas of their lives separate, like friendship networks, finances, and even their homes until 7 years earlier, when one lost his sublet. These guys were more like couples I saw years ago, which were still so strongly impacted by their own homophobia. They had mostly straight friends and conventional jobs, and did not even recognize the chances to embrace the more positive aspects of coupling. The dominant one was shocked by the threat to leave, thinking they had been more successful then most gay couples, simply because of their longevity.

Ellen, one of the two lesbian therapists interviewed, and Carlos, a gay social worker, believe this lack of a sense of personal entitlement is due in part to male gender socialization, and in part to a lack of vision of what to include and how to proceed in relationships.

> Even after the infatuation wares off and the honeymoon phase is really over, they are trying to figure out who this person is they are with and also trying to figure out some of their own fears about intimacy that they are not even aware that they have. Lesbian couples go right there, I guess women are more aware of intimacy concerns, but men, who tend to be more goal focused, get more stuck when there are not preset goals like going steady, getting engaged, getting married, etc. Many want out because they do not know how to proceed relationally.

Carlos paralleled Ellen's point when he said:

> Men tend to come in with an initial presentation where they want to have the sympathy of therapists to what a jerky boyfriend they have, and some to have their boyfriends fixed, and maybe some awareness they are participating in some ways with some difficulty. But usually they do not come in with that awareness. Often there was the honeymoon and its over, and then after the initial infatuation fails, they have confusion about how to proceed so they become unsure about the relationship.

Several therapists, while discussing why male couples enter therapy, made a reference to "the honeymoon" period ending. This heteronormative phase, though universally understood, paradoxically points out why it can be more difficult for male couples to gauge where they are in terms of their relationship growth, because most gay men have not adopted the other assumed or ritualistic milestones that define normative stages of heterosexual relationships. In contrast, David, a gay social worker, told of what he called an "out of the norm" male couple that utilized many of the rituals of heterosexual couples to define their relationship that started out as a long distance affair.

> I first saw this couple after they had already 'gone steady' for around 6 months, and when the one guy visited New York, and after they had announced to friends and family they had 'gotten engaged' and the New Yorker was moving out West. Like their support network, I was skeptical of their need to use these labels. It became clear they made use of these rituals in ways to not only bridge the geographical distance, but also chart their progress for themselves and others like their dubious family and friends. These guys went on to have a commitment ceremony and from what I can tell, are quite successful in their relationship. This experience highlighted, for me, why many male couples are lost once they declare their love, with moving in together being the final rite of passage that they are officially coupled. This couple helped me re-think such ideas as getting engaged and commitment ceremonies as potential rituals that could help male couple slow down and consciously commit to various next steps.

Unlike this couple, without utilizing the clear gradations of commitment outlined most obviously by heterosexual traditions, the questions about the extent of commitment and the direction of a male relationship would ideally need to be acknowledged and explored in their own way and in their own time frame in order to become conscious.

Otherwise, without these defining rituals, which help couples experience a sense of psychological safety and stability within their relationships (O'Hanlon & O'Hanlon, 1991), it might become more difficult for the couple to survive. It seems some men might come to therapy to replace these rituals with the affirming voice of the clinician who helps them organize their experience and facilitate the emergence of their own personal milestones.

Difficulties with Intimacy Associated with Being a Gay Man

In virtually all the case examples already presented thus far, when couples lacked awareness, structure, direction and/or milestones, it led to a lessening in intimacy. That is not to say that non-gay couples don't have generic difficulties with intimacy, and that this reason for entering therapy might fit into the universal complaint described by Karpel (1994) as withholding and/or receiving intimacy. However, male couples present in therapy with unique struggles over the terms of their intimacy, as related to some of the distinctive factors already referred to, such as: 1) a lack of structure and direction about how to be or proceed as a couple, combined with 2) the ease of breaking up, as well as 3) patterns of male gender socialization, that encourage competition and discourage emotional expression (Drescher, 1998; Green, Beetinger & Zacks, 1996; Ussher, 1990).

Barry, a 38-year-old gay social worker, when sharing about a recent therapeutic impasse, described a couple where:

> Both guys began with, 'there is not enough intimacy,' where one guy, away on business, had not called for several days. Both had higher educations, professional men, together 3 years, in that category of just past the honeymoon. Both were sort of lawyerly in their approach to the world and often very hostile and aggressive, sometimes playful and sometimes incredibly cutting, also both very composed and controlled about how they want the therapy to work. Since one man travels a

> lot, the therapy began to mirror their life as struggles with meetings turning into every other week and then less frequently. Neither feeling quite taken care of by the other, but in the room constantly attacking each other, seeming to have a need to have this aggression out there all the time, as I have come to understand, as a kind of protecting them from having closeness, like George and Martha (a reference to the main characters in the play "Who's Afraid of Virginia Woolf"). We started to reveal that this is a contest of intimacy and dependency that has deep roots in their early attachment linked to deep yearnings for closeness, which was made to feel inappropriate for both boys. Their relationship struggles correspond to both men's early attachment difficulties that have been played out in destructive behaviors.

Similar to this couple, a large number of the male couples referred to in the interviews seem to enter therapy when some stressor or conflict surfaces varying levels of intimacy and/or commitment between the partners. And analogous to other types of couples in distress, this example portrays two people with a mutual unconscious avoidance of intimacy that presents as behaviors of withholding the tenderness and comfort they entered the relationship hoping to find. However, unique to male couples and referred to throughout many different interviews is a negotiation process between the partners' desire for connection with the male attributes that preserve independence and competition (Brown & Zimmer, 1986; Johnson and Kern, 1996; Odets, 1997).

Michael, a heterosexual psychologist, described a couple with this type of tension surfacing in a game of distancing and pursuit.

> I saw this couple, one a working class guy 32 and the other, 10 years older, brought up upper middle class. The younger one said he never got to see his boyfriend. He was willing to end it. The older one said they both had 'intimacy problems'. It turned out the older one wanted an open relationship where he could even feel free enough to have sex in the steam room at the gym where his partner also goes. The older one was also open to having an ongoing ménage, since he had had a past relationship where he was mono-gamous, bored and unhappy. The younger guy wanted some outside sex, but felt his partner was out of control. The older one realized he was pushing the other one away with all his sexual demands and the younger one was com-plaining about everything but his discomfort in the sexual arrangement. After

> several sessions, the older one agreed to stop running away with his sexual distancing even though he still felt he that was denied one of the perks of being a gay man. And the younger one said he would stop nagging about all his partners' behaviors, but also had held on to concerns that he was left without power. These guys wanted to stick it out, but they could not tolerate deeper work or really changing. Eventually, I found myself doing relationship 101, where they learned some communications skills, but that was all they could tolerate or wanted at that point.

These men were not willing or ready to discover how their developmental histories, including how they came to know their gender, sexuality and sexual orientation, impact their present conflicts (Drescher, 1998; Hendrix, 1992). However, Michael insinuated that with a couple who want to or who are prepared to this deeper work, once at least some of the specific concerns related to being two men in a couple are addressed, the next steps of treatment can precede much like any exploratory couple therapy.

The Need for Education and Prevention

Michael's assessment that this most recent couple referred to needed "relationship 101" indirectly referred to a common pattern noted by several of the therapists: some male couples enter into therapy in need of some of the basic skills of being in a relationship, including the development of communication skills, and preparing couples for expectable transitions and potential problems. Coincidentally, Mark expounded on this need:

> You know the percentage of couples I do exploratory work with gets smaller. Most couples need tweaking and clarification about communication problems and learning to live and be a couple and a smaller percentage want to do the deeper work. I think some clinicians would be startled by my approach because they feel all couples need deep work. I do deep work. However, I feel that with couples there should not be a presumption that the couple needs to do deeper work, not to say it does not

> happen, but I am troubled by clinicians who adamantly see couples work through the lens of let's say analytic work, or object relations, from the get go.

Marietta, a heterosexual psychologist, despite her background in systems work and more long-term conventional psychoanalysis, confirmed Marks' comments:

> Many of the male couples do not want to know 'why,' so I go back to the symptoms or presenting problem first and go in another way by giving them what they want, and explore the symptoms concretely. Sometimes that is all they want, problem solving about a particular issue, psycho-education in the short term, and that is fine, and necessary.

David, a gay social worker who shared how he has learned not to expect all couples to explore their psychodynamics, gave an explicit example of this type of work in action.

> It fascinates me how a little information, strategically given, can go a long way in helping reveal and normalize, This one couple I saw only 3 times, together 3 years, with a 15 year age difference, had all the expectable power struggles, but it took the therapeutic environment to get them unstuck. In the first session they both admitted their fear of being left either because the older one feared the younger one would feel tied down and would eventually resent his lack of independence, and the younger one feared not being 'enough' in the long term. This started a process of putting their fears on the table and learning about how to consciously communicate, even though the younger one said he did not believe in therapy. They were able to both agree on their next level of commitment. It's been two years and I just got a note they are moving to Santa Fe together.

These last several remarks reveal how these therapists' experiences point to male couples that are less interested, and therefore less invested, in long-term therapy that explores the roots of their intimacy issues, and are more concerned with finding shorter-term solutions to their relationship struggles. The few potent

statements and examples given by this cohort of clinicians suggest sme male couples may benefit from psychoeducational and preventative style therapy that give them the skills and the vision to keep their coupling experiences more open to the often difficult journey that lies ahead.

Fitting into Gay Community Norms

Several, more current, gay authors refer to a generative tension in popular gay culture that on one hand seems open to expanding domains of sexual practices and mores and on the other hand does not support dating and relationship building with the same passion or acceptance (Browning, 1993; Rofes, 1996; Nimmons, 2002; Signorile, 1996). Nimmons (2002) describes a gay culture that embraces diffuse patterns of intimacy, many of which include communal love and friendship networks, while indirectly implying that dyadic relationships that mirror heterosexuals are not in accord with the true souls of gay men. His anthropological argument seems to reflect another common tension that brings male couples to therapy. Mark reflected on this concern when he said:

> The pressures within the gay community can be so confusing, especially what happiness looks like, whether you're in a couple or single. Do you lean toward the hetero and have a commitment ceremony or marriage and adopt children or do you go to Twylo (a dance club) every weekend and be tribal. In some way the classic relationship structures have been blown wide open. It is quite a burden to have so few guidelines and an urban culture that focuses on youth, beauty and sex. I just had another couple who presented that one wanted to continue participation in the dance party culture and the other wanted more domesticity, and this was pulling them apart.

In accord with the ideas behind Robert's series of "outlines" or sketches that need to be colored in, John suggests that when working with male couples, therapy is enhanced

if, together with the couple, you fill in the details of the specific gay cultural sub-group/s which define the particular ideals and standards by which they surround themselves.

> I like to know how important their sexual self-identity is to them, and how visible is that publicly and how has it affected their experience as a couple. Ultimately exploring these concerns are an important way out of the little tight boxes that gay communities box us into. Like A Fire Island muscle boy versus the middle aged, chronically single, theatre queen. Both categories do not freely embrace committed relationships because of how it threatens the stability of the friendship networks or the status quo. Our adolescent longing for belonging sometimes compromises our individualized growth and separateness, and that particularly impacts couples that have contradicting values.

The last two comments seem to suggest that a dichotomy or split can develop between friendship and community networks and dyadic relationships. The negotiating of this split and tension might bring some couples into therapy, particularly when the two members have different needs for belonging. In contrast to heterosexual culture, where at the least the normative process reinforces leaving the culture of singledom, for gay men there can be cultural pulls in many directions with no particular, culturally sanctioned direction.

Extensive Differences and their Power Struggles

In reviewing case examples of couples already referred to in this study (see, pgs. 138, 148, 150) various therapists readily pointed out that the men in couples often contain different ages, races, financial statuses, cultural backgrounds, social classes and/or temperaments. Except for those couples that met when they were younger, most often during or right after college, (see, p. 143-4), it seemed it was the exception to hear about couples with many similarities. Therefore, the majority of the descriptions support the suggestions of such authors as Isay (1988) and Drescher (1998) that male relationships

incorporate many obvious differences more regularly then non-gay couples. Isay (1988) believes these differences most often serve to maintain the sexual excitement as well as allow space for individual growth.

However, based on examples provided by the interviewed therapists, it seems men often arrive in therapy blaming these differences for their relationship distress. Bill gave an account of just such a couple that entered therapy specifically because of the disequilibrium caused by their many differences.

> In an initial couple session, this 37-year-old concierge complained his 52 year old, extremely rich investment banker treats him like a child and uses his financial power to justify what he wants in outside sex, even though they are still very hot for each other after 5 years. He wanted his partner to be more honest about his desire for outside activity, rather then his history of lying. The older one said that the younger one was not adverse to taking his money and shopping. The younger one said he did that to even the score, to get something from his partner, to make him feel special because his partner did not. It turned out the banker had an ex-wife and children that also diverted his attention and money, and the younger one felt secondary.
>
> Here was a deep-rooted problem. The older one felt the younger one wanted him to sacrifice his past and everything for him, and he got out of his marriage so he would not feel controlled. The layers of power were encrusted with their many unexamined differences. Ultimately, the older one admitted he wanted to be in charge, seeing his sex as a last hurrah before he lost his attractiveness, and the younger one saw how he acted out with shopping rather than challenging the status quo, which gave him a good life. They were able to understand how their differences kept them feeling safe in the relationship.

As this case illustrates, sometimes dissimilarity comes with greater tension, related to these differences. In the same vein asBill's example, Margo, a lesbian social worker, clarified how differences can surface in entrenched power struggles.

> I pay more attention to power struggle with gay men. In these guys I talked about, where one made almost all the money and the other was more the poor artist, they came to therapy with some awareness that there is an unhealthy power dynamic that got stuck, or extremely imbalanced and/or destructive. The artist guy felt he had to do all the housework and still felt guilty, as the exec. asked for unrelenting

> emotional support and care taking. When there are financial differentials, or age differences, or other differences, they often need some form of conscious balancing. Ultimately wielding power over someone is not about power really, it is about feeling not powerful, and low self-esteem, and low self- worth, where growing up gay becomes an important part of that equation.

Like many other concerns, the many ways the therapists dealt with the presenting problem of differences varied immensely, depending on the needs of the men and the theoretical orientation of the therapist. For instance, Mary, a heterosexual social worker, expressed how exploring the underlying object relations helped one couple move to a less competitive and more nurturing space.

> This one case I worked with a long time, was a couple where the younger, Asian guy presented as the insecure one, holding on to his early rejection from his friends, culture and family as sort of a badge. He feared feeling helpless again, and was often hostile and rejecting of his partner. The seemingly more content older American lover came from privilege but always felt rejected by his father, and had now engendered disapproval in his often hostile lover. Therefore, he acts out sexually on the Internet, against their agreement, even though he has gotten caught three times. The cycles of unexpressed anger, acting out, and disappointment mirrors dynamics left over from his father-son dyad...They both were capable of consciously understanding how this tension expressed by their different personalities and development mirrors their childhood defeats and wounds. They became able to catch the adversarial posturing and gained compassion for each other.

Both Robert and Henry, when presented with partners whose differences were projected in verbal power struggles, said they often teach couples to use intentional dialogue based on Hendrix's (1992) model of Imago Therapy, which emphasizes both early object relations and ways to build empathy through communication. Robert believes:

> Particularly couples that present with ongoing battles can benefit from the non-competitive mirroring, validating and empathizing skills that are emphasized when they slowly take turns communicating. The Imago stuff is great with gay men because it not only breaks the pattern of male competition but also aids in

> healing the common history of insecure attachment difficulties seen in many gay men. By that I mean the perceived and real rejection, the often ambivalent and value laden loving, and the general lack of mirroring.

This opinion of how to begin work was similar to many of the other therapists' assessments, in that most of the therapists referred to presenting problems and their ensuing dynamics as often directly associated to developmental and social characteristics of being a gay man (see pgs. 147-8,154). These distinctive characteristics, which complicate functioning as a male couple, were referred to and categorized in the literature review as the "distinguishing characteristics of male couples" (Levy & Koff, 2001; Murphy, 1994; Ussher, 1990). The next segments will more specifically address how these and other collective characteristics surfaced in the case examples shared by the interviewed therapists.

Section 2 -Distinguishing Characteristics Revealed in the Work

This section will start with the interviewed therapists' examples of specific characteristics that distinguish male couples from other types of couples, many of which support and build on findings published in earlier studies (see, pgs. 62-81). Based on this groundwork, the next part adds fresh insights or updated knowledge pertinent to clinical work wth contemporary male couples. Finally, this section concludes with the therapists' beliefs about how more recent socio-cultural changes have generally impacted gay male's coupling patterns.

Building on and Supporting Previous Research

The Impact of Disruptions in Attachment and Development

Most psychodynamically based theories recognize that early attachment patterns and developmental opportunities in childhood impact adult psychological health and the ability to sustain future relationships (Cornett, 1995, Drescher, 1998; Scharff & Scharff, 1995). In applying these theories to psychotherapy with couples, it is understood that committed couples of all types inherit not only the impact of both members' disruptions in early attachment, but also particular developmental deficiencies that often then get played out through adult partners efforts at achieving intimacy (Forstein, 1999, Hendrix, 1992; Karpel, 1994). Beside intrapsychic forces that impact all individuals' relational evolution, the gay affirmative literature added the missing pieces of the puzzle for same-sex relationships, how homophobia and heterosexism get embedded into the developmental and relational lives of LGB individuals (Greene, 1996; Herek, 1995; Isay, 1989).

Several of the interviewed therapists presented examples of coupled men who had inherited the intertwined legacy of their early attachment experiences and the impact of homophobia (see. pgs.145, 148, 154). Others directly commented on how disruptions in the normative process of development and socialization, which were in part originated in both externalized and internalized homophobia, affect coupling. Ellen believes:

> What heteros get to do in high school when the stakes are not as high, they explore their romantic, and sexual identity and begin to see how it fits in the dominant culture. We (as gay people) get to do it once we are out in the world and with less support. So one might have their career at a high level of functioning, but their relationship is still functioning at an adolescent stage of development.

Barry believes traumatization due to homophobia disrupts not only traditional developmental milestones, but also a sense of positive regard of being in a couple that non-gay couples may take for granted:

> Many gays and lesbian are developmentally delayed because, for many, all that time they were developing, they were traumatized, or bullied, or unconsciously rejected by their parents. And many are at least trying as hard as they could to survive or appear like the majority, which creates a culture of deniers and late bloomers, who still develop the desire for intimate attachments. Unfortunately they are socialized to expect it at a certain age, so they get into relationship before they are ready. Coming out, as much as it consolidates identity, is thought to restart adolescence, so put these adult age teenagers, who want to be coupled, in a relationship with someone with similar experiences and add to that the reality they could be gay bashed if they show their affection, or turn on the Television and hear how they are sinful, and it is really hard for some to feel optimistic about their union.

Margo added her own view on homophobia's impact on gay male socialization and its effect on their capacity for relationship:

> Gay boys I think have it harder than lesbians. Girls can be tomboys and even hold another girl's hand with less notice then a boy of the same age. I mean, 12 year old tomboys are more acceptable then the sissy boy, so boys figure out earlier than girls that they are different and feel alone longer and they bring this wounded self and shame into relationships earlier, because guys also come out earlier, and then they try relationships, get disappointed and become doers not feelers. And this impacts their ability to blend their lives because their patterns of living and psychology are so established. It is more of a challenge to let the others in when on one level you are accomplished and romantically you feel unprepared.

Edna, a married social worker, gave an example of a couple whose members seemed to demonstrate the effect of the developmental impediments referred to by Ellen, Barry and Margo. She thought both young men had not yet consolidated their own identities and therefore their relationship was about "playing house."

> There was this pattern of relating that was rapid and so hurtful that I could not control it. They pushed each others' buttons in such negative ways, and it was so hard that it would spiral out of control, and when I tried to get them to talk to each other, the hard competition would move to finger pointing and blaming. And some of the content they screamed was so hurtful, like "you are such a faggot" or

> "you are such a girl." I felt so shocked and helpless and could not even get them to look at their own internalized homophobia. Eventually, I came to understand they both suffered early abuse, one mostly verbal and the other sometimes physical, in part due to their parents' inability to accept their sons atypical maleness. Finally, I realized they needed individual work, and was quite directive in saying this. This was for both of them their first relationship, and for one, this was his first time with a man. That one had never even dated, but was the one telling the other how to be in a relationship. Beyond testing out relationship skills, they were like two teenagers trying to play house.

In actuality, some of the therapists' examples confirmed not only the contribution of the male socialization process and homophobia, but also the impact of individuals' specific unmet childhood needs and longings on their attachment patterns in adulthood. Henry offered his thoughts on one specific outcome of this process, when boys, who were aware of their early "differences," but were unable to get the vital mirroring they needed, become adults who get into a relationship together.

> I've seen a common pattern in male couples, where the gay boy learns early on that he better not reveal his true self if he wants to be taken care of, so he becomes a care-giver who keeps his needs and feelings secret, and most everyone accepts him because he has a capacity to please and listen. Sometimes they become-mother's little housekeeper, confidant or assistant mother to the siblings. Then this adult child finds a similar guy with a similar development, but who adapts in adulthood as a needy, care-receiver. This one couple I saw, they both thought they were caregivers to the world, but it turns out that one had become the insecure taker and the other the insecure giver. This clash surfaced in bickering and unmet expectations that brought this couple to treatment. Even though they took pride in their ability to communicate, they both justified many secrets and difficult areas they could not talk about. We explored how their problems were directly traced to their early attachment relationships, with both being the confidant to mom, staying out of daddy's way, unable to express negative feelings toward their parents. And now they play out their well-known childhood patterns, still projecting, and recreating disappointment.

Henry commented that this couple exemplified "complementarity" as theorized by Bowen (1976). In this case, both members' adaptation to their childhood disappointments fuel what becomes a complementary defensive pattern of interacting, that includes what develops into a normalized place of living with and/or expecting

ongoing disappointments. In other words, the longing to get healed from these earlier unmet expectations often resurfaces once the "honeymoon is over" and the commitment of a loving 'other' allows a mutual projection of each partner's unmet desires onto each other (Cornett, 1995; Hendrix, 1992; Mitchell, 2002).

Even though this pattern is not really different for heterosexuals, several therapists alluded to this multi-layered process of expectation, rejection and disappointment as the deeper context of much of their couple therapy with gay men (see pgs.142-3, 147-8). Bill shared the quintessential example.

> I had this couple together 12 years that were totally entangled. They had envy or jealous if one was fifteen minutes late for anything, including a scheduled phone call. Now they had sex 2 times a day, and if that was missed it led to suspicions and accusations about betrayal. They set such high standards for being in a relationship. My challenge was how to help them become more independent and less focused on how they disappointed each other. They both wanted to be recognized as complete, creative people, and got that outside of the relationship, but could not give that to each other. They were a perfect example of two good boys who never voiced their early parental disappointments, and their rage mutated into defensive structures against these feelings that have so impaired both partner's ability to mirror and to accept each other. They came to me firmly stuck in this pattern. Ultimately, as a couple they were not ready to let me in. However, one has stayed with me in individual work, and we are making progress.

Edna, building on her thoughts previously reported on having two developmentally delayed individuals, believes an important part of disrupting these repetitive and destructive patterns is to help the men find a deeper empathy for each other.

> It is my job to get under the presenting problems, and for me this starts with doing some family of origin work. Sometimes this helps them have empathy for each other; you know you can't have empathy unless you have an understanding of why the person is the way they are. It is not, 'he just wants to infuriate or disappoint the other and can do better,' but that the other is coming from an emotionally limited response pattern that he has lived in for a long time. So, in treatment, they can begin to tie the behaviors and reactions to earlier family

> experiences, and traumas, and their parent relationships. Then you begin to see this person is bringing this stuff in and it is not the partner's fault. But the bottom line for gay couples is different. You do a very healing and therapeutic thing when you readily validate that two men actually have a working relationship, complete with all the intimacy problems that come with these types of long term, complex, commitments.

The only parts of this aspect of her treatment approach that in any way varies from more conventional couple work seems to be the greater emphasis on validating both the efficacy of this couple's very existence, and the two men's potential to find the necessary empathy to disrupt the cycle of disappointment.

Developing Boundaries between the Couple and the Outside World

The challenge for all types of couples is to build relational boundaries that sensibly fit within both partners' distinctive needs for closeness and autonomy (intra-couple), while also balancing both individuals' needs outside the dyad (Friedman, 1991; Johnson & Keren's, 1996; Whitbourne & Ebmeyer, 1990). Jill, for a second time, referred to her " bubble" metaphor in that she believes it helps her clients clarify what make them a couple, with explicit boundaries created specially for their needs.

> Gay men need to work to explicitly define what keeps them together... My job is to create boundaries that may not have been there or that they have not clarified. For instance, I try to get the guys to clarify *when* they became a couple. Straight couples answer their marriage date, so I ask gay men what they consider their 'marriage date.' So that beginning point, like the bubble, starts to define their relationship. You know with straight couples, when they get married, they clearly separate from their past, they clearly have a demarcation, they shut out the in-laws and others and the boundaries begin. Many gay men once they declare themselves a couple, they start becoming diffuse in their boundaries, which works for some over the short term, but not for many.

Articles by Johnson and Keren (1996) and Green, Bettinger and Zacks (1996) cover many of the specific subtopics that are associated with and impact on male couples'

boundary formation such as: male-gender socialization, sexual norms in the gay male community, and internalized and externalized homophobia. It appears that all of these subtopics represent powerful forces that together pervade almost every area of male couples' inner and outer lives, from the aforementioned capacities for attachment and empathy, to their ability to make clear what they keep in and what they keep outside of the relationship.

The Impact of Male Socialization on Boundaries

Even though many of the therapists alluded to internalized and externalized homophobia at various times in the interviews (see pgs.141, 142, 153-4, 157) the most common subtopic mentioned in relation to boundaries seemed to be the impact of male socialization. Interestingly several therapists offered warnings about how the extent of incorporation of traditional male gender patterns by each member needs to be assessed before working directly with clarifying boundaries. For instance, Bill cautions that prior to helping couples clarify their distinct relational boundaries:

> Be aware of the different degrees of maleness *culturally.* Yes, and who is in the dominant role, and in what activities? Expand beyond the top, bottom clichés that couples can fall back upon. And that leads into- what roles does sexuality play in the coupling in general, is it about sex, sex and romance, or is their relationship more pragmatic? There are a lot of issues about male sexuality and culture that need to be asked about early.

Carlos claims, before naming and normalizing any variations in boundaries:

> Be aware, most gay couples have a different vitality, in that roles tend to be more fluid. And the complex gender issues between two men pull in so many issues of competition, each asking if their intimacy can survive their maleness. It is the same with less traditional straight couples, but is so heightened by the similar gender.

Similarly Barry, when referring back to the lawyer-like men who argued like Martha and George from, "*Who's afraid of Virginia Wolf*" (see, p.147-8) said:

> Well with this particular couple, their gender predisposed them to being that way, and that seems more important then their sexual orientation. It is related to male gender socialization that they are both instrumental in their approach to the world, (as opposed to expressive), and that causes problems when the need in this relationship is to relate on a more feeling or emotional level. Therefore, before dealing with concrete issues, with men like that, I tend to be more educative about feelings, identifying feelings, how to communicate them, how to develop a sense of empathy, how to be able to listen actively without becoming defensive and shutting down communication, that sort of stuff.

Mary made the related point that she thinks it is generally difficult for men to utilize their emotions when negotiating boundaries:

> Honestly, I work with the premise that most couples are the same, they have similar wants and desires, and so boundary setting it is all about getting comfortable with needing and wanting, dependence and independence. However, it is harder for men to talk about these things, so it takes different ways to get there because, often when men feel needy, even gay men, being men, lead with rage or anger first - so when you have this gender defined stuff it gets played out differently.

Irwin, the oldest clinician interviewed, a heterosexual psychologist, seems to give an example of Mary's, Barry's and Carlos' thoughts, with his account of how one couple's standoff, was in part related to one member's confusion with his indoctrination into stereotypic and traditional male behavior:

> These guys presented that they could not decide if they should break up or both move to where the older one found a great new job. They already had a rocky, year and a half relationship, with several break –ups initiated by the younger guy, who was determined to be independent, but kept coming back with his tail between his legs. We explored how he did not 'feel like a man,' in the relationship, and often felt controlled by his older, more accomplished, partner. His partner seemed to have taken the lead in most decisions and the young one believed he had not contributed, and wanted more say in their future. The younger had significantly less money, little clarity about his career and spent most of his time in the older guys apartment. He was also the more sensitive and less

> stereotypically male in his emotionality. His older partner said he valued his sensitivity and his natural intuitions and intellect. However, there were times when the younger one would throw temper tantrums and act aggressive and hostile. In the course of the treatment, the younger one revealed extensive early neglect and abuse that was in part due to his mother screaming that he was too feminine, or weak or too dependent. He realized he was trying to feel powerful and become more male by taking control, and through threatening like his mother would, that he would leave. He eventually decided to go with his partner, but only after finding two jobs in the new location, which gave him a sense of independence.

Arthur, himself in a monogamous relationship, offered both a more positive vision of how gay men incorporate male socialization, and an indirect warning about straying too far from traditional relational norms that leave men without a clear vision of how to proceed.

> I have learned to respect gay men' s fluidity in regard to gender and sexuality, in that gay men tend to be less stuck and defined by gender stereotypes than straight men. This role flexibility is maybe part biological, part developmental, part life experiences, and a lot of self-acceptance that can be enhanced by therapy. Therefore, I believe two gay men in a couple have the potential to be more open to their own and each others fantasies. Like Kernberg said, they can readily make available each other's own polymorphous fantasies, and then men can find a play space, verbal or no verbal, porn or not porn, where they can find a place to move fantasies back and forth. And that capacity lends itself to a successful couple life. Of course the relational potentials born from this flexibility can be quite confusing, particularly if the couple reaches beyond the more common social and sexual rules that create what we commonly think of as a committed couple. Then they can find themselves in unknown territory that for many leaves them anxious and insecure.

Homophobia and Boundaries

Mark provided a direct example of *externalized* homophobia, and how in this case, it helped solidify boundaries:

> These days most men do not refer to homophobia or its result. It is often more subtle. However, I actually just had a couple, where one of the member's old mother, in talking about leaving more of her money to his dead sister's children, said something like, "And if I leave it to you, what are you going to do with it, leave it to Maury. He's not blood." The speakerphone was on and Maury heard

> her. He had been in her life 27 years and had just vacationed with her, as he drove with her and his lover to Key West. His hurt, and the other's anger at his mother, motivated them to get their wills in shape and actually invest in the relationship in ways they had never done before. That is even why they agreed to therapy.

Henry mentioned a couple whose interactions with one set of parents pointed out not only one of the partner's *internalized* homophobia, but also led to external boundary clarification.

> These two guys in their forties were still weathering one of them having a romantic, long distance relationship. But what they said brought them into therapy was the stress from dealing with demands from one partner's family of origin, to show up more, this time to a large family reunion, where in the past the partner was introduced as his "Buddy." And this one, who had just moved away from his outside relationship, was not willing any longer to deal with his partner's mother's demands and devaluation and still gratify his lover who he saw as over-gratifying his mother because of, what became clear, was his internalized homophobia and fear of disappointing his parents. This was the beginning of re-negotiating and unearthing many other unaddressed power struggles impacted by internalized homophobia, related to public versus private visions of their coupling, including how to mutually integrate friendship, families and outside sex partners.

Flexible Boundaries and Sexual Arrangements

Validating prior literature (Bettinger & Zacks, 1996; Goodrich et. al, 1988; Johnson & Kern, 1996) many therapists claimed that negotiating sexual arrangements other then conventional monogamy is the most profound example of boundary formation distinct to male couples (see, pgs.141, 144, 148-9, 153, 154). Arthur, for example, expressed how negotiating outside sexual involvements is not only a common area of disequilibrium for male couples, but also a complex challenge for even gay therapists, like himself.

> Many issues are dealt with in the sexual realm, how do people handle sex, how people handle outside sex, what happens when one wants monogamy and one does not, how to get that to shift during the course of the relationship? How do you reconcile two very different ideas about what people want? I think all that is

> unique to gay couples. Because straight people have it defined for them, for the most part, they work with some very inflexible rules. Once you open up the rules, which can be a wonderful thing, it opens up a particular burden for the couples to define the rules themselves.
>
> It is interesting that I always seem to struggle with how to be able to help couples reconcile different desire for monogamy or non-monogamy, because once you hear why they want it and where they come from, it is hard to take a position. I can't draw upon the Bible and say one is right and one is wrong, it is not there, except in their individual dynamics and belief systems. It is a difficult thing to reconcile and in a lot of cases those difference end the relationship.

Paul, from the point view of a heterosexual psychologist, added the proposition that some male couples seem so accepting of open relationships that even when they are struggling with balancing relational security with reasonable sexual expectations, they do not always recognize or present extra-relational sex as a concern.

> I just saw a couple, together 8 years, dealing with whether they should stay together because one has revealed himself as a drug addict. The one in recovery said, "and when Mark went to see his boyfriend the other night, I felt both lonely and free and then felt like using." If I had not asked about 'the boyfriend', I believe they both would have not reacted to that statement, it was so normal for them. Maybe I'm too heterosexual, but they did not even see their not giving weight to his partner having a 'boyfriend' as a symptom, which it was, of other bigger intimacy problems they had. Talking about it opened up many unexpressed concerns and insecurities from both men. Mark did scale back this connection, spending all his nights with his partner, leaving the boy friend as a strictly sexual outlet. And it opened up a space to explore what needs they expected to get met from their partner. There was no longer the same threatening escape risk. In retrospect, they had both so scaled back their expectations for relationship that it had almost disintegrated. This renegotiation marked a significant new era for this couple, in which they both seemed reenergized.

David, from the perspective of a gay therapist, seemed to validate Paul's experience, when he said:

> It seems many gay men who present in couple counseling or individual psychotherapy have already struggled in isolation with their desire for outside sexual encounters within their relationship because of their own shame, lack of support and confusion. And unfortunately I have seen this further entrenched by the failure of a previous therapist to normalize the complexities of their sexual

> needs, so they may check me out as to my beliefs about monogamy, before revealing the true nature of their sexual arrangement.

Based on both his practice experience and his 15-year relationship with his partner, Henry believes some gay men in couples go through different phases in their viewpoints and concerns about boundaries in their sexual arrangements.

> I guess I see 3 phases, similar to the developmental stages many gay people go through in the coming out process, if they stay conscious and communicate. Phase-1 is the same fantasy that many people have when they start a relationship. Monogamy is the only answer, that anything else is bad, or an indication of moral weakness, or an incomplete capacity to have a relationship. They ape the hetero norm as the ideal, but for gay men it can come from a defensive place, for some disavowing or disowning their sexuality in all its complexity. And then they move slowly to phase- 2. Non-monogamy, the other side of the binary, is the only answer that in reality gay and even straight couples can't be monogamous, that it's all a farce, that everyone is secretive. Then, if that progresses, the realization that it is complicated, that different people have different needs. Which moves toward phase 3; believing that some version of monogamy may offer more opportunities for intimacy, and I guess valuing intimacy as a result questioning non-monogamy more, to find out if and when it is not defensive. Ultimately it is asking all of it less judgmentally, what you value more, sex, connectedness, security, etc... asking at this point in my life do I value sex with a lot of people more, or the work of building a deep relationship with just one person more or maybe still both. My experience says that male couples that stay together the longest tend to be the ones who are most flexible and adaptive, and find ways to challenge traditional formulas for sexual satisfaction.

So the developmental journey of clarifying sexual boundaries, through Henry's model, becomes one of experimentation and collective awareness. He believes many relationships begin with what might be called an "idealized or assumed monogamy." In phase 2, the men come to realize their beliefs and values that connect sexual exclusivity and idealized monogamy with the longevity of a relationship are not always practical and/or integral to their commitments. Based on both Henry' comment and the majority of the couples referred to in the course of this study, many of the men embark on opening themselves to accepting into their relationship a vast number of divergent sexual

arrangements, including nonsexual unions, part time partners and varied outside recreational liaisons. But on further inspection, the repertoire of arrangements all have in common the inclusion of many of the values often associated with conventional sexual monogamy, particularly a sense of security, long-term attachment and mutual support through thick and thin. Yet they also allow for modification from the traditional code of sexual exclusivity. Therefore, true to Henry's phases, during the course of their partnership the configurations go beyond a static either/or dichotomy, as the concerns for monogamy/ nonmonogamy vary as per the needs of the couple.

Value Clarification, Boundaries (and Body Image)

Robert mentioned that he has helped members in a couple clarify the impact of their values on their boundaries, by introducing an exercise that he says sometimes works to emphasize why they are together, sometimes emphasizes their differences and often helps them problem solve more effectively.

> With some couples I do an exercise where I ask each member to prioritize their top five-values. By values I mean such concepts or influences as self- growth, family of origin, or choice, the relationship itself, sexual freedom, financial security etc, and then they compare each other's lists. I had one couple where one member chose 'sex' as number 1 and 'relationship' as 4, and the other 'relationship' as 1 and 'sex' was not on his list. Not only did this reveal a strong sexual compulsion, but also put out on paper their incompatibility, since one clearly desired and valued customary monogamy and the other did not. It also clarified how they problem solved differently. For instance, the one who valued the relationship mostly would spend his time doing things for their house, and preparing dinner for both of them. The other lived his values of first seeking sex and then his number 2 value, doing things related to his career. They eventually broke up because the one who valued sex kept trying to bring third parties into their living situation.

Marietta, in her own way, supported the need for values clarification when boundary making, with her description of a couple who moved on to a mutually agreed upon value system with potentially more useful sexual boundaries, in terms of both their sexual agreement and other relational expectations.

> This couple that had been together in a relatively 15 year stable partnership, very involved in each other families and had a large group of friends. The more hunky, I will call partner A, had been unfaithful with an anonymous encounter that historically this couple would have labeled as a devastating betrayal. They said they did not have an open relationship, but had not clarified exact boundaries, because extreme flirtations and occasional cyber sex was seen as acceptable. Partner B wanted to punish his partner, but also claimed to understand, because he felt his partner was more handsome and could get anyone he wanted. Partner B, was to my eye quite attractive, maybe slightly less muscular than his partner, but believed other men did not see him as hot as his partner. Partner A did not want to acknowledge his partner's hurt because he said he had not kept his encounter a secret and his partner might have done the same thing, if faced with this opportunity to be with this guy. Partner B bought into the same value system about bodies and therefore agreed with his partner, but felt at a loss because he believed he could never compete.
>
> I spent time getting them to listen to each other's needs in less defensive ways and attempted to get them to question their need to interact in the meat market of hot bodies. The assumed idea that a "hot" body is a commodity that gives entree into many areas of the gay community was so engrained in the social circle of these guys, it seemed somewhat impenetrable. However, they did set down new guidelines that included no affairs, and only one time sexual encounters, with full disclosure. But the major focus was about how much to expect the other to take care of each other's needs, which included sexual desires and fantasies. They did seem to loosen the rigid criteria by which they navigated their relationship, and their sexuality, but the "A-list" scene was still placed on high regard.

This was the first time this couple had clearly communicated and negotiated new boundaries based on their collective values. Nevertheless, this couple had incorporated the body image ideals of what Marietta referred to as the "A-list scene," gay men who live within a value system that strives for a combination of youth and/or beauty and/or money that they believe gives them more entree into an elite social network. Hence, they both continued to give power to a "hunky" body being an important commodity, a value

fueled by this gay sub-group. Even though other studies and literature have addressed body image concerns as an important topic for gay men in therapy (Beren, Hayden, Wilfey & Grilo, 1996; Wood, in press), in this study, only one other therapist, Mary, directly referred to another case when body image, surfaced as a value-based concern during the course of couple treatment.

> One older member of a couple, in a declared open relationship, was always in a bad temper because he claimed he does not look good enough and does make enough money to get the attention he wants. His partner traveled and readily acknowledges having sexual encounters on his away trips. The older one is always reacting to a culture that he says cherishes, youth and beauty, which he says he does not want to embrace. He feels a lack of self worth that impacts his feeling good about his relationship. So first his 'biceps are not big enough' or he wishes he could 'look and be more of a top.' And when I asked, he realizes his responses are misguided, he gets it, but then says, if he just had this stuff it could really heal all the bad self-feelings between him and his partner. When again confronted, he said, he was afraid to leave his focus of this stuff behind for fear he will become even more invisible than he already feels. His partner claims to find his partner sexy and did not even want an open relationship, but the older one still wanted the possibility of outside sexual validation. The member with the body image concerns was directed into individual therapy, because his issues kept pushing his partner further away. During the course of therapy, they decided to try being monogamous. I don't know how long it lasted, but in that time, they worked on validating each other romantically and sexually.

So typical of other couples mentioned by the therapists, this couple presented in therapy when their existing boundaries no longer worked in conjunction with their different value systems. In this case, the older member's overvaluing of some romanticized version of a better body over the available validation and love of his partner differed from his partner who seemed to value the relationship over some hyper-masculine body image.

Interestingly, Mary went on to explain how her work with the prior couple impacted her work:

> In the next couple I worked with I found myself helping the individuals in the couple flesh out what they valued most. We discovered the younger guy was

> recycling values that did not fit the realties of his partner or himself, but instead his old, immigrant parents. I found myself advocating for the possibility of sex outside the relationship, something, as a woman, I never thought I would support. I thought the insecurities and anxiety churned up by outside sex would disrupt all relationships, but just accepting the possibility of openness was a powerful catalyst for these guys to find renewed passion. So the younger one allowed himself to use the internet and the phone for sex, which gave him a taste of the sexual experiences he never allowed himself to have, but also maintained the relationship's specialness, he feared losing. This modification somehow took the pressure off the relationship to carry the full weight of each member's erotic fantasies, and desires… I came to realize *my values* changed, in that I had been quite heterosexual in my ideas about monogamy as some core need for healthy coupling.

In fact, as will be discussed in more detail in the next chapter, many of the interviewed therapists, gay and heterosexual (non-gay), through their ongoing work with male couples, moved beyond their own previously more static and limited beliefs about what boundaries and values constitute a "healthy" relationship. Their examples clarify that no relational boundaries, particularly ones as morally and pathologically laden as sexual boundaries, have universal meaning. Similarly there are no core vales that represent a functional couple. However, the examples offered imply that couples that have similar priorities in terms of what they value might experience less conflict then those with divergent values, particularly when trying to decide upon mutually agreed upon boundaries.

Psychosocial Bed Death

In the course of the data analysis there surfaced a typical problem that was referred to several times throughout the interviews. It seems it is not uncommon that quite early in their relationship, male couples dramatically slow down or stop having sex together. And sometimes, because of the array of sexual arrangements and relational

values male couples accept, some do not directly offer this phenomenon as the presenting problem that brought them into therapy, even though it is a major reason for their discontent. Bill put forward just such a couple.

> These two very respectable, open, intelligent guys, together 9 years, presented with a general dissatisfaction, complaining they were bickering more often and were feeling distant. It was revealed that they cuddled and hugged, but could not bring themselves to have sex with each other. I think their many problems with power and vulnerability played out metaphorically in the bedroom. This sort of psychosocial bed death is quite common. Even general transformation can play out in the sexual arena. These guys when they did the work to own and communicate their true experiences, the safer they felt to take the risks to connect again, in the bedroom, and in time that included hotter sex. But I had to be quite directive and persistent supporting all attempts and even setting up a behavioral system of rewards.
>
> I think some gay men have sex all over the place, but not with their partner, and that is quite an acceptable occurrence in gay male culture, and even acceptable to many partners, even when there is something obvious they are protecting that needs to be explored. I guess there are so many permutations. I do not know the answers anymore. My gut says for some, sex is a great place to avoid dealing with emotional intimacy and for others emotional intimacy is a way to avoid sex; both sides of the coin are true. There are no absolutes. It needs to be taken case to case.

Bill infers this type of waning passion between partners is partly due to both individuals' psychology, and in part due to the sexual freedom gay men incorporate into their coupling before exploring its full impact on their relational connection.

When referring to this couple's situation, he borrowed the term "psychosocial bed death," an idea more commonly associated with lesbian couples, where supposedly a high degree of fusion within the couple leads to an inability to keep the partnership erotically charged (Green, Bettinger & Zacks, 1996). Henry elaborated on a category of male couple he called "the idealized or role model couple," a type he has seen several times in his practice (see p. 158), where he believes there is a propensity for psychosocial bed death. He surmises that that the loss of each other's otherness, created in part by their

need to please and get acceptance from others outside the relationship, impacts thinking of themselves as sexual being.

> So this role model of a couple appears truly compassionate, is loved by their families and friends, but had given up on sex with each other. In one way, they try to live this ideal gay life, with the ideal relationship, the ideal apartment, great careers and they buy into being good people who happen to be gay; and the sexuality gets even further split off. They sort of lost the erotic pull of their differences, as they appear as this dynamic, almost asexual duo. With these guys, the more their families depended on them and the more their energy went into all the other things they value, they could avoid their waning sexuality. It's the opposite of the rejected couple of the past, but still it comes back to internalized homophobia where not only gay sex is kept secretive, it becomes so separated from intimacy it gets pushed out of the coupling experience as the messy, unidealized thing they take care of away from each other. Sure this is in part due to the lack of childhood vision of how to be this good, healthy, integrated gay couple that can have it all and also be sexual.

Carlos shared a related case example from his present practice:

> I still am working with this couple, together a year. They are both highly successful in their careers. One has already been going to SCA (sexual compulsives anonymous) because even though he still thinks his boyfriend appears hot, he had lost the desire to have sex with him. This member thought it was due to his history of anonymous sex, which he has now renounced, as these guys tried for a traditionally monogamous relationship. He felt so pressured to prove he was turned on; he could no longer get an erection in his boyfriend's presence. The younger boyfriend saw it as a rejection and had already broken off with him twice. This younger one had become overly jealous, even when his boyfriend went to the gay beach to see his friends. He has started withdrawing and becoming depressed, whenever he is not the focus of attention. This is a complicated problem that takes into account both men's sexual and relational development, not to mention both their fairy- tale ideas as to what constitutes a normal healthy relationship. They have this rose-tinted vision of how they should be as a couple, particularly since both travel in very visible social crowds in which they present and are seen as "fabulously together."

Both Henry and Carlos (and Paul, see p. 143) gave examples of couples that in attempting to live up to their own idealized visions, burdened the men with standards that seem to negatively impact their passions for each other. The lack of a clear vision as to what they can expect as usual in their relational development, combined with external

societal and familial pressures to desexualize, and gay community norms that push to sexualize others, leaves the men confused by how to deal with sexual difficulties that arise in the course of their relationship. Correspondingly, in his answer to the final question as to what advice he would give to other therapists working with male couples, Arthur summarizes:

> Support and explore questions of sexual neutralization that can be problematic, particularly when sex gets placed outside the relationship for various reasons, including the partner's own particular connection to their sexual scripts. Even when sex and love have been separated by many years of anonymous sex and or multiple sexual encounters, men still expect they can bring it all together in one all encompassing and loving romantic relationship. In addition, factor in social and political gay pressures with male socialization that both value sexuality over intimacy, and sex can be difficult to maintain.

Managing the Flow from Friend to Lover and Back to Friend

Several of the therapists mentioned that one of the most unique aspects of the male coupling experience is the tendency for gay men to make family out of their past lovers and lovers out of their friends. John commented on this very clear way in which same-sex partners and gay culture differ from the dominant, heterosexual culture:

> Well, I guess I have seen a lot of couples redefining, when they separate or divorce, using legalistic language, what they want to be to each other, very similar to the flow of defining the sexual arrangement, but this goes beyond that, after they have decided to no longer be defined as a couple. I wind up supervising often about this, because this seems to be a common dilemma, not that there should be a standardized rigid approach, but there is not a standard in the field and little even written about how to manage this flow.

Eric, a gay psychologist, volunteered a case example of what he called an "amorphous" blurring between friendship and lovers.

> This couple who had been together, I think almost 20 years, officially broke out of their old supposedly monogamous relationship, and physically separated, and yet wanted to maintain an intimate relationship without being thought of as a couple. They came to me, two years later, still connected, and struggling with how much

> to share with each other about their outside sexual and romantic meetings. And should they be open to re-engaging sexually. What is the line? Part of the problem was old dynamics that never got addressed, and therefore, they could not make this transition very easily to being close friends. It was all very amorphous, new territory, and the gay community does not define guidelines. I have seen other couples trying to manage these arrangements that go beyond the sex, but it often starts there, helping define what type of relationship they have. These men, as far as I know, are still interconnected, even though one now lives full time in Ft. Lauderdale.

Mark questioned the reasons for this tendency to morph from one social role to another with a fluid blending of different forms of intimacy. He posited an explanation based on gay male sexuality and their lack of acceptance of conventions most often assumed by different-sex couples because of the influence of traditional marriage.

> There is fluidity of friendship, dating, romance, partnering, ending, transitions, etc. Is it because we don't have marriage, so that when we leave a dyad we don't smash some structure that holds us together? We were always told we were promiscuous, maybe there is a good, fluid side to that, or maybe we just got with the idea of serial monogamy quicker than the straight community, so we have five relationships that are all valid versus having five marriages, and the first five were just all wrong. And for us, it is possible we have gained friendships for a lifetime.

Robert questioned if this ability to move between friends and lovers, has to do with childhood acculturation, in which same–sex friends are the social norm.

> For gay men is it easier, because we grow up acculturated to interact with having male friends, so that we can move back to that place once the relationship ends. Because to have friends whom you could potentially be attracted to is the norm; we have been infused with this dynamic. Whereas with straight men, there is little place for female friends. So where do you put the ex-wife if you still like her and the chances are your new wife won't go for it? Whereas this inclusion of the ex-partner is not uncommon in male couples.

Margo seemed to summarize and explain this trend, linking it to the impact of learning to depend on friendship and families of choice, versus the more traditional dependency on one's families of origin and children.

> This is so unscientific, this idea is stereotypically applied to lesbians that a couple breaks up and becomes best friends. But I think that does happen frequently with men. I have been wondering how much of that is the bleed between community responsibility and couples/individual responsibility, this taking care of your own sort of thing when the typical others, like family are not part of the picture. Is that the sort of the impetus to have endings that I think are more often much healthier than their counterparts in heterosexual world? For some reason gay break-ups are not as injurious, and not as frequently vindictive because their sense of helping each other goes through it. Certainly some gay relationships end in horrid ways, but there is also the potential to have the ex- as part of the family

Updated Manifestations of Ongoing Concerns

Impact of HIV

As discussed in the literature review chapter, for the last two decades HIV/AIDS has not only been the hub from which many studies about gay men have radiated (Lipton, 2001), but also a prominent factor included in much of the research with male couples in the 1990s (Mattison & McWhirter, 1994; Shernoff, 1995; Signorile, 1997; Ussher, 1990). Considering the central place of this issue in regard to prior research, it is notable that even though some of the therapists refereed to one member of a couple being HIV-negative or positive (their sero-status), there was only one spontaneous example of a couple presenting with problems related to HIV, or sero-discordant concerns (see, p. 183). The only time HIV was readily discussed was when I asked directly about its impact. Eric provided a probable response to this occurrence:

> HIV has changed its place as moving to the bottom of the list, in terms of presenting stressors for couples. Since it is not in the forefront of gay mens minds they way it was ten years ago, there has been a shift of social pressures, again to more open relationships, not to mention drugs, which are even more apparent than they were in the past.

Several other therapists had similar observations in regard to the minimizing of concerns related to HIV. However, while HIV seemed not to surface as a presenting problem for couples, many therapists were in agreement that unprotected sex and the consistent numbers of men who are still sero-converting needs to remain in the vanguard of concerns for all gay men, including those in couples. Carlos commented that:

> HIV has gone from an era of devastation, to an era of denial, so several years ago it was knowing someone dying or thinking about your own death and dying yourself, to trying not to think about it. Those issues are much less relevant and pertinent and men are not making coupling decisions based on that anymore. But still I think HIV needs to be included as a theme during initial sessions. I hear about more men in couples having unprotected sex, yes, I hear about that a lot. I have had a couple of patients in the last year sero-convert, two of whom were in couples.

Henry mirrored Carlos' concern about denial and increasing numbers of men having unprotected sex.

HIV ebbs and flows, it seems to be less of a focus, even though more and more of the 20 somethings I see seem to be accepting bare- backing (anal sex without a condom) as everyday phenomena, and that is an alarming concern that needs the attention of all therapists who work with gay men. I try not to let supposedly innocuous comments related to unprotected sex go unaddressed.

Margo encapsulates her view that even though HIV has been incorporated into the psyche of many male couples:

> HIV interferes and interacts with basic issues of power and control in couples, and has become a metaphor for these issues and more, including the right to health, feeling entitled, and the right to growing older or old together. Some younger men live with the idea they better enjoy their life now, almost living as if it is inevitable that HIV will interfere with their lives at one point. Mix this with the difficulty many gay men have even thinking about or picturing themselves being middle aged or old and becoming HIV positive on some unconscious level functions like a potential escape route. I guess now it is easier to use it that way, since we are not seeing the ugliness of death and dying and the pain of ongoing mourning as much. So the realities of HIV might have changed, but it still impacts how a couple sees its commitment.

To recapitulate, HIV's penetration into the social environment and individual awareness of almost all gay men impacts male couples along a continuum from acute consciousness to thoroughgoing unconsciousness. Many of the therapists generally agreed that, particularly with sero-discordant couples, HIV and it impact needs to be included in an assessment even if the members do not refer to it directly.

Drug Use

The continued normalization of substance use and abuse by significant numbers of men in the gay community was an ongoing concern mentioned by several therapists. Michael described how drug use can tear couples apart:

> I had a couple that had been together a year and a half and was coming to me because of escalating drug use. It was one of those situations where they both used and one abused, and the issue was what drug use was acceptable, and when was it unacceptable, since now the heavy user was often checked out, or missing in action. This was a couple that basically functioned very poorly as a couple. They never established themselves as a couple because drugs so defined them. Drugs were the biggest commonalty, and the recreational user wanted to stop, so they could get somewhere else, if not completely, for a period of time. It was really a ploy to get the boyfriend to slow down because he was actively self-destructive. Every step I took, I was thwarted by more drug use. I finally read them the riot act and confronted them with what is most important to them as a couple: drugs or their future.

First Ellen and then Henry mirrored this concern, focusing directly on the escalating usage of metamphetamine (crystal).

> Gay men have always had drug use as a concern, but now it is club seekers versus the bar seekers, and drugs like Crystal or Ecstasy that seem to create a quicker downward slide, worse then even cocaine, which is also still being used. And most of these guys already know that Crystal use is a highly causative factor to many of the new cases of HIV conversion, but that idea gets pushed aside readily with the drug's usage. The social pressure to fit in is so high and usage of drugs to participate in these club and circuit party environments continues. These drugs blur and take care of a lot of social ills. Men find themselves with Crystal feeling

> freer to not only dance all night but also try wild sex, and really have no skills in managing these environments without drugs.
>
> Henry said the growing epidemic use of 'Crystal' has caused him to become:
>
> More directive, and less permissive then I was in the past in regard to all drugs. Crystal destroys men and their relationships. It is so destructive. It has caused me to take a harder stance on drugs, as it pertains to couples wanting to stay together, particularly if the couple uses drugs to engage sexually or relate. It is not unusual that these substances mask depression and/or weaken people and that leads to depression. Once into cycles of use, and failed attempts at stopping, without 12 step programs and other supports, the prognosis is not good.

It appears that both the shadow of HIV and the growing usage of met-amphetamine were viewed as interacting factors that need to be in the awareness of all therapists who work with male couples.

Choosing to be Parents

According to several of the therapists, in the last several years more and more same-sex couples are paying attention to, examining, and considering the possibility of becoming parents. Mark explained:

> Recently, in the genesis of the queer movement, as compared to where they were 30 years ago, men and women are thinking both outside the box and now inside the box. Therefore, there has been an avalanche of couples in my practice considering children, wanting children, and getting children. For me it has become a mini-specialty. What was quite the rarity has become quite in vogue. My belief is that we now give ourselves permission to have things previously considered only in the domain of the heterosexual. And as long as you are free in your own psyche, you can ask; and more are ready. And many couples could not be any more ready, from an emotional, psychological, and financial place. Others arrive with a blockage, usually in one of the members, and my job is to find out what the blockage is about, which includes how they see themselves. Some guys could be thought of as developmentally arrested and not ready to be parents, and others it is giving up and mourning the old life style, and like all couples anticipating the change.

This recent upsurge of same-sex couples feeling entitled to have children does not come without a cost. For many the process begins not only as a psychosocial challenge,

but also as a series of administrative and legal hurdles. Irwin, a married psychologist with two older children of his own, clarified how he works with these men and the type of obstacles they encounter:

> Gay couples often struggle with the decision and understand that they do not want to take for granted the privilege of having children, because for many it is a long, often expensive process. Often, gay men have done so much work with themselves, it predisposes them not to take anything for granted. So they think about if we are a viable couple to have children? And then think about how are we going to be good parents? I have one couple that are over-ready but have gone through three failed surrogates, tens of thousand of dollars and still want a child more than ever. They have spent years rearranging their lives by moving, and planning. They joke they can't believe you do not even need a license to have children, and so when some heterosexual have children left and right they express anger and jealousy, because it is sociologically, and legally so much harder for them. Just yesterday I was asked by an ex-client to write a letter to an adoption agency, verifying his stability and his ability to parent, even though he and his partner had already gone though several interviews, home inspections and other steps to prove their stability and readiness.

Summarizing the Impact of Ongoing Sociocultural Change

This growing entitlement to choose being parents is just one example of how socio-cultural changes over the last 30 years have affected the way gay men couple. On the one hand, Carlos strongly embraced how the growing acceptance and acknowledgements of mainstream American society has facilitated maturation for male couples.

> What I am seeing, that I did not see 10 years ago, is healthier couples, and what I mean is they see themselves as healthier. I think we have a process, an ongoing continuum of depathologizing of our versions of couplehood and the many versions of couplehood. I mean healthier functioning, more self aware, in the continuum of the larger culture and geo-political environment. As we as a queer underclass become less of a marginalized underclass, this leads to individuals in the couples seeing themselves as healthier and when that happens it screams for healthier couples to shore up their own unit. The validation and affirmation is starting to happen, because twenty years ago there was not this visibility. I think it a natural maturation for male couples.

On the other hand, David describes a downside, expressing how the ongoing social transformation has complicated same-sex coupling and created a more stratified and divisive gay community.

> The broader societal acceptance has shifted, in both good and bad ways. As the possibilities of a gay life becomes more varied, it seems to make it more difficult to bring two lives into simpatico. So even thought the high powered lawyer, can be the out lawyer and you are no longer limited to just an out bartender, waiter, florist, closeted teacher, etc.,who lives in an urban environment, the choices can be overwhelming. And so, the more choices of ways to be gay and the more ways to be a couple, the less guidance from a tight knit gay community that is protecting itself. It has diluted the community. In the 70s, I encountered older gay men who acted like uncles and fathers who were mentors. There was more of an inter-mingling of generations. Today, there is more of an arrogance of youth, those who did not have the same obstacles to coming out. That negatively impacts a relationship, because they think: who wants to work on long-term relationship and grow old together, when no one wants to grow old, and there is not a place for that in the community.

In the following statements, Henry and Arthur imply male couples are appearing more assimilationist then in years past. They believe that with social acceptance, many male couples are embracing more conventional relational norms and more hybrid models of relationship referred to at the beginning of this section. Henry claims:

> The areas of change that I see most often in my practice are that men are following more traditional, almost hetero relationship patterns, not about dating or courting, but about setting up their lives together. I think male couples have always done this, but now with the greater acceptance over all, I am seeing more couples utilizing traditional paradigms, particularly younger couples. Times being what they are, they are feeling freer to explore what they want, there is more available, they have choices. It no longer is, "We cannot do that, or we need to take the default position, or let's not think about it, because that is too hetero, or not gay enough."

Barry's experience is that:

> There is an emerging sense of monogamy that seems to be developing over the last couple of years. I am hearing more guys, mainly younger guys, talking about wanting monogamy and not wanting to fuss with all these other complications. They do not get why a couple would want an open relationship.

Fully supporting one of the original assumptions of this study, what was beyond question for many of the interviewed therapists was the certainty that the social changes of the last thirty years have changed the coupling practices of male couples. In almost every comment by the respondents, they demonstrate that gay men, as much as they feel freer to assimilate norms and behaviors from the dominant heterosexual cultures, are still creating new models for how to live and share their lives with other gay men. Understanding how couple therapists have witnessed these changes and widened their therapeutic lens to work with all these variations is the focus of the next data chapter.

Chapter 6-

THE THERAPISTS: RECURRING CHALLENGES THAT BUILD THEIR PRACTICE WISDOM

This chapter focuses on how the distinguishing clinical concerns revealed recurring themes that impacted the clinician's clinical stance, level and focus of activity and intersubjective process. In other words, how the ideas developed in the last chapter connect with and build on the main body of couples research with male couples, gay affirmative psychotherapy and clinical theory and how negotiating inside, outside and across these bodies of knowledge has brought these clinicians to their present state of practice wisdom.

As already established, almost all of the interviewed therapists dispelled the need for the widespread warning from gay affirmative literature that many therapists assume all relationships are similar and therefore follow similar patterns and respond to similar interventions (Goodrich et. al, 1988; Green, Bettinger & Zacks, 1996; Johnson & Kern, 1996; Levy & Koff, 2001). Instead most of the therapists, no matter their sexual orientation, seem to have learned to expand beyond a vision of relationships that represents hetero-normative ideology and social convention.

What will become even more understandable in this chapter is that most of the clinicians have actively challenged their ideas about the development of a "normal" relationship, recognizing the need to move beyond static and limited narratives of what constitutes healthy boundaries and functioning. In the process, these same therapists expanded their repertoire of how to more effectively execute therapy with gay men.

The most significant, personal, example of this shift was Marietta, who grew up in Mexico, and trained analytically in Argentina. She shared:

> When I arrived in America, gay culture was a shock to me, because I was taught the sickness model, so I had to make a full shift. I still wrestle with the unfortunate legacy of my former training. And even though Minuchin (by whom I was trained in family work) believes a couple is a couple with universal, relational concerns, I have learned there are central differences, like the difficulty of two men being dependent on each other. So I have to work to bring out their need for attachment, and another is the result of men being taught the ideology of manhood and resolve, to be result focused, or leave. With male couples, I have to work to be clearer, and more careful, in order to join them in their world,.. it really is like going to a new country.

Marietta's challenges, similar to many of the others, were made more difficult because the context of therapeutic knowledge related to couple work is almost exclusively hetero-centric (McGoldrick, 1996; Seigel & Walker, 1996). Working with and around the hetero-centric context of their training, and personal experiences, the therapists, like the men they work with, have the task of not only clarifying what aspects of this context are relevant to the interpersonal life of the male couples they see, but also finding other unifying therapeutic constructs to guide their work.

In a parallel process, male couples' general lack of adherence to many relational norms considered conventional seems to stimulate many of the therapists to do the same, not necessarily adhere to conventional therapeutic norms. In addition, these therapists' "coming out" processes are analogous to gay men's coming out, in that even though it frees them from certain societal and cultural restrictions, it also leaves many of them revaluating what is important and essential in their work.

In order to explain the often unconscious starting points whereby many of the therapists obtained a sense of organization by which to begin their re-evaluation, I

borrowed from the metaphorical images of " a coloring book with many different outlines," "creating a bubble" and "going to a new country" volunteered by Robert, Jill and Marietta, respectively. With these metaphoric frameworks as generic starting point, what follows are the common struggles, experiences and clinical stances many of the therapists shared in the development of their practice wisdom. Unpredictably, these varied clinicians, all with very different theoretical backgrounds, often arrived at many similar conclusions about priorities, stylistic approaches and utilizable practice knowledge.

Section 1-What Remains Inside and /or Outside the Work

Starting Points- Choosing the Potential Knowledge Bases

Jill utilized her "bubble metaphor"(see p. 139) not only as an organizing picture to help couples clarify how they want to define their relationship, but also as her own preliminary organizer that illuminates the need to decide what remains inside and what remains outside the work, both technically and theoretically. For instance, what technically remained inside for Jill was often the psychoeducational work of teaching more effective communication and what remains outside would be transferential interpretations made to certain couples. Or on a more theoretical level, what could be included is an analysis based on family systems, and what gets left out is a Freudian psychosexual understanding. In obviously unexpected accordance with Jill, the interview guide focused on illustrations of therapeutic impasses that seemed to raise similar decisions for the other therapists, correlated to what to embrace in their arsenal of techniques and knowledge, and what to disregard.

Utilizing Robert's more specific "coloring book" image (see pg. 137), a therapist could make use of and choose from a series of outlines that need coloring in, helping him to organize and choose from varied sets of knowledge and their related technical considerations. The choices might include: 1) Where to start; does he color in his dominant theoretical leaning and/or his training in couples work and/or what he knows about gay men and their relationships? 2) What happens when something does not fit into one of the chosen outlines, does he then cross the lines and co-create a new way of working with the couple?

Both Jill and Robert's images more or less help describe some of the preliminary, often unconscious considerations, demonstrated by many of the interviewed therapists, when faced with a new male couple. Many of the struggles and technical controversies could have been viewed as a battle over different theories and the complicated and confusing political manner in which they co-exist. However, most of the interviewed therapists did not talk in terms of theoretical contradictions. As a group, they seemed quite clear about which model/s and/or theories most informed their clinical thinking. Instead, similar to the complications many male couples experience in balancing traditional and alternative ideas about coupling (see hybrid models of coupling, pgs. 143-145) and in line with Robert's conceptualization, many of the therapists questioned how much and when to utilize and integrate particular theoretical frameworks and knowledge. In that sense, as per Marietta's reflection of "going to another country"(see p.181), the work is about knowing what is translatable, and what is more akin to learning about a specific culture with very different values, epistemologies, histories and norms.

As Robert clarified in his second interview, beyond generic knowledge about psychopathology, techniques that facilitate therapeutic change with couples, and theoretical commitments:

> The art is knowing which clinical knowledge bases to call upon, and when to just fly by the seat of your pants, all the while assessing how much structure does this particular couple need to make both their relationship and the therapeutic work more effective.

Similarly, Bill, even after almost 20 years as a couple therapist claims:

> Gay couples break the mold and blow all my theoretical stuff out of the box, breaking boundaries and parameters about what couples are. Even as a gay male myself, it delightfully surprises me when couples come in and have different explanations and versions about what is a couple. Certainly with each couple I work with, I add to my repertoire about what it means to be different and it enhances and changes what couple work means to me.

Like Bill, and similar to what Robert expressed as flying by the seat of your pants, some of the more experienced therapists seem to continually play with what remains in the background and foreground, not actively focusing on utilizing any one framework, and sometimes creating out of the bounds of any one approach. For example, Eric, a gay therapist, when asked to summarize how much he utilizes his dominant theoretical training in structural family therapy, answered:

> At this point, I don't really think structurally, I suppose because that is so ingrained. Instead I try to focus on how and why the members think of themselves as a couple. My old formulations are there, but with male couples, I more often tend to go with their flow.

So parallel to some male couples that attempt to make meaning of their coupling by borrowing from both conventional and unconventional possibilities, some of the therapists attempt to create and continue to sketch some original versions of where to

begin the work and what to expect along the way. Carlos, a psychoanalytically trained social worker, states:

> This is not necessarily specific to male couples, but it is so complicated, allow yourself to be aware of the dynamics happening in the room, and then point out the difference between the individuals and where these differences negatively collide. The potential is so much quicker in couples because the dynamics are being brought into the room. With a couple things happen fast, watch for the dynamics; allow it to flow, stay out of its way, and allow yourself to be non-linear.

The last several quotes epitomize the experiences of many of the respondents. It seems, that regardless of their sexual orientation or training or disciplines, adhering to one particular theoretical model or attempting to transfer skills from a different modality does not necessarily complete the picture for practice with male couples. Besides deciding what to keep in and what to keep out and which unifying constructs (outlines) to prioritize or integrate when working with male couples, many continually struggle with staying open to new combinations of knowledge that might include the unconventional or the innovative. And even before becoming available to this inventive practice wisdom, almost all of the clinicians made the point at least once in the interview process that they first had to feel competent about the basics of general couple work.

Shoring Up the General Outlines of a Couple Therapist

Barry, a gay therapist in full time private practice 7 years, the shortest time in the sample, but who has developed quite a reputation working with serodiscordant (different HIV status) couples, shared:

> For me the difficulties are *not* related to understanding sexual orientation. I think my gaps are more in overarching clinical conceptualizations and general skill building in couple work. I do not have gaps in understanding the psychological or

> psychosocial experiences of individual gay men, because I have spent an inordinate amount of time studying and observing these concerns.

None of the therapists interviewed had formally studied how to work with male couples and only 7 had studied, beyond workshops and/or one class, how to do couple work in general. Despite the fact that all of the practitioners had studied and been supervised in how to do individual work, most of these clinicians learned couple work through direct experiences. Edna, a married social worker in practice for over 20 years, could possibly be speaking for close to 90% of the practitioners with her response to the question of what most prepared her for her work with couples:

> Life, my own treatment, both couple and individual, and a course in couple work in my doctoral program, in that order. Oh, and a little bit of supervision as needed when I had, you know, couples to work with. There's some borrowing, certainly, you know from the literature on conjoint therapy and family therapy, but mostly from my social and life experiences.

Mary, a social worker, explained her conception of couple work begins with utilizing her more established individual assessment skills, commenting that all couple therapists:

> Need to distinguish between how the individuals and their issues impact the couple. We all know some version of individual work. So I think there are three identities in every relationship, the two partners and the "we", which help me get a direction and helps them imagine the different pieces. After that, the therapy tends to move quickly.

Despite limitations related to insurance restrictions, financial constraints, and scheduling, as well as their clients' individual pathology and a willingness to do the work, many of the therapists spoke of a journey, through working with couples, where they became generally more active clinicians, trying to establish alliances quickly and in general being more directive than when working individually.

Margo, who trained at an analytic institute in the early 1990s, recaps:

> I think I am more active with couples, because that is what they need. They need more active interventions to challenge how they actually act in the room, it is right there in your face, often more obvious than in individual work. But I will let things go on too, if they are on the right path, but if they are off in the wrong direction, I will challenge it.

Similarly, Marietta said:

> Yes, of course, I am more active. I am more in my head, directing traffic, maintaining a higher level of activity, throughout.

It seemed that for most of the therapists, couple work could be quite challenging, particularly because the clinician can quickly wind up losing focus and clinical distance as they get triangulated into the dynamics of the couples. Here are two gay male clinicians, first Carlos and then David, describing strikingly similar experiences and outcomes:

> After the first male couple I ever worked with misinterpreted my attempt to be impartial as a desire to become friends, that's a long story, I consciously changed my stance, trying to be clear as I can as a real person, in a way to dilute transferences, clarifying what psycho- education needs to be done, putting myself in charge, saying that we will work 12 sessions. Setting up this short-term pressure to clarify what they want. Now with all types of couples, I tell them sessions can run 45 minutes to 2 hours, at my discretion. I might see one of you or the other, asking one to leave; it is not personal, just what we need to get the work done.
>
> When one man in a couple thought that I was seductive, I started to wake up and change my stance. What got in the way was probably my attempts at a neutral stance, that seems to confuse the two men in the room, making way for so many crossed transferences so as to dilute the work. Now I approach a couple, with all my quirkiness intact and checking my potential sexual seductiveness, along with more definitive guidelines and a clear frame of hour-long sessions. Sometimes I utilize a systemic approach, sometimes I focus on the environment, depending on the presenting concerns.

For these practitioners, some of their techniques, particularly the more neutral stance they utilized for individual work, lacked the applicability to couples work. In the context of Jill's bubble image, it became an aspect of technique that more often got relegated to the outside when working with couples. Paul, one of the psychologists who has published about family work, recapped his view:

> As I got frustrated with the limits of individual techniques, I got family-systems training, and I found my paradigm. But I have learned an integrative approach, and I've written about this, that includes psychodynamic work, behavioral, but also includes some post-modern systemic work, where the couple remains the real experts in how to proceed. It's a matter of being tuned in and utilizing what is needed.

I believe if Paul's integrative viewpoint regarding couples work were presented to many of these clinicians for their approval, it would be widely accepted.

Even when their primary techniques and theories did guide them to tune in to a helpful interactive frequency, all the clinicians agreed that it is harder to meet two people's expectations and define common resolutions. Henry, whose special training was also in family work claims:

> In general, couples are very tenuous patients. It is very challenging. It does not last long. People want to be told they are doing great, or your boyfriend has the problems, let's fix it, and when that doesn't happen and couples see it is more complicated, many want to run for the hills. And I do not think that is because I do not engage them. Every session, both members have to be checked in with, as goals are re-clarified, as you strive to get on to the same page.

Mary, who often utilizes visualizations to help her anticipate couples and relieve her own anxiety in regard to this work, believes:

> People are exposed in couple therapy in ways they are not in individual work. In individual work you can still split off from the rest of the roles you play in the world, and for gay men, in particular, that can be a continuation of a life long experience of splitting parts of themselves from each other. In individual therapy you can pour your guts out and really work, but not threaten the stability of your

> world with it and not expose yourself to someone who knows you outside of therapy. And, like group work, but more so, with couples work you areexposed and it means confronting core issues related to intimacy and trust.

To summarize, the challenges in doing couple work with all types of couples are as complex as the many challenges in remaining a healthy couple. Almost all the therapists, despite their varied years of experience, seem to constantly rework what constitutes competent couple work and rethink how to be more confident building on their prior knowledge and skills. Frank re-framed this struggle in an encouraging manner, when he said:

> I think one of my better qualities, as a therapist, one that I encourage in my students, is that I love to be surprised and admit I am wrong or do not know. I sort of thrive in this space, and in couples therapy there is so much room for discovery that it does not trouble me when I embarrass myself by saying something that does not work. That's how I learn and I model that sort of experimentation for the couples.

Gay Clinicians: Finding the Unique Filter for Working with Male Couples

Eric, one of the two gay psychologists in the sample, explained:

> It is hard to generalize or stereotype that gay couples work is so different from straight couples because gay couples are so different from one another. So I find I do not bring myself any differently into the room. It really depends on what issues are brought into the room. For instance, I see power issues played out with straight as well as male couples. But, I think my own attuning to it might be different. I might listen with a different sort of third ear. Certain kinds of power dynamics, for example, with a male to male couple, that I might not listen for, or listen with a tin ear, so to speak with straight couples. For instance, a male couple talks about how difficult it is to have a joint bank account, I might listen in a different way for what power dynamics are being played out that might not be the same as with straight couples.
>
> So it shows up in different ways, therefore I put on different filters, that cause me to listen for different things based on being around male couples, things that have happened to me or my clients, and little has to do with prior clinical writings. Again these are gross generalizations, but I might listen with a certain filter as to what dynamics are going on that are very likely not going on with hetero couples. So, yes there are nuances.

Eric's description of a filter sensitized by gay concerns seems to speak to an alternative framework (outline) he now reflexively employs with male couples.

With a different emphasis, David conceptualizes his couple work with men, similar to Marietta, with an initial focus on the interaction of the two individuals' psychodynamics.

> I think the idea of gay and lesbian issues is more effectively discussed in a more general theoretical context, but when it comes right down to it, I start with individuals first, so the overarching theory of working with a specific population is secondary to the particular dynamics of the individuals in the couple. So we can talk about, and need to remember clinical concerns related to being a male couple in sort of a macro- theoretical sense, in terms of dealing with homophobia, heterosexism, stigmatization, and marginalization. But when it comes to applying these ideas to couple cases, the individual dynamics of the men override both the gay concerns and the couple concerns.

Like some of the other gay respondents, David seemed so steeped in the specific concerns of gay men and gay lives that he also could involuntarily employ the "gay" filter described by Eric as secondary, keeping his primary focus on how the two individuals' dynamics blend into their coupling.

Arthur, a gay therapist who like David also prioritizes the individuals, claimed his principal framework always begins with classical psychoanalytic techniques with all patients, including gay men and male couples, in order not to stray from theory and get caught in a murky countertransferential situation. Not that this is in itself a problematic approach, but by the end of his interview, he readily acknowledged that sometimes he feels like something might be missing because "there are many multi- cultural influences that need to be considered and are sometimes difficult to incorporate, but, ultimately, how I work technically, is generally not different."

In addition, all the gay clinicians, including Arthur, noted that they used their history as gay men, in and/or out of couples, as a reference point. Mark, who unlike many of the others, has trained in several theoretical approaches to work with couples, confesses:

> Ultimately, I think being a gay man, I have an inside understanding of being in a gay couple, in this world where heterosexism is so rampant in so many overt and subtle ways. It provides me with a sort of attunement that I think is hard to come by, but not impossible. And I guess more than anything, it is the thing that has most prepared me for this couples work. However, the other thought that came to mind though was basic training, the same skills I would need to work with anybody, are the skills I need to work with gay couples.

The two lesbian therapists, both of whom had been in specific training geared toward the psychodynamic treatment of gay men and lesbians, first talked about the differences between men and women, prioritizing the gendered aspects of the work. However, they both also shared how they utilized this knowledge along with gay friendship networks, their work at gay- focused agencies, and their first hand experiences of marginalization as lesbians to inform their work.

Clearly there were varied ways the therapists filter the reality that the couples consist of two gay men. Besides what seemed to be preliminary priorities informed by differences in theoretical loyalties and familiarity, all of the gay clinicians, including the women, noticeably clarified how at one point in the treatment process, they either actively or reflexively prioritized the body of knowledge that pertains to clinical practice with gay men to inform their work with male couples.

Bill, despite being extremely well published in couples work and known for his supervision of clinicians who work with male couples, still professes thathe is not sure how to do couple work, particularly with male couples. But like many of his colleagues,

he utilizes what is useful from his primary theoretical orientation and his life experience and mixes it with his current clinical interest. He sums it up by saying:

> Nothing in my training prepared me for working with same–sex couples. I suppose, being in my own relationship probably most prepared me. I actually started working with straight couples. The work with Minuchin enabled me to see the dance in front of me, but he had not applied his model directly to the dynamics of two men. The biggest limitation of family systems work is its failure to look at affect rather than behavior, because of the focus on complementarity. If you stick to this you can miss the idea of how to make this relationship a safe place. And since the affect is not always obvious, particularly with some men, you need a way to bring it into the room. So I am bringing more attachment theory into my work. However, there is still something in the work that I both fear and cherish, and that is finding yourself in the space where you don't know the best way to proceed. And sometimes just allowing yourself to go in that place enlivens the process.

Despite an eclectic theoretical background thatcreates both an intellectual framework and a technique that provides Bill varied choices, he seems to be constantly developing different foci and varied sensitivities. Strikingly similar to Frank's comment about "not-knowing" (see, p. 191) in the prior section, Bill worked from a humility that acknowledges there is something in the work that goes beyond prior theoretical and practice knowledge, that can't be clearly framed and captured. And both these psychologists seem to believe that allowing yourself to be in this "not-knowing place" creates the practice wisdom that fills in the space and enlivens the work.

Starting Points for Non-Gay Clinicians: Finding a Personal Identification

Non-gay clinicians offered different answers than the gay clinicians when asked about what knowledge base and experiences they prioritize to start their work with male couples. As a group, all 8 were not only gay affirmative, but also realized this was not enough to bridge the dissimilarities in development and socialization between them and

their clients. Jill, the therapist with the "bubble" image, seemed to represent the others when she said:

> In all my education and training no one really approached the questions of how to work with gay men. I remember at some point debating the psychoanalytic view of development as it applied to gay males, but I don't remember the outcome. If I didn't have gay friends and had not been assigned a gay supervisor, I'm not sure if I ever would have gotten started. Except my particular history has always left me feeling like someone on the margins, and I used that not fitting in experience to start to identify with gay men.

Although all of the non-gay clinicians acknowledged they were not well versed in the clinical literature of gay men, they all mentioned some personal experience or reason that led them to working with male couples. Almost all stressed discovering some deeper empathic connection. For instance, Marietta, the Latina therapist shared:

> For me being an immigrant, I sense the same concerns as gay couples. Being discriminated against, I am more sensitive to diversity now, and how sometime, like me, gay men feel like uncomfortable outsiders. That happens to me when I open my mouth, they hear a Spanish accent and they treat me different. It is oppressive, and I cannot pass, and just as gay men show affect and then they may be perceived as gay, and they do not pass, not that they need to, but it makes life infinitely harder.

For Irwin, his connection to gay concerns sparked after a close family member came out to him. However, he also explained that he discovered some deeper connection in his own identity:

> I learned it is about finding what's queer within yourself, and for me that relates to my Jewishness, as well as the impact of my childhood bookish ways that left me feeling not masculine enough and different than my peers.

Edna relates not only to the lack of visible, healthy role models, "Because as a woman of 55, without a hard body, you become invisible" but also shared:

> When I was a little girl my best friend in the neighborhood was obviously gay by the age of nine. Of course, everybody made fun of him. I adored him. We spent

> every day together for years. He died of AIDS early in the epidemic. I'm best friends with his sister now. I guess I have always felt a very special feeling for gay men. There is something exceptional in my connection that values sensitivity.

Paul talked extensively about the journey that got him to working with gay men:

> I was an intern and we all had to lead a group and I was assigned to co-lead the gay men's group. And I said, "who me?" and the director said, "yeah, you." So I was a little bit anxious about that and my co-leader was a well-known gay psychiatrist. I stayed on with the group for a year and a half and I think that that experience was probably one of the most profound clinical experiences in my life in terms of the personal impact and the professional impact on me because I came to it not with raging degrees of homophobia or anything, but having had some anxiety provoking moments as a high school student where I was followed out of bathrooms by men who were making sexual comments and chased after me. I came to not only *not* be afraid but actually to deeply enjoy and look forward to working with gay men. And in fact, I always get excited when the hour comes when I work with gay men because - because I find that gay men as opposed to straight men are, *generally* speaking, and this is a gross generalization, because its not always the case, much more interested in relationship.

He added that despite having helped his younger sister come out to his parents and that she and her partner are close family, it didn't come together for him what this work was really about, until one day, visiting his former co-leader's apartment where he lived with his partner.

> I walked into the bathroom and there was a huge bottle of the male cologne, that I also use, sitting on the toilet, and I suddenly realized this is about men who love men, who are as manly as me or any other man, enjoying what it means to be a man, and enjoying it with another man...and I know it sounds simple, but it is not about being confused about just coming out or your gender identity or mimicking heterosexual relationships.

Frank, the sole heterosexual, male social worker in the sample, recapitulated:

> What is most helpful for me in connecting is not anything specifically to do with couple work, or my experiences with same-sex couples, but my valuing of my male friendships. My roommate in college was gay, and his later death influenced me in my working with people with AIDS and then into this work with male couples.

All of the non-gay therapists interviewed had been profoundly affected by their connection to a gay person in their life. This collective sense of connection, both personal and empathic, impacted how these heterosexual clinicians worked and what they first paid attention to. All 8 readily acknowledged not only the differences between themselves and gay men, but also seemed to maintain an awareness of these differences throughout their work. The following questions remain: If this small sample speaks to the importance of having or finding a personal history that helps non-gay therapists connect and value male couples, how important is this phenomenon to effective work with this population? How do these experiences of identification cause them to work in a different way than the more obvious identifications of gay therapists? In addition, since many of the heterosexual clinicians are without a firm footing in the distinct clinical knowledge developed for working with gay clients, how does this influence their effectiveness and/or how do they compensate for this absence of clinical knowledge? Although later sections and the next chapter will respond to and develop answers to aspects of these questions, future research needs to further explore these various factors.

Predominant Stylistic and Procedural Modifications

Frank who believes part of his connection to male couples is related to his formative friendships with men such as his gay college roommate, was clear that having three men in the therapeutic space impacts how he works. He commented that:

> I think I tend to start to conceptualize more with mixed-sex couples. I think I start to work more intuitively with same sex couples, maybe because I didn't have the training and because I tend to feel an easy rapport with men, particularly gay men.

Above and beyond their own personality, their sexual orientation, their training, and the particulars of the couple in treatment, many of the therapists offered similar versions of how their style of working with male couples evolved out of their intersubjective experiences of these men. Even though some of these modifications could also be categorized as common countertransferential trends, this segment focuses on stylistic shifts and changes in procedure that a preponderance of the therapists attributed to their ongoing experiences with male couples. More personalized transferentail-countertransferential reactions similar to the clinical material revealed in former literature (Green, Bettinger & Zacks, 1996; Goodrich et. al., 1988; Johnson & Kern, 1996; Mann, 1997) will be discussed in a later segment.

Like Frank, many of the respondents commented on common stylistic variations by highlighting what they might do differently when faced with related situations or conditions with heterosexual couples. For instance, Carlos, whose roots were in psychoanalysis, explained:

> I am also a lot looser and more relaxed with men. I play with them a bit more, and I also play with the boundaries of individual and couples work more, often seeing them individually as well. Even though I have started to bring that to my straight couples, it started with the freedom I felt with the male couples's willingness to try different things.

Correspondingly, Mark, another gay male social worker trained psychoanalytically, said:

> Believe it or not, I continue to get more directive because that is usually what men respond to more than women. I name things much more quickly with male couples, not necessarily waiting for them to arise, especially if it's destructive behavior. I get in there. And I give more behavioral homework with male couples, something really outside my analytic training. And though I am thoughtful, I may disclose a little bit more about my relationship experiences in a general way. I was working with a couple recently ending a ten year relationship, and I thought it was helpful, without revealing the details, to let them know that I had been through a similar, long term, break up, several years ago. I have never revealed that sort of information with hetero couples.

Similar to the non-gay male therapists quoted earlier, these gay male therapists believed that their stylistic changes were based on their gender similarities and not necessarily on their shared sexual orientation. Only Michael, a heterosexual psychologist known for his integrative work, believed that for him, it is less about gender and more about sexual orientation:

> Gay men's world view and the often more flexible, more accepting (gay) world which they inhabit has influenced how I work, which can be more free flowing, less prescriptive. I loosen the reins, and go with the flow; similar to the variety of ways they couple.

In this small sample, the adjustments in therapeutic stance and procedures by the male therapists, for instance, the just mentioned "being more relaxed," were associated with having three men in a room with shared masculinity. Interestingly, the women therapists, who also talked about becoming more active or directive, for the most part spoke more about this shift as being influenced by general couple work and less so by the presence of men. These variations among the male and female therapists raised the larger question of, to what extent are stylistic differences and other potential concerns about therapy with male couples a function of gender matching and gender in general, rather than sexual orientation? These questions will be further explored in the final discussion chapter.

Self- Disclosure

One stylistic variation where many therapists found commonality was in their tendency to more actively consider self-disclosure with male couples than with other clients. As already discussed, many of the gay therapists readily utilize their own history

and experiences to inform their work. In addition, many of the same therapists not only utilize this self-knowledge, but often self-disclose aspects of their own stories when they believe it might be helpful to either model behaviors and/or to encourage a strong identification. Bill revealed:

> I often find myself self-disclosing and using my relationship as an example, or some version of any other couple I have known or seen. Then the couple in treatment, actually light up and move to the end of their seat as if to say "tell us." Even identifying myself as the difficult one in the relationship, therefore joining with the more difficult member opens up a space to normalize the challenges of being in this investigative space together. The bottom line is this lack of role models for these couples is still amazing to me. And the isolation profound.

Mary shared how her awareness of a lack of role models similarly impacted her self-disclosing as well. Noting that she is profoundly aware of the sense of isolation experienced by many gay men as children, she said:

> I try to access not only how they feel about women, but also whether it matters if I disclose my sexual orientation. Often, just raising questions about my self-disclosing and exploring how it impacts them seems to help the men feel freer to self-disclose. More often now, I am more disclosing, I suppose to dilute the transferences, and let them in to my first hand knowledge of gay relationships through examples of my gay friends. I guess I want to, in some way compensate for how being gay not only produced separation from the very families who often claimed they wanted the best for them, but also how this led to a lack of role models combined with an obvious pressure to conform.

Eric, who mentioned that it seemed typical that in his couples training led by a well meaning heterosexual woman the gay students had to motivate the application of the clinical knowledge to same-sex couples, clarified his process of self-disclosure:

> I figured out how important their sexual orientation is to their coupling. I often link then try to figure out if it is helpful to self-disclose, if I reveal my experience of this aspect of life? Do I need to be more human, or more clinically distant in revealing, what is the best mix here? Each couple involves that experimentation, by checking in how a less significant revelation impacts, then knowing how to utilize this information for the future. Just like in my class, I don't want to leave them feeling alone, or overlook a chance to psychoeducate by role modeling.

At another point in the interview, Eric shared an anecdote about a couple, together 20 years, who he has worked with off and on for several years. When one of the men in the couples found out he had AIDS, after taking his first HIV test due to problems that revealed themselves in his blood work, they came back into therapy:

> These guys were more connected to a straight friendship network and had few gay friends still alive. The HIV infected guy remained depressed despite medication and even after inclusion in a time limited, serodiscordant support group for couples that left him feeling more alone because he and his partner were the only long- term couple. He felt the guys in the group were not like him. After debating with colleagues, I revealed I was also in a long-term serodiscordant relationship. This disclosure seemed to become the beginning of a turning point for easier interaction in the therapy. The man with HIV soon reported feeling less depressed. He had felt great shame, but he believed I was not only of his generation, but had similar ideals and problems, and still managed to have a good life.

Here was a specific example where self-disclosure from this therapist provided the missing mental picture for a potential future that had eluded this couple's awareness. Eric went on to say this type of self-disclosure was not only chosen due to a lack of reference group for these guys, but also because both men feared homophobic responses from their families, coworkers and friends. In a session after his revelations, Eric believed:

> The HIV infected member seemed less obsessed about having destroyed his future with his partner, and was able to start a move to other issues related to his fear of rejection from others. Both men mourned over how HIV, which had been their biggest fear, impacted their sense of control over their own destiny. All of this was necessary and helpful work

Transposed to couples work with gay males, where the men are sometimes lost in an array of heteronormative choices that do not necessarily address their particular social, interpersonal and cultural concerns, the role modeling utilized by the interviewed

respondents seemed to be used sometimes to evoke images of functionality in long -term male coupling (see, Eric, p. 201), and sometimes to normalize their struggles and concerns (see, Bill, p. 200). Just as the "out" gay therapist who discloses his sexual orientation might serve as a stimulus for expanding the self-expectations of gay clients, role modeling by couple therapists such as Eric has a great deal to do with his awareness that:

> Most male couples' concerns are not addressed in Oprah, New York Times' Sunday Magazine or even by their friends and family.

Therefore, he believes a therapist can fill the void, by facilitating identification, judiciously becoming a role model for potential coupling and healing. Challenging more traditional notions of psychoanalysis that believe in a more neutral stance, personal disclosure is seen as aiding in not only a sense of belonging, but also identification, potentially helping clients to feel understood and to gain a sense of self-respect (Cornett, 1995)

Thinking about self-disclosure has been one of the major areas that gay affirmative psychotherapists have championed in response to the oppression of a homo-negative environment that still leaves most gay men with a lack of positive role models (Isay, 1989; Silverstein, 1991). Challenging more traditional notions of psychoanalysis that believe in a more neutral stance, personal disclosure is seen as aiding in not only a sense of belonging, but also identification, potentially helping clients to feel understood and to gain a sense of self-respect (Cornett, 1995). Since the interviews did not further question if this tendency to utilize self-disclosure represents a trend in their general practice, something they more readily use in individual work, it remains unclear if it is

used more frequently with male couples. In addition, in a future study it might be helpful to investigate if the self –disclosure revealed by the gay male therapists is a function of having three men in the room, whose male gender predisposes them, for example, to want more concrete solutions and examples?

Capitalizing on Sex as a Focal Point

As previously discussed in the segment on boundaries, many male couples reflexively utilize the sexual arena as a starting point for re-conceiving and experimenting with new "rules " about intimacy and relationship. It follows that since "coming out" as a gay man involves breaking down sexual and cultural norms, that men with this experience could carry this legacy of liberating oneself into their coupling experiences. In the best of scenarios these couples could experience a freedom to pioneer ways to forge and maintain innovative relational norms. Bill, a clinical supervisor for many clinicians who begin their couple work with gay men, explains why talking freely about sex is a necessary part of working with male couples:

> Men often bring a more surface sexuality to their coupling, and as an out gay male practicing with them, I present sex and sexual matters very matter of factly and encourage my supervisees to raise sexual issues in more direct ways then they would with straight couples. If you are comfortable with the subject, it can not only help build rapport, but also lead into an examination of how they came to know many aspects of their coupling.

Many therapists not only mirrored Bill's outlook, but also had their own theories as to why sex is the most common topic of discussion and emphasized by many therapists. Margo, one of the lesbian therapists, believes:

> Often one of the first things they talk about is sex, because it usually had a prominent place in their relationship, at least at one point. And because gay

> men's adolescence gets pushed into their 30's, they are both experimenting sexually but wanting to be in a couple at the same time. Only by being a psychosexual detective, can you help them best reconcile these conflicting desires.

Ellen, the other lesbian therapist, with what she self-describes as a very candid style, compared her work with lesbian couples:

> I think, with two men, unlike the lesbians, I am always talking about sex. With women I fine myself exploring relational needs first. But with men, so many issues get played out through sex, including the issue of being close, because of the preoccupation with sex. So understanding the role of sex in a nonjudgmental approach, with all its varied meaning, including the meaning of 3 ways, S and M, anonymous sex, and what it all expresses and how it plays out with individual expectations, is essential. For instance, some gay men, when they fuck like rabbits, they say they are just being men, but I help them see it *does* mean something. Is it a running away or is it about desiring closeness and maintaining closeness?

Mary, the social worker, who believes, "many of the gay men often come to couple therapy, because of problems with sex," said.

> It seems many of the men I have seen in my practice begin their relationship based on sexual gratification. Therefore, for those who don't bring up sex, who might be concerned with my reactions, because I am a woman, I have to bring it up. I take the first step, because, and I hate to sound stereotypic, it is so important. And then, for the many men who are ashamed to be a victim, particularly around sexual issues related to power struggles, I tread cautiously. You, know, I used to resist the idea that men and women were sexually different, but I have learned from this work.

Similarly, Irwin stated:

> Males are taught to be independent around life goals, around career and around a lot of things, so that sets up a struggle when it comes to coupling, sex and two men.

It follows that since relational norms are most often *assumed* in dominant culture, many out gay men men, like many of their heterosexual counterparts, hope to find a suitable way to translate what they have learned and have been

exposed to about sex and relationships into their male coupling experiences. Unfortunately, without guidelines or the skills for applying these psychologically ingrained and often-unconscious heteronormative beliefs and representations about commitment and sex, many men may have to struggle with the differences between their actual relational experiences and the influence of heterosexually inspired coupling norms through trial and error.

Once this difficult task brings gay men into couple therapy, several of the therapists seem to capitalize on the strengths and beliefs found during the "coming out" process to help couples deconstruct these ingrained sexual and relational expectations. In other words, therapists use this legacy as a jumping off point to help the couples explore their own unique relational requirements. One of the most frequently stated differences between the work with gay men and heterosexual couples is this very openness to utilize the sexual arena as a metaphoric starting point for exploring general relational satisfaction and expectations. Arthur, the social worker, who prioritizes classical psychoanalytic technique said:

> Even though I try to apply the same technique, I am more likely to ask a male couple about their style of sexuality. It not only adds to their comfort level, to make it more matter- of- fact, but more importantly, gay men are gay men, and in gay relationships, mostly because of their sexual selves. This is in obvious contrast to heterosexuality, because for those couples, for the most part, it has always been both their conscious and unconscious reality. So for gay men, for so many reasons, sex is often more complicated and important.

Eric, who acknowledged that he is now in the longest relationship of his 46 years, explained:

> After I finally discovered that one member lied in couples therapy for over a year to me and his partner about his outside sex, what I did with the next couple I saw was to explore early in the process their sexual concerns in relation to both individual's identity and sexual-self esteem. And I

> explored how the coming out process played into why this couple had stopped having sex with each other. The same way in a couple where race is a complicated issue, I find out how their different dynamics and beliefs about sex affect the relationship. Now almost all the male couples I work with, I go further in exploring sexual issues in relation to identity. Once they are willing to truly talk openly about sexual desires and fantasies, it can open many doors.

In seems that the generally less restrictive experiences of sex and relationship among male couples allow the couple therapist to more openly question his/her own assumptions about what is important in relationships and his/her work with these men. Paul explained how being faced with men with a more fluid sexuality impacted his development as a couple therapist:

> The other thing that I certainly understood through my work with gay men, like the last couple I worked with who had a triadic relationship for a while, is that because they're aren't so many rules, you know, and because there are no rules or very few, there's a lot more possibilities and that, in a way, it frees you up as a therapist. You're not as free, I think, within the social construction of heterosexual relationships. As you said, I probably wouldn't have gone or been as easily enthusiastic about the idea of a couple, a heterosexual couple engaging a third party. I would say, well if you want to do it, do it, I'm not against it, but I would predict eventually dire consequences. In a way, it is clear that the boundaries in gay couples, for better and for worse, are more fluid. It's both an asset and it's also a challenge. I think coming into the work with gay men, I come in more opened up to all these possibilities. And, that's very important to our therapeutic relationship.

Through comparable circumstances, where one of the couples he worked with existed outside conventional sexual boundaries, Irwin seemed to experience a similar liberation.

> I worked with this couple who were upset about how to proceed now that one of the guys had started a relationship with a third guy who lives in another City. In taking a history, it was hard enough understanding how they functioned with all their outside sexual escapades, but this threesome, I believed, would break them apart. In the process of working with them, I learned they have been upfront and honest since first starting this experiment and could identify it as giving them enough space to get a

> renewed appreciation for each other. It fits into their very complicated, practical reasons for being together in the first place, that had never had anything to do with sexual fidelity and was more about security after both of them had lost past lovers to AIDS. And even though I could have easily conceptualized that they were acting out some unmet needs, what became more important was to help them be clear about the risks and rewards, discovered along the way. The bottom line is I felt enlivened by their lack of moral restrictions.
>
> Really, I am surprised by the outcome; because since this third person was introduced, they are probably more communicative, and less rigid, with each other, and though this might not last, both seem happier. This is so different from what I was taught and what I would expect form heterosexual couples, that extra marital affairs almost makes couple work, crisis management, and leads to chronic unhappiness. In the process of unraveling the real reasons this couples stayed together, I have opened my eyes, to not only my own limited viewpoint, but also how I must work to leave out my own presumptions about successful relationships, particularly in regard to how sex is incorporated.

So instead of believing they had to engage in some version of a moral policeman by giving out insightful advice, these therapists placed their social and sexual judgments aside and prioritized efforts to more dynamically understand their client's arrangements. Consequently, Paul and Irwin experienced the freedom to help their clients truly search for ways to find meaning and more fluid connections in their relationships. Ultimately, a more enlivened and trusting environment seems to create a more effective treatment relationship.

More Frequently Cited Transferential- Countertransferential Reactions

Similar to the examples just presented about prioritizing certain procedural choices discovered through the actual work, asking clinicians directly about their countertranferential reactions led not only to their elaborating and expanding on ideas about possible countertansferential impasses and their outcomes, but also to

the expression of collective therapeutic concerns that tended to get enacted in the transference-countertransference experience. For instance, Eric, when asked about how and if he utilized his countertranferential experience with the "separated couple" described as "amorphous" (see, p.173-4), with his subsequent cases, he went on to say:

> I discovered that these guys' new freedom sexually and intimately, gave them less security about their futures. We had to work on that, but at the end, they remained more interested in breaking out of their familiar security and taking some chances. To me it felt incomplete, scary, I couldn't live with that lack of security, but they seemed more satisfied to have moved on. I had to stretch, not project my fear and accept what seemed like to me, a tenuous future. I have been aware of this potential countertransferential response ever since.

It seems that just as this couple released prior relational and sexual norms and moved toward a new phase in their affiliation, Eric's countertransference led him to examine not only his own narratives about satisfying relationships, but also, normative resolutions in therapy.

Correspondingly, Barry, after sharing a story of a couple that had broken up after 13 years together, expressed a concern, similar to examples referred to in the clinical review chapter (see, pgs. 83-85; Goodrich,et. al.,1988; Mann, 1997).

> Because of my own biases, and because of how hard they worked, I wanted to see them last. The struggle was they clearly wanted to get permission to separate and work on leaving, and I think I initially slowed down the process. I think I want most male couples to succeed, to prove to the world we can, but that can't be my therapeutic mission and through that wish I have come to learn, through my practice, that I should not come in with desire or memory but rather, to simply come in to understand the dynamics. What I have to come to realize, this sounds so superficial, is that some couples are meant to be together and some are meant to be separated.

As Eric and Barry's accounts typify, the possibility of a therapist to over-idealize, or hold same –sex couples to a "higher standard" that includes staying together, was a commonly cited countertransferential struggle for gay therapists.

Even though the central aspects of sex in the lives and therapy of these couples was alluded to as another potentially strong transferential trigger (see, pgs.189), only two male therapists highlighted how they were triggered with their own erotic counter-transferential pull. Arthur mentioned that in a recent couple case, his erotic counter-transference moved so directly into the foreground of his awareness that it became difficult not to be reactive, making him feel unattuned to the problems at hand. He is now acutely aware of this possibility in his couples work.

> It sometimes subtle, but again, just recently I noticed the member who I was more attracted to, I was siding with him more and giving him more credence. I thought the other one had to take the larger burden. That was also countertransferential, distracting me from clarifying a mutual course of action.

David, who in an earlier quote (see, p. 189) commented on how one member of a couple thought he was being seductive, elaborated on the effect of his erotic counter-transferential feelings in both this prior case and the following example:

> I realized from that other case and my own therapy and my life that maybe I did put something out that can be interpreted as an acceptance of a covert sexual nature. So then, with that insight in my consciousness, in walked this new couple, where one of the guys really wanted to change the dynamics, to feel less criticized and more open to take the lead, but the other one was content with the status quo and resistant to the therapy. I felt I had to focus on the resistant member. The next session, the resistant one freely volunteered details, almost bragging, about their sexual escapades with friends, and most every one they met. It was an area of his life, probably the only one, in which he felt confident. I encouraged him to open up. So then, in I guess the third session, he turned to me and tried asking personal sexual questions, alluding to my sexual life. No matter how much his partner and I called attention to the inappropriateness of what he was doing, he continued. I understood this to be one hypersexual guy that sort of intrigued me even as I addressed the experience he was creating in the room, particularly, the discomfort of his partner.

> In retrospect, it all seemed too late. I realized I had once again minimized and ignored the sexual and hostile energy brought into the room in prior sessions, and got distracted, and that caused me to avoid confronting him. He had succeeded in throwing me off and in a way, seducing me. At the end of the session where he was more blatant and I voiced my disproval along with his partner, he pinched my nipple on the way out of the room. I was shocked and thought to myself, "what a fucked up homophobic asshole. He really needs individual work." He could only see me as a sexual conquest. And I guess deep down inside, I had felt a strange flattery even as I knew how fucked up he was. The couple broke up in the next two sessions, with the one who wanted to change initiating it.

Even as this member's attempt to directly provoke David finally provided an actual demonstration as to the deeper problems in this relationship, it also made him aware that he colluded with the aggressive sexuality and avoided this seduction dynamic in prior sessions. David indicated that he missed the opportunity to point out how the provocative member probably brought this dynamic to many other situations in his life, in a similar seductive/avoidant strategy. David went on to explain how these cases influenced his subsequent work.

> At first, I found myself being more self–conscious, and with the next attractive male couple, I reverted back to a stance that felt more distant and withholding. My supervisor pointed out that I was reacting to the vulnerability I felt with that last couple. His comments helped me return to a more empathic place, but I definitely was being less intersubjective, taking more control, and checking in with my sexual barometer often.

In a similar sort of reaction to his erotic countertransferential occurrences, Arthur, when pressed about his reliance on neutrality, even when working with male couples, said:

> I freely admit to needing to be aware of erotic feelings. Sometimes I allow myself to get involved in my own sexual fantasies, and in individual work I expect it and I use it. There I trust my technical skill. But I know in couples work it can feel overpowering, especially if both partners are operating from a sexualized place or one is extremely narcissistic and needs to get validated for his sexual power. When I saw that happening with me, I mean getting sucked in by these types of individuals, that unfortunately I have seen my fair share of in gay couples, I

> sometimes hold firm, with more interpretation, to deflect them. I need to pay attention to technique, and be less gratifying.

Interestingly, not only Arthur and David, but also Carlos (see, p. 189), at one point in the interviews shared how they initially countered both their erotic countertransferential and general countertransferential reactions with a more "neutral" or "technical" and "directive" stance. These gay male therapists' disappointments or discomforts also played out with a similar distancing that included reestablishing "appropriate boundaries" and/or interpretations that sometimes emphasized at least one of their clients pathology and need for individual work. Their self-assessments not only identified what had been countertranferential blind spots, but also may have led them to revert to techniqual strictness and react from a place of internalized homophobia, for example, beliefs related to gay men's narcissism and developmental failures. Since the focus of the guided interview was not on recontextualizing analytic technique or theory and this trend only became apparent when reviewing the data collectively, I did not delve further into this concern during the interview process. However, pathologized assessments, combined with a move back to a more neutral position, remains an area of technique in both individual and couple therapy that merits further investigation, particularly in light of the gay therapists, already quoted, who retreated in order to avoid or directly confront work with transferential-countertransferential complexities with couples.

The conundrum of working within one's own minority status seems to heighten the potential for these countertransferential impasses due to heightened expectations and therefore additional disappointments from both the therapist and the client. Barry, the

younger social worker, indirectly expressed his concern about this possible development, when he questioned:

> And this is where I get stuck, regulating myself when I work with these couples. I need some guidance with what are realistic expectations for the therapy of male couples. Is lending them hope my countertransference or does this cut across individual differences as a clear social need? It is so much clearer with married couples, it can be normalized as Men are from Mars women are form Venus, that sort of thing. But sometimes, these men are both striving to be closer, but protect each other's vulnerabilities by shutting down or sexualizing others, when they feel so misunderstood. Maybe that is part of growing up gay, being in a gay couple, being a gay male therapist, this self-protection. I feel it too in the work with gay men; I want to protect them from their maleness, their defense to sexualize, but also live fully. My inclination is male couples should know better. On the other hand, I think they expect the same from a gay therapist, we should know better and therefore, when a disappointment occurs, they can be harder on me, too. When this self-protection, slash disappointment thing happens I try to bring this dynamic into the room, but with two male clients together the defenses can be doubled, so it has blown up in my face. So sometimes, I feel like I avoid the inevitable maze of this confusion, even as I know it would be better to have the skills to work it through.

Barry's countertransferential pull and confusion seems to emanate from his desire to fill and satisfy the lack of direction and support that many gay couples may require and/or demand when entering into therapy. Unlike David and some of the others who shared instances when they restricted the interpersonal field, Barry raises important questions about which expectations and theoretical ideas a therapist should bring and keep in the forefront of the therapy with male couples, particularly if the couple is surrounded by a lack of expectations outside the therapy room. In his uncertainty, he asks constructive clinical questions regarding how his countertransferenential pull can be employed to open up possibilities, instead of potentially reenacting a familiar lack of attunement that potentially rigidifies defenses and restricts interpersonal experiences.

Section 2- The Potential Limitations of Cultural Identification

One of the most significant reasons given for creating this study was a concern that therapists, particularly non-gay clinicians, do not fully realize the impact of male couples being in a marginalized culture and might project a heterosexually inspired vision of healthy coupling. However, for the most part the non-gay clinicians seemed more acutely aware of their potential to project their cultural and social vision than the gay therapists. Accordingly, unlike the heterosexual therapists who almost seemed to overcompensate with a willingness to admit their lack of awareness of gay culture, very few of the gay or lesbian therapists directly referred to cultural competency as a clinical concern or, utilizing Robert's metaphor, a necessary "outline" to be filled in during their work. I also colluded with keeping cultural competency an unspoken presupposition by not explicitly mentioning cultural competence as a clinical concern during the interview process. According to Jill's metaphor, I kept it outside the "bubble" of consciousness.

This is not to say that the gay therapists had not incorporated the need for cultural competency into their work, but thathow it seemed to get played out did not become apparent until the data analysis. In what appeared to be their desire to help couples succeed and lend them a vision, some gay therapists chose to point out more general ways their journey was similar to that of their clients. More than one of the gay therapists acknowledged certain shared cultral experience s, from fundamental commonalties like "coming out" as gay, or being in a male couple with power struggles(see, pg. 200), to less significant experiences like taking pleasure in Fire Island, or enjoying the musical theater. Some hoped these commonalties, actual or assumed by the clients, would assist

in a mutual therapeutic identification that would strengthen the therapeutic alliance and facilitate engagement.

Unfortunately, as demonstrated in some of the case examples just discussed, assumed cultural similarities when not fully explored or made explicit, often manifested in both transferential and countertransferential expectations that led to therapeutic impasses. John, in a relationship with struggles analogous to those of his clients, thought his personal similarities would inform his work. He shared:

> I saw this suburban couple from Long Island, where I grew up, together 18 years, where one wanted to fix it and the other was equally invested in not changing. I aligned with the fixer, who I related to, more because the other guy was not only cut off in the style of my partner, but also, not even out to many of his co-workers. I could not feel compassion with him, despite hearing about his horrid childhood with a Jehovah's Witness mother and family who had ex-communicated him. By the time I realized they both had created this system as a way to keep their conflictually based sex-life intact, they left claming I was too uptight to help them. Because I thought I was taken in as a role model, and had shared similar experiences in my coupling, I thought I could move them along. I failed to start where they were at and see the idiosyncratic parts of their coupling, instead projecting my personal solutions on to them.

Mark also shared a case, in which focusing on similarities between his life and the couple's negatively impacted the treatment.

> I had a couple into the circuit party scene where the presenting problem was the lack of connection. They were very attractive, successful individuals, and even though I was clearly older than these guys, they could have been my friends at another time. I liked that they treated me as one of their peers, and I knew enough about their scene from my past to sound informed. The core of their struggles to get closer, I also related to from my life. However, it turned out one was into Crystal Meth., and they both accepted his drug use. They talked about the scene as creating a sense of community, particularly when high. I empathized with the need for connection and even the high one gets feeling connected in the circuit scene, but not the Crystal use. They said they did not want to talk about the drug use, because they had it under control. The even claimed I was homophobic, when I expressed my concern that this is a serious problem in our community. In my experience I had actually shunned that scene due to all the drugs. But I had already let the similarities get in the way. I think, in retrospect; I could have been a stronger therapist (been more challenging of the drug use and not so tolerant),

> but that was like challenging a cultural reality. From the place I had set up, I felt out on a limb, and hypocritical when I tried to go back and change my position.

In attempts to connect, relate and facilitate the clients' sense of being understood within their own minority status and general gay culture, gay therapists like John and Mark overlooked or ill-timed the chance to acknowledge their lack of compliance with behaviors normalized by specific gay subgroups and therefore, assumed to be acceptable to their clients. The types of behaviors that lead to these impasses are often the ones the clients are most defended against, like potentially shame driven sexual behaviors or drug use. In both cases, it raises the more intersubjective question: Who needed to be understood by whom? As suggested by Kanuha (2000) and LaSala (2003), gay therapists working from an insider position may still be impacted with the same collective internalized and cultural oppression as their clients, and may not always be aware of ways these forces impact their own clinical judgments. In Mark and John's cases, this might suggest they could be projecting their own need to belong into the couples work.

On one hand, these examples could represent a negative aspect of Robert's "coloring in the outlines" metaphor, where a shorthand type approach to cultural competence can lead to a sketchy depiction that is completed not with the client's distinctive information, but with some of the countertransferential and transferential assumptions and disappointments just described. On the other hand, "coloring in the outlines" could still be employed and helpful even when working within an assumed cultural match between client and therapist, as long as the therapist over time , carefully attempts a fully realized cultural sketch filled in by the client's specific life experiences.

Nonetheless, it seems that most of the gay therapists recognize their clients' cultural pulls between the heteronormative world, their gay sub-cultures and their

families' cultures and how this tri-cultural reality generates meaning and conflict in couples and couple work. Most of the these therapists used this knowledge, combined with carefully thought out self-disclosure ranging from their shared sexual identity to more specific personal revelations, to facilitate identification, empathy, and role modeling. However, as suggested by the struggles of several participants in the last chapter, attempts to facilitate engagement through self-disclosing cultural identification may contribute to impasses that get internalized by the clients as feeling misunderstood even within one's own culture, providing fertile ground for further marginalization.

It is important to remember that the interview guide asked the therapists to reveal examples of impasses, struggles and countertransferential growth experiences that helped to inform their present practice knowledge. And they were not directly asked to reveal examples when things went smoothly and they knew exactly how to proceed. Nonetheless, it seems many have let both these types of experiences continually influence how they work. It seems important to note that several therapists include caucuses with friends or other gay therapists, two still enlist gay supervisors to share concerns that either feel too close to themselves or thatthey had not previously encountered , and one attends a weekly reading group consisting of gay –identified therapists. Several mentioned that certain clinical dynamics that they encounter, such as the permeable boundaries that move lovers to friends (see pgs. 173-175), are rarely, if ever, explored in the clinical literature and therefore, have been a recent topic in two separate settings.

The Outsider Perspective

Most of the non-gay clinicians appeared to be attuned to ways in which being outside the marginalized sexual identity of both men in the couple led to distinct differences between themselves and their gay clients. In addition, it seems that heterosexual therapists like Paul, Irwin, and Edna, whose disclosures will appear below, work with their gay couples without the same countertransferential pulls elicited from the cycle of identification and potential disappointment experienced by the gay therapists.

Paul not only marks his approach to the cultural differences by openly acknowledging what he does not know, but also actively demonstrates his interest in knowing.

> I worked with a couple where the older one acted like a mentor. He was apparently a fairly well known man about town in the gay community and quite a bit of an activist. He would challenge my knowledge in ways. Like he would talk about, "...so we were rimming..." and he would look at me and say, "Do you know what that is?" And I'd say, "No, I don't actually, could you tell me?" I guess I sort of assumed from the outset that I would always be, and I still will always be, somewhat or largely ignorant of a lot of people's experience. And in some sense, this clinical cross-cultural experience of difference sets up a profound space to work in, revealing the need to try to connect to the "other." I apply the same thinking when I'm working with African Americans, straights or gays, women, anyone who is significantly different in some ways from what my characteristics are. So, I just believe so much in learning from the client what's going on. I'm not afraid to do that. So that some degree of not having knowledge would be the next block, but it wasn't a block, and in some ways I think it was a real asset to this couple, because they had to explain themselves to me and, in the process, to each other.

Similarly, Edna discussed a case where she voluntarily disclosed her cultural ignorance and catalyzed this potential limitation as an opportunity to demonstrate genuine concern, interest and connection.

> With my gay couples, I have to ask more questions and deal with all the issues that come up when you have to admit ignorance about something. I had a male couple; one of the partners was very into domination and submission. I knew nothing about that, really. My doorman could know more about that than I did. And I remember when he first brought it up and I believe his feedback was, "you just sat up in your chair like you couldn't wait to hear more." Whether that was his fantasy or what he wanted it to be, I don't know, but it certainly was something I didn't know anything about and was open to really be educated and internally educated, what does this mean to me, how do I feel about this, what are my fantasies about all of this? It was a very important part of that treatment, and related to his partner's distance. I think that he was happy to be able to talk about it, in that sense of educating somebody about. This was not something his lover was interested in; yet this was something that was very important to him. Going through that whole process took away a lot of shame about it for him and helped his lover (of 22 years) be more open to his explorations.

The two case examples suggest that a psychotherapist's effectiveness is not necessarily determined by the presumed similarities between a client and therapist. A better way to evaluate effectiveness may be to assess how the similarities and differences between therapist and client are handled in the therapeutic relationship. For instance, Irwin demonstrates how his acknowledgement of perhaps erotic and cultural rules very different from his own helped his clients to liberate themselves from their own unexpressed ambivalences and discomfort.

> With this couple, where their sex life had dried up and one could not get an erection, I went after it as I would with straight couples, with Masters' and Johnson exercises. However, I realized there were the 'top' and 'bottom' identities that I marginally understood, that they uncomfortably hinted at, but had not really been explored. When I came clean as the uninformed straight guy who was well meaning but didn't know about what this really meant to them, in having to explain themselves to me, and acknowledge and work through both our discomforts, they brought up experiences that clarified their differences with each other that went way beyond sexual roles. Then, in a later session, when describing a newly attempted sexual encounter, I said spontaneously, "Oh, that's sexy." That became a magical moment, an important event of mutual acceptance. I think there was a feeling that they've reached the enemy in a way, to the extent that I represent the other world. They said they shared things with me they never could with straight people, particularly their families. In part, safely working through not trusting to trusting me, allowed them to trust each other more, and might have contributed to them reengaging sexually.

Mary observed what was distinct and potentially effective about her outsider status when she described a case with two young Hispanic men in their mid 20s who came to see her about their jealousy:

> This couple, they were into the discos, with partying being their bond, came into my office one day, after almost 6 months where they were in and out of treatment and the relationship. They get into a huge fight, in my office, which was on the 31st floor of an apartment building. Knives came out, all I could think of is there's gonna be blood everywhere in my office, oh my God, what am I gonna do .One is yelling "you don't love me, I'm gonna kill myself " and with that he flies up on the window sill, these huge paned glass windows, standing there saying "I'm gonna throw myself out of the window," and I don't know, maybe I was already being a mother, I don't know, but I looked at him and I said "GET DOWN FROM THERE! RIGHT NOW!" And he did. He got that it was about being protected. They needed boundaries. And then, you know, they came down mood-wise; they got better controlled as they were sitting in the office. They needed a mother, and I guess I trusted my instincts and acted like one, so that I could be in a place of caring and be tough and bring that into the clinical arena. It was the right thing to do and it opened up for me a way of practicing that was right for these guys. Here were guys in a developmental stage when they were not ready for interdependence, but responded to my mothering in a way that helped them deescalate, examine their acting out, and eventually break up, even though one guy stayed with me and started to get his life in order.

Not to say that a heterosexual male or a gay male therapist could potentially respond with the same maternal quality, but here was an example where Mary took what she called her "instinctual motherhood" and brought it into the clinical arena in a clear display of how a distinctly outsider role elicited a supportive and firm response. In fact, most of the non-gay clinicians who volunteered in this small sample not only seemed aware of their potential ignorance, but also demonstrated ways they acknowledged their lack of knowledge and differences to facilitate situational circumstances that enabled the treatment to progress.

As if coming full circle from the literature and clinical review chapters that informed the interview guide, which more often than not focused on and made me aware

of potential biases based on an outsider status, the data both revealed advantages of an outsider perspective and brought up concerns about treatment then tends to arise when working from the perspective of an insider. Therefore, in the final discussion chapter, examples from this chapter will be placed within the larger context of the potential advantages and disadvantages of coming from an insider versus outsider perspective in couple work with gay men.

In fact, the next chapter widens the scope of other foundational categories of this study, particularly what is defined as culturally competent work, gay affirmative psychotherapy, or even practice wisdom; demonstrating how these concepts also, at times, seemed deconstructed by the data. Not ever reflecting a clear dichotomous divide, between those in the know or outside the know, or those with one epistemological focus over another, the data seemed to reflect an ongoing need to keep turning over and monitoring what is considered objective knowledge.

In summary, the data revealed potential problems with the generic application of available theories to clinical practice of psychotherapy with male couples. Even when a therapist had an intellectual understanding of many theories and was aware of varied epistemological viewpoints, the translation of this knowledge into actual practice proved to be a consistent challenge for the respondents. This would suggest that just as gay couples may need help distinguishng their own needs from the expectations of dominant society, so might therapists need help in deciding what is supportive for relationships that are often untraditional and unfamiliar. As a result, practice wisdom that integrates validated knowledge gained from direct experiences with couples becomes an indispensable resource for sound clinical practice with marginalized populations.

Chapter 7-

EPISTOMOLOGICAL PLURALISM-ACROSS THE LINES

This final chapter will explore how the data revealed the need for therapists to consider working with male couples with an amalgam of both essentialist and queer frames. What the ensuing technical and epistemological pluralism suggests for effective work will be illustrated through not only the various psychotherapeutic tensions of remaining open to similarities and differences, but also how it translates conventional ideas related to coming from the insider perspective of a gay therapist versus an outsider, non-gay viewpoint. These two groups' different journeys and therapeutic processes will be explicated in terms of how they might more effectively embrace, expand and mirror the unknown aspects of working with the hybrid, complex, ever-evolving nature of male coupling.

With the area of therapist's subjectivity acknowledged and the issues that most often challenge them identified, this final chapter provides some potentially translatable guidelines and questions that might help therapists to act more consciously in areas that might otherwise hinder their genuine relatedness to those male couples who choose to go to therapy. Finally, the seeds for future inquiry, suggested by the data, will be named.

Section 1- Queer(y)ing the Data[1]

Efforts to assimilate and mediate divergent epistemologies, theories and styles during the data analysis revealed the age old tension between theory and practice. Even as many of the clinicians attempted to capture the most applicable, supportive and

[1] I am borrowing the term queer(y)ing from the article by Newman, Discursive Condoms in the Age of AIDS: Queer(y) ing HIV Prevention (1998).

comprehensive principles and methods for working with the wide range of ways thatgay males' couple, many explained how they sometimes struggled to reconcile the values inherent in their core theories and clinical techniques with the here and now phenomenology of the process of treatment.

For example, Eric determined that a couple was experiencing isolation, in part due to a lack of direction or vision for how to feel vitally connected to the gay community as a long-term middle aged couple (see p. 201). He felt the desire to satisfy their need for psychoeducation byusing his relationship as a role model, but struggled with how his more classical psychoanalytic theory base required him to prioritize neutrality, avoid self disclosure, and withhold gratification in order to facilitate transference. In another example (see p. 206-7), Irwin recognized the constructive aspect of a couple's experimenting with nonmonogamy, but his theory base and its sociocultural parameters imply that the couple might be a dysfunctional system with a fear of intimacy. This could have lead him to pathologize their sexual arrangement. In each of these cases the clinician recognized the divergent, value-laden trajectories inherent in their dominant theory base, on the one hand, and some of their therapeutic choices that might have been experienced by the clients as either gay affirmative and most immediately helpful, on the other. These conflicts between theory and practice should not have been a surprise since they correlated with the types of negotiations presented by prior clinicians represented in the clinical review chapter (Bernstein, 2000; Drescher, 1998; Goodrich, et.al., 1988; Green, 2000; Green, Bettinger, & Zacks, 1996; Seigel & Walker, 1996).

It became clear through analysis that the data consistently exceeded the boundaries of the theories that originally informed this study, such as psychoanalytic psychotherapy,

gay affirmative psychotherapy, and structural family therapy, as well as the clinical conceptions of countertransference and cultural competence. For example, all of the therapists seem to incorporate the major lesson of countertransference: aspects of practice theories are always in need of a personal evaluation that takes into account the specific needs and interactions of both therapist and client (De Simone, 2001).

So when Irwin encountered the couple experimenting with nonmonogamy, he recognized through his countertranference that he might impose his contradictory values and this awareness enabld him to absorb his own ambivalent thoughts in order to continue examining the complexities of the couple's sexual arrangement. However, as much as his countertransference allowed him to remain open to the couple's sexual exploration, his overarching frame of reference embedded in structural family therapy still privileged heteronormative conceptualizations about healthy functioning in a committed couple.

In addition, the concepts underlying cultural competence in therapy (Cramer, 1997; Lefley, 1985; Mays & Albee, 1992) which emphasize male couples as a distinct cultural minority require therapists to continually recalibrate many of their theory bases, values and training in order to make space for what they understand about gay culture and gay men. However the question remains: Dthe concepts of countertransference and cultural competency provide a strong enough challenge to a therapist's investment in hegemonic conceptualizations with regard to heteronormative coupling? Deconstructing the presumptions that the therapists utilized in understanding the deeper developmental aspects of gender, identity, sexual desire and relational attachment seem crucial when working with these men, in order to sufficiently examine and appreciate the meanings

behind the sometimes diffuse and permissive patterns of dyadic intimacy witnessed in male coupling.

And as I began to sift through the data via a grounded theory methodology, I found myself sharing similar dilemmas with the therapists, caught between the push of theoretical dogma and the pull of practice wisdom that surfaced through their clinical experiences. In a parallel process, the data propelled an analyticalsearch within me for missing theoretical constructs with regard to working with male couples.

It was at this point that I reconsidered queer theory (Butler, 1990; Sedgwick, 1990) in order to understand how and why we need to continually negotiate and tolerate ambiguity when it comes to attempting to synthesize often conflicting epistemologies. As alluded to in prior chapters, queer theory employs the key concept of heteronormativity in order to both define the context of gay/lesbian as distinct and marginal and to call attention to the power imbalance that valorizes and naturalizes all things heterosexual. In the arena of couple work, the heteronormative values embedded in many accepted psychological views about sexual orientation, gender, "healthy" relational behaviors and even asymmetrical power differentials in therapeutic relationships, minoritize the norms of many male couples, and for that matter, all things "homosexual" or queer (Butler, 1990).

In retrospect, I realized that during the interview process of this project, I unconsciously engaged in a kind of minoritizing when I questioned therapists about the "distinguishing characteristics of male couples" and implicitly compared them to heterosexual couples, thereby emphasizing how certain behaviors or dynamics--and not others-- fit into or vary from the dominant social and cultural structures that define

contemporary coupling. I thought I was guiding the therapist toward identifying how their *in vivo* clinical work broke the clinical mold in order to include the specifics of this population. But in actuality, my line of questioning inevitably minoritized gay men and therefore did not directly examine the meanings underlying more universal behaviors and themes found in all types of couples.

Queer theory with its social constructionist foundation not only exposed these unconscious collusions with hegemonic ideas about coupling, but also allowed a critical examination of the problems that therapists faced in applying the values and conceptualizations of heteronormative clinical theories to male couples. Without the regular inclusion of a social constructionist or queer overview in the everyday lexicon of the therapists' work, or until the norms of male couples become the model by which healthy coupling is understood, teasing out the heteronormative biases and recognizing when to challenge theoretical concepts and interventions that minoritize are necessary actions that fill the theoretical and analytical gap.

Remarkably, no respondents in this study identified queer theory as a knowledge base from which they practice. However, although none directly state that their work is informed by queer theory, a number of the therapists are reflexively engaging it in their practice. Some challenge the heteronormative and minoritizing aspects of their thinking by asking themselves and their clients questions that focus on eliciting, reprioritizing and deconstructing beliefs and values (see pgs. 167, 194, 198). Others allow the non-conventional aspects of male couples to stimulate navigation into unfamiliar aspects of the therapeutic process (see pgs. 189, 205-6, 210).

Additional deconstructive insights started surfacing when some respondents volunteered how they thought about their work with male couples in atheoretical ways. These therapists' descriptions of breaking out of the confines of convention were captured in statements such as: "fly by the seat of my pants," "go to another country," or "(go to a) place of not knowing." These phrases demonstrated a need for these therapists to think and work "outside the box" of heteronormative-based theory and practice principles and to embrace the most subjective parts of their practice experiences. In fact, some of the most effective therapeutic moments seemed to go beyond any fixed process, minoritizing practice principles or universally applied essentialist theories. These more queer moments happen when therapists trust themselves and the therapeutic process, and strive to deconstruct their work as it simultaneously moves forward.

Other therapists despite a lack of awareness of the outside/inside dichotomy that underlies much of the thinking of queer theory (Fuss, 1991), nonetheless emphasized being aware of "coloring within or outside the lines" or the "bubble"metaphor that left a flexible, context specific boundary between what remains inside and outside the work. These more metaphoric aspects combined with the other moment to moment impulses revealed in the work suggest an unconscious "queering" of the therapeutic process by a number of the interviewed therapists.

In tandem with this awareness, it became apparent that living with the ongoing need to deconstruct and interrogate what at other times might be taken for granted was analogous to the challenges experienced by the couples that are at the core of this study. They are also trying to work with many contradictory factors which they attempt to assimilate into a meaningful whole. In other words, the sometimes destabilizing and

often enlivening analytic, theoretical, and interpersonal tensions and trade-offs, impact the journey of both personal and therapeutic relationships.

Consequently, in accord with the clinical phenomena witnessed in this sort of reflexively queer therapeutic environment, what finally developed was a data analysis which contains an appraisal of the push and pull between expectable therapeutic variables in couple work, commonly utilized theoretical foundations with heightened attentiveness to the therapists' heteronormative presuppositions and their impact on the male couple. Within this theoretical negotiation, rather than unearthing an essentialist inspired list of "best" practices that could be straightforwardly summarized, I found myself in the crux of the therapists' personal practice wisdom, constantly being balanced and re-developed by the mutually constructed interactions of both the therapists and the couples.

Section 2-Lessons Learned about and from Practice Wisdom

There is no ultimate guideline for producing practice wisdom, (Scott, 1990) even though Klein and Bloom (1995) and Scott (1990) have produced frameworks that chart its creation. And since the interview guide for this study took into account both their processes, it was designed with the assumptions that therapists consistently reassess their espoused theories and practice principles based on their subjective practice experiences and then develop intuitively based hypotheses that they then apply and experiment with in future cases. Operationalizing this process in the series of questions in the interview guide proved quite effective in extracting the therapists' intersubjective experiences with their clients. These experiences revealed how the working though of clinical impasses can, over time, generate practice wisdom.

Similar to Klein and Bloom (1995), who mapped their model of practice wisdom as a circular route, what became apparent in the work of the more seasoned professionals was an ongoing reassessment process through which new experiences consistently informed their evolving "wisdom." This non-linear, unending analytic experience confirmed aspects of Klein and Bloom's (1995) process of generating practice wisdom, particularly ongoing efforts to keep applying assumptions that might have worked in the past. However, rather then landing on distinct, formulated hypotheses (Klein & Bloom, 1995), more often there was ongoing deconstruction thatdid not assumethata fixed "hypothesis" was discovered within a previously revealed formula or established intervention. Instead, in partnership with the couples, the therapists' relational and therapeutic experiences revealed a collaborative style practice wisdom, uncovered subjugated knowledge that gave voice to the couples, challenged existing paradigms and sometimes caused the therapists to leave behind the role of the expert (Hartmann, 1992).

In that sense practice wisdom itself can be understood as queer -- a process that strives not for easily applied formulae or objective generic principles, but which is instead a link in a chain of the process- -where what becomes known by the therapist and clients has to be in certain ways unknown or at least reconstructed for the next situation, because all understandings are contingent on context (Butler, 1990). Therefore any clinical knowledge that evolves out of practice wisdom is part acquired, general knowledge of how the therapist works best with a distinct population, part specific suppositions triggered by familiar circumstances that in some way parallel one particular client to another, and part creativity fused with continual self-discovery and questioning.

Along these same lines, what emerged in reviewing the data was how different therapists actually utilize their practice wisdom in different ways. As previously demonstrated, many therapists find themselves trying to negotiate moments when their core theoretical formulations do not fit with their therapeutic instincts or the needs of the couples. These situations, when therapists shift their style and modify their theoretically informed technique, builds a type of practice wisdom that first functions like an intervening bridge thatis specific to a particular clinical moment , and then, over time, gets shaped into stylistic and technicalchoice s that may be generalized to a specific population and circumstance.

There were instances of this process throughout the data. For instance, when Mary shared thatshe has gay friends to a new client, she self-disclosed to build rapport at the very beginningof the work, despite her more analytic traditions thatdiscourage self disclosure (see p. 200). Over time, she modified her view about this injunction and now more readily, but still strategically, reveals personal information tomale couples, when she believes it will either dilute the transference or aid in rapport building. Similarly, despite their confidence in classical psychoanalytic technique, both Eric and Arthur (see p. 205), described how they now actively bring up sexual concerns as a matter of course, breaking from the tradition that believes the client determines the content of the work. These are two among several examples that demonstrated how therapists utilize their practice wisdom to help recall and re- utilize stylistic methods, creating a re-usable filter by which to modify their dominant theoretical framework and their use of selfin a more flexible and effective way.

Others seemed to utilize their practice wisdom more as a path, a route that has signposts that steer the therapist in a familiar enough direction to create enough safety, but also allows for detours that make each therapeutic trip distinctive (see, pgs. 188, 189, 191,198). And though some of the respondents imaginatively searched for fundamentals or fixed applications of prior experiences, most did not suggest that their ideas had congealed into a permanent set of 'practice principles" that are finite and testable, (Scott, 1990) even when asked for directly. So instead of the more static categorization of "best practices", espoused guidelines were more often indirectly expressed by the therapists as personal strategies that seemed to have helped sensitize them to their work with male couples.

The Best Available Strategies, Advice and Warnings

As evidenced by the freedom with which they answered the final question of the guide that requested advice to new therapists, no matter the route to their practice wisdom the majority of respondents seemed most comfortable sharing their ideas more as recommendations than as finite practice principles. What follow is my best effort to use representative data as a cumulative summing up of the more commonly expressed, "advice" (question 17 in the guide), that these therapists offer to others practicing with this population.

> 1) First know that a couple can still walk around with the reality they could get gay bashed and can't hold hands, and can turn on the television day and night and freely hear how they are sinful, or deviant or don't deserve equal rights or are the butt of common jokes. Know how all that impacts gay men's world view and the relationships they establish. After you educate yourself to the complexities of this stigmatized identity and how it can eat away at a couple's strengths, learn about unique aspects of gay development and the different stages and stressors of being gay and continually coming out in this world. Also seekconsults with

experienced gay practitioners to help you look at your blind spots, biases and your own homophobia.

2) Help couples explore when and how they got to be a couple, and when they named themselves a "couple;" all the structural stuff that speaks to how they constructed this coupling experience and how they expect it to grow, and what they based their decisions on.

3) Allow yourself to be present and show up being real, do not be avoidant of risk, taking the lead, risk being controlling, more directive; naming things more quickly. As an out gay therapist, don't withhold in an effort to appear impartial, use and share your life experience, in other words allow yourself to consciously self-disclose, including coming out with your knowledge of what goes on out there. If they mention a particular place, I will reveal my familiarity. In that vein, don't be afraid to bring sex and sexual matters into the room early and be explicit and direct.

4) I would want a new therapist to make sure they ask the couples:

a) What is it like to be in the room, to give so much attention to your coupling? If they respond differently, help each member experience the differences, in order to understand the varied level of commitment to the process, and to their coupling experience and the impact of their homophobia on their commitment. This can lead to clarifying very personal vows, one member to the other.

b) I would ask how they met, how dating went, what brings them here; allow each person to see if there are differences in how they view their story and their problems.

c) Over the course of time get a sexual history, alcohol and substance use history

d) As two men, expect to see issues regarding frequency and quality of sex, confusion about roles and division of labor in the relationship, money concerns and their related balance of power; and how they came to their beliefs and how much they borrowed from heterosexuality.

e) Do those things you would do with a straight couple. For instance, get a family background and you will find out that each partner reminds the other of someone in the family.

f) Don't be afraid of the elephants in the room-like the couple I recently saw who needed me to say it seems like they need to separate, which freed them up to start connecting in a more related, more nuanced, more real manner.

5) Sometimes all they want is problem solving around a particular issue, psycho-education in the short term, and that is fine and necessary. And sometimes you have to talk about and help them get clear about what they want and problem solve around a particular issue, but you and them can get stuck in that. So, don't be afraid to try to look beyond the presenting issues and symptoms. Especially

with gay men, who because of a lack of entitlement keep long term relational longings at a distance, or like other menthink if you have to work on a relationship, it is not worth it. You need to help them look at the underlying desires, ideals and fantasies that each person brings to the couple.

6) Break down the male stereotypes, like men don't struggle with dependency, or the gay stereotypes, that all gay men are focused on sex. Those role socialization aspects that impact all male couples differently need to be brought to the table. Help them claim their competencies, not based on gender roles. In the same vein, they are men and might want to avoid affect, so don't be afraid to go for it. Many couple therapists go for behavior but do not free up the affect with each other.

7) Explore where they are in their "coming out" at work, with their families, with their friends because the coming out experience and that ongoing process is something that forever impacts their entire relational dynamic, good and bad. That might include doing individual work in the couple work, sometime even talking to each one privately and /or recommending individual work

Advantages and Disadvantages of the Insider and Outsider Viewpoints

It was hoped that this dissertation could generate a cross-fertilization of ideas as it cut across sexual and theoretical orientations to discover how clinicians assess and challenge their own beliefs, culture, and training to be more effective and self aware when working with male couples. During that quest, most of the therapists, regardless of their sexual orientation, revealed how they questioned their therapeutic practices enough to be aware of not wanting to replicate in their work the types of oppression potentially faced by male couples outside the therapist's office. As the data reveals, many of the therapists realized thatdoing psychotherapy with male couples also caused them to confront the ethical concerns about male couples' lack of equality and social justice (see pgs. 141, 142, 157, 163, 179). However, the two groups, the gay therapists (insiders) and the non-gay therapists (outsiders) seemed to emphasize different needs, patterns and

pathways when describing their journeys toward gay affirmative clinical competence, responsiveness to ethical values and the most effective use of self. As a result, some clear differences in process emerged based on the sexual orientation of the therapists.

All of the interviewed gay and lesbian therapists clearly emphasized the need for therapists to have basic knowledge about gay development and implied that non-gay therapists who have not experienced the type of stigmatization experienced by gay people need to become informed and learn about its impact (for instance, see advice #1, pg. 230). Gay therapists asserted the helpfulness of having personal knowledge of gay stigma and personally living with or having had a same-sex coupling experience. They readily shared how their life experiences were a familiar source of inspiration, connection and understanding that inform their work with male couples. These therapists recognized that there is a certain therapeutic benefit when gay men allow themselves to feel empowered and cared for by someone like themselves.

Nevertheless, none of the gay therapists directly claimed that only a gay man can do effective work with male couples. However, applyinghe limited research on matching a therapist's ethnicity, race or culture with that of a client (Bergin & Garfield, 1994) might suggest that there would be more rapport and sensitivity if the therapists' sexual orientation matches their clients. Challenging this application, despite the fact that they admitted to feeling the burden of being less informed about gay development and life styles than their gay colleagues, negative outcomes related to a lack of sensitivity by the non-gay therapists chosen in this sample never seemed to be the case. However, as a result of the non-gay therapist's strong concern about how this lack *might* impact their understanding and rapport, they often compensated by taking time to explore with the

couples what it is like to visit a non-gay therapist and to tread cautiously when relying on their prevailing practice methods or own life experiences.

Even though the interview guide did not have a specific question for the non-gay therapists about the pros and cons of being similar to or different from their clients, many of the therapists volunteered that dissimilarities not only induce different concerns, but also, if handled correctly, might allow for specific types of healing through bridging these differences. Jill believes:

> I think it has to do with safety, an expectation of being nurtured perhaps more by a woman, in my case, which leads to me exploring their homophobia and do they expect they can't get that same care from a gay man. And what does that say about their relationship. Sometimes it may be easier to do this type of work with a straight person, when there is less chance of offending the therapist. The other question is, do some guys just want something else interpersonally and dynamically? They know the gay scene; they know what they might get from a male therapist. In fact, many have experienced individual work with gay male therapists and now they want to see what they can get from a woman. They don't have to be monogamous about it. They know they can get stuff from a woman, stuff from a straight man and stuff from a gay man

Similar to Jill, Mary also shared her point of view about how certain pairings might help bring out specific underlying concerns that might facilitate the treatment.

> I am always trying to be aware of the interplay of gender issues and how the opposite gender and sexual orientation of client and therapist can bring certain concerns out, like all kinds of issues with mothers and gender roles. I presently have a couple who both have a complicated transference with me, one because his father left the family early, and I think for these guys they would be better off working with a man so they can confront these issues in the transference.

Both these therapists believe that just as the heterosexual therapists have a heightened awareness of the need to bridge differences, so might some gay clients have a conscious or unconscious awareness of different expectations and concerns related to their therapist's dissimilar background and sexual orientation. It follows that certain

couples might choose a gay and/or non-gay therapist because of these different expectations and concerns. Michael, like the women therapists, commented on the necessity for different couples to have different choices.

> It also has to do with their relationships to the larger gay culture, you know, how much you need to be in your own culture. I think to search for a straight male therapist is to have some reason to go outside, and that needs to be respected and explored. Some of the gay couples I've seen have tried a gay therapist and want another point of view, some come by chance, some are acting on homophobia, some seek me out because of my reputation and some need the interaction around difference. Whatever their reasons, with gay couples I become acutely aware of my limited frame of reference and use that to continually look at how to be in the room.

It seems the obvious differences in sexual identity, development and experience, when recognized and allowed by therapist to impact how he or she intervenes,gave some of the non-gay therapists and their gay clients a definitive space in which to explore expectations and differences inside the therapy room. It would also seem thatone of the core areas of distress for any two people in a couple is how to create a space to acknowledge their differences and still work on compatibility and intimacy. If these parallel experiences can be brought together in the therapeutic relationship, then the intersubjecitve experience between therapist and clients might reveal the potential pathways and skills necessary to connect with the dissimilar aspects of their partner. It follows that this type of experience could potentially open the door to new levels of intimacy within a couple.

It seems important that the only reported disadvantage in seeing a non-gay therapist was the time spent by the clients educating the therapists about aspects of gay norms that are not common knowledge (see pgs, 198-199). If the couples were looking for psychoeducation or were in need of speedy solutions, a non-gay therapist might not

always be the fastest or most useful route. However, for those open to exploration, most of the non-gay therapists turned the line of questioning about such things as sexual behaviors or gay cultural norms into an opportunity for the men to slowly examine and at times deconstruct what they sometimes took for granted, particularly aspects of gay culture or their development that might otherwise go unexamined by someone immersed in the same cultural norms

The Insider's Disadvantage

Statements expressed throughout the interviews not only helped me better appreciate the many ways of being the same and different in the therapeutic dyad, but also further destabilized my original conviction rooted in theories of cultural competency that assumes being similar to one's client, or being inside the know/versus outside the know of sexual orientation, is a solid indication of who might most effectively treat male couples. Robert, the gay social worker who shared the "coloring in the lines" metaphor, pointed out how having the same sexual orientation does not imply a maximizing of treatment outcomes; that sometimes it is not about matching sexual orientations, but other aspects of similarity.

> I know gay therapists who have focused their adult lives on assimilating into mostly non-gay identified communities, including their careers, their families of origin and their neighbors. When they encounter a gay client who lives more on a radical edge and is against assimilation, there is a good chance there could be cultural, philosophical, and behavioral clashes that greatly impact treatment. On the other hand, the straight therapist could encounter a gay client with a familiar relational problem; with similar cultural and class related values that greatly enhance the effectiveness of the treatment.

Robert clearly argues that just because a therapist is gay, it does not mean that he is the best person to treat a male couple, particularly when a couple's expectations of being understood, are based purely on having the same sexual orientation as the therapist.

Cases shared in the last chapter demonstrate how both a gay therapist and the client(s) can start out the therapy by minimizing the impact of their differences (see pgs. 208, 213) in order to maximize engagement and the hope for connection. This can allow the client to take for granted that they share common cultural, social and personal ideas and experiences. In these situations, the therapist and the client seem to collude by utilizing a more essentialist view of gay culture and development that when combined with transferential and countertransferential phenomena, obscurehow different individuals use their uniquely developed psychosocial filters to interpret personal beliefs, values and customs.

So, later on in the treatment, when some of the gay therapists risked trying to examine these differences and concerns in more depth, what the clients previously interpreted as the therapists' acceptance of certain behaviors or beliefs, evolved into feeling misunderstood or rejected. These seemingly mis-timed attempts to explore differences on the part of the therapists sometimes got reframed by clients as therapists being uptight or even homophobic (see pgs. 208, 213). The latent message from the clients was, do not go near those behaviors that are most fraught with conflict, or I am going to project the ambivalent part of myself onto you, the gay therapist, who should understand and know better.

In other words, gay therapists working long-term with male couples need to be careful when allowing unspecified or real cultural or personal connections to go

unexamined, particularly when these assumed similaritiesmight have contributed to a sometimes difficult process of mutual engagement, identification and/or relatedness. When these similarities have been used as a shorhand to engage a coupleand the therapist does appear to or has professed to be similar to the client, going back and taking the time to explore the meaning of these so-called similarities and potential transferential sensitivities might help open the therapeutic space for unconscious conflicts to emerge and to be addressed.

Frank, a heterosexual social worker who earlier in his interview had talked about feeling less prescriptive with gay couples (see, pg. 196), describes a similar minimizing of differences with his straight couples.

> I can take certain things for granted with a heterosexual couple that I feel I really have to think twice about with gay men. When you perceive people are "the same," there's a certain shorthand which could be terribly wrong, but it's there and it's operative.

In other words, validating the insights of Fraenkel (1982), who believes that couple therapy must address the ways each individual assimilates and employs sociocultural experiences and integrates them into his relationship, any projected, essentialist views, whether coming from a gay or non-gay clinician, can lead to assumptions that fail to deconstruct the specific ways that each individual makes meaning out of cultural constructs.

Gay Therapists-Striving for Legitimacy in the "Inside" World

Among the gay therapists I interviewed, it seemed many wanted to be acknowledged outside their sexual minority and become accepted and legitimated within

the greater psychotherapeutic profession --the more universally thought of, more powerful, 'inside" world which necessitated their 'coming out.' Similar to other minority groups looking to legitimize themselves, assimilate, and reduce feelings of stigma, gay and lesbian psychotherapists made sacrifices in order to integrate themselves into the previously homophobic mainstream of psychotherapy that struggled to keep them out for many years (Drescher, 1995). As evidenced by some of the comments of the gay therapists, these sacrifices, which sometimes included down playing one's sexual orientation, still might get played out in a theoretical and clinical tension between their analytic selves and their gay affirmative selves. As John explains:

> Psychoanalytic language is more useful to me now than any language, including the gay affirmative language. And maybe I feel like the gay affirmative stuff is in my bones, so I don't think I conceptualize problems first and foremost from a gay perspective any more. And may be this is a problem, a result of both my oppression and my indoctrination. However, even when I do conceptualize oppression, I strive for the result of the individual's experience of that oppression, without necessarily jumping to a gay lens. So it is not because you are a gay men or in a gay relationship, but how that oppression mixes with other factors in your development. So whether the problem is the individual was exposed at an early age to homophobia, or criticism for being fat, or whatever part was not valued, the curative responses is still the type of acceptance emphasized in the gay affirmative literature, but also creating an opportunity to identify the loss, and mourn the loss of what ever it was as seen through a more analytic frame. The work for me has become finding a way to meet the yearnings that may have been denied, repressed, or suppressed, and hopefully, help both members get that missing piece for each other, and find a better experience in the process that they can take out to the world.

John explained that despite his working for five years with a highly esteemed supervisor well known in gay affirmative circles, he felt compelled to seek more legitimization as a psychotherapist by becoming skilled in more conventional psychoanalytic traditions. His story was similar to several of the other gay clinicians who went on to psychoanalytic institutes for training after they received their graduate degrees

and who identify with one of several psychoanalytic orientations (see Table 1). Like John, they believed thatthey would be more able to embra ce a complex set of social, developmental, sexual, and relationalconditions with those symbolic concepts as their universal starting points. These gay therapists, in their efforts to be more informed, became immersed in psychoanalytic theories and techniques whose underlying doctrines most often view the therapist as an authority in her/his knowledge of psychodynamics who then acts as a neutral interpreter to help the patient find meaning, uncover, bring insight to and repair the past (Stein, 1996).

John, like several of the others, recognized how he has come to bridge his more classical psychoanalytic position with a sort of practice wisdom that has helped him to modify his technique, particularly when applying it to gay men and male couples. He balances hismore dominan t psychoanalytic training with basic principles emphasized by gay affirmative work. He seems to make himself more of a real object for his gay clients so as not to repeat the isolation and oppression of their childhoods by sometimes revealing pertinent countertransferential reactions, sometimes self-disclosing commonalties, and in general, modifying his "neutral" stance. Yet, he still appears to project himself as the expert, a stance that blends with a gay affirmative approach, since both of these perspectives are rooted in an essentialist model.

That is not meant to negate how gay affirmative psychotherapy and its creation of a more essentialist-style view of gay identity provided a solid foundation to break away and subvert more traditional psychoanalytic theories that pathologized homosexuality and its related concerns (Bohan & Russel, 1999; Isay, 1989; Silverstein, 1991). However, it seems there was an effort to work within and eventually re-join psychoanalysis by linking

up objective gay affirmative theories on gay development to theprevailing deterministic theories of human development (Drescher, 1998; Isay, 1989). Therefore, similar to traditional psychoanalytic technique, in gay affirmative work the therapist often works with his predominant "objective" method and uses this knowledge of development to help unlock the unconscious parts of this gay client to more fully adapt to his environment (Bohan & Russel, 1999). This approach was most simply explicated by Eric (see, p. 190) who talked about applying a gay filter to his psychoanalytic training that he employs to most effectively listen and choose interventions.

However, the data still left me questioning if the addition of a gay affirmative filter to psychoanalytic technique, even with inclusion of individualized practice wisdom, provides a free enough space for therapists who see themselves as authority figures to seek and explore problems and questions they don't know the answers to? In other words, does this combination of practice options allow them to shift the experience of the process of therapy to one that co- creates with their gay clients the social reality of the therapeutic experience, instead of recreating the asymmetrical binary that represents therapist as being "inside" the know and clients, once again, "outside"? In the words of Milton Erickson (1980), "Too many psychotherapists take you out to dinner and then tell you what to order. I take a patient out to a psychotherapeutic dinner and I say, "you give me your order.'" Erickson's statement reflects my concern that some of these therapists, even with an incorporation of a gay affirmative perspective, are still operating from an authoritative position that continues to reinforce a male couple's identity as outsiders.

This type of concern leads me once again to ponder questions that at their core are about the impact of epistemological choices. How does the application of an essentialist

knowledge base, such as classical psychoanalysis, with its origins in a heteronormative world view of relationship development and power, and/or gay affirmative psychotherapy, even with its attempts to modify, rework and create new constructs related to gay identity, restrict what gets defined and therefore explored bythe therapists as a healthy, functional gay male relationship? Is it important to have the choice of various frameworks so they can get employed based on the particular needs of a couple? In a related context, how do different interplays of power affect different male couples and different needs? When does being the authority provide the most effective method? When is it most effective to be an equal in the co creation of a relational map specific to the couple? Most of these questions will be addressed in the remainder of this chapter.

Non-gay "Outsiders" wanting to "Come Out"

Similar to the subgroup of gay therapists, who mediate their more classical psychoanalytic theories with ideas from gay affirmative psychotherapy, the non-gay therapists in this study often mediate their dominant framework with their own emergent gay affirmative practice wisdom. However, there were differences between these two groups that stem from experiences related to sexual orientation. Just as many gay therapists want to have the choice to fit in and be accepted by the larger mainstream, many of the insiders (in this case, the non-gay therapists) seem to want to "come out" from the restraints of the hetero-dominant insider world and achieve the freedom an outsider may feel from "coming out" and owning their differences. Paul expressed this idea clearly when he asserted:

> I've come to deeply enjoy and look forward to working with gay men. And in fact, I always get excited when the hour comes when I work with

> gay men or a male couple. I find that gay men as opposed to straight men are, *generally* speaking, and I know this is a gross generalization because it is not always the case, much more interested in relationship. They have been forced, out of oppression and survival, to look at from whence they came, to think, at least a little about their family of origin, to try to understand how they fit into the bigger picture of our culture. They're also more interested in the nuances of it, they're interested in their feelings about it, they want to talk about it. They can cry, they can laugh about it and I don't feel that I have to generally do sort of Emotions 101. And again, this is not always the case, but it talks to a powerful pattern in gay male development that is unique. It makes me feel liberated.

Paul, as well as most of the other non-gay therapists interviewed, experienced freedom in working with gay male couples as compared to heterosexual couples. As a result of their heterosexuality, they were freed from the pressure of being an expert and "in the know" of all things gay, as they all acknowledged working outside their area of comfort and personal experience. Allowing the subjective realities of the couples to impact their inquiries seemed inadvertently to lead to a more social constructionist stance. By illustration of these constructionist leanings, they were liberated from usual, implicit, and sometimes unexamined restrictions with regard to gender and coupling that typically inform their work with non-gay couples. For instance, besides his focus on the potential for a positive relational outcome that stems from gay male development, Paul demonstrated throughout his comments how he has taken his overarching clinical paradigm of systems theory and extended it to include not only the individuals and their families of origin, but also the extended families of choice, the gay community, and the dominant culture.

It remains uncertain why the non-gay therapists in this sample seemed to more readily accept socially constructed foundations then some of the gay therapists. Perhaps capitalizing on this "coming-out-like" experience put the non-gay therapists in a frame of

mind that led them to more readily challenge the relationship between their dominant practice patterns and their socially constructed foundations? Or perhaps the interviewed gay therapists, because they wanted both to be legitimated and to feel assimilated in the competitive culture of private practice New York City, felt more compelled to demonstrate their grasp of more traditionally acknowledged essentialist knowledge? Perhaps for the non-gay therapists, the less familiar subject matter necessitates accepting more ambiguity and uncertainty than the gay therapists felt the need to do because they were more familiar with this area of practice, more personally entrenched, and as discussed earlier, had more rigorous expectations for answers demanded from their clients?

Moreover, as a group, the non-gay therapists averaged 8 years older than the gay therapists (see Table 1) and had been in practice longer. Perhaps they had less of a need to legitimize and demonstrate their knowledge, both because of their established years in practice and because, as heterosexuals, they never actually had to choose being "inside" throughout their lifetime. Or perhaps these differences are better accounted for by the random, skewed sample of this study, in which, for example, many of the non-gay therapists trained in a systemic approach that more readily lent itselfto social constructionist thinking.

Queer/Social Constructionism Encounters Essentialism

None of these questions in the last two segments are meant to imply a simple dichotomy: all gay therapists hold essentialist assumptions and are interested in assimilating and being legitimized by the mainstream and all non-gay therapists are social

constructionists who want to "come-out" from the heteronormative hegemony. There were examples given in these interviews where gay clinicians actively questioned the presuppositions that underlie their therapeutic interventions. Perhaps the clearest example was Bill, who is the therapist with the highest proportion of couple work making up his practice. He readily and actively questioned more established essentialist methods, integrated constructionist theories, and felt comfortable operating from a place of "not knowing" when working with the multiple and variable ways men couple (see, pgs. 192-193).

In fact, both gay theorists (Butler, 1990; Segwick, 1990), and gay psychoanalysts (Dresher, 1998; Goldner, 2003) are starting to lend their queer thinking to questioning and unpacking the social regulatory functions not only of psychotherapy, but also the limited ways of being gay in the world. However, the distinctions between non-gay and gay therapists are emphasized because the differences in the data were compelling. These differences highlight a warning to alltherapist s, but particularly to gay therapists, to remain aware of the combined impact of their personal and political journeys on their therapeutic leanings. Only when therapists have a process that unhooks the socially constructed aspects of their prevailing theories and therapeutic imagination, can they be free enough to question their own sociocultural and intrapsychic pressures and limitations and understand their implications for working with clients, particularly when the clients share similar socio-cultural and/or identity based characteristics.

Including a constructionist/queer stance among other perspectives not only challenges both the therapist and the client to become aware of how their social, cultural, familial, and psychological conditioning dictates how they create intimate relationships,

but also brings more diversity to the table of psychotherapy. In that vein, a social constructionist approach would argue that psychotherapy could first explore the nature and sources of client's beliefs about and experiences of sexuality, gender, and sexual orientation (Bohan & Russell, 1999) and then investigate how these forces shaped their personal narratives about coupling. Rather than working off a pre-determined pathway or developmental course with regard to relational intimacy, this process might create considerable space for male couples to more fully develop and accept more personalized approaches to coupling.

This is not to say that essentialist ideas cannot be helpful for many couples searching to feel more safety and security in a world that oppresses them and leaves them without guidance. The integrating of a GLB identity with other life issues focused on in gay affirmative psychotherapy and other essentialist psychodynamic psychotherapies offers a conceptual framework that helps both gay men and lesbian women to consolidate their sense of self, a necessary precursor to developing meaningful relationships. However, as demonstrated so clearly by the countless ways gay males construct their romantic images, sexual desires, gender identities, familial combinations, and life experiences into an intimate relationship, a therapist can no longer afford to rely on a single perspective or simply think of male couples as an alternative version of more conventional couples when doing couple work. Rather, access to varied epistemologies and psychotherapeutic inquiries that do not rely upon or require allegiance to already imagined answers can create enough therapeutic freedom to help male couples enhance their functioning and develop adaptive survival strategies specific to the two individuals.

As part of a larger picture of clinical practice's ongoing discourse about essentialism and legitimization versus social constructionism and postmodern thinking (Robbins, 1999), this data gave evidence of the complications that arise when the application of any theoretical knowledge base becomes an ideological stance or behavioral standard that gets strictly applied or assumed. Therefore, the direction suggested by this data for psychotherapists working with male couples might be drawing upon both essentialist and constructionist perspectives. The art becomes knowing when and where to use which one and when to emphasize the interaction of the two, in effective work (Mitchell, 1996; Appleby & Anastas, 1998).

All of us, in fact, regardless of sexual orientation, must play both sides of the epistemological fence, between essentialism and social constructionism, in order to maintain our sense of identity and live with some degree of security in an often insecure world. In other words, even as we recognize that essentialist constructs of identity and culture are fictitious, we nonetheless, inevitably at times, believe in these fictions as if they were essential truths.

In a sense, methodological pluralism also mirrors real life social and political negotiations and tensions. An example of this can be found in the current debate over same-sex marriage. Besides a fight for equal rights ("Excerpts," 2004), this struggle represents for some a desire to be part of the dominant institutions thatgive structure to relationships, but also, for many, a challenge to the very socially constructed core of what created that structure. As unsettled as this fight remains at the time of this writing, it offers the challenge for all people to confront how they think about the fixity of identities

and gender, the transformative possibilities of deconstructing traditional coupling, and new lessons about ways to enhance dyadic intimacy for all.

Section 3-Future Directions

As much as this study attempted to historicize, analyze and report on both the current state of male coupling and the ways therapists work with them, the inclusion of social constructionist and queer theories introduced further inquiries in need of answers. Perhaps, if I had relied only on essentialist epistemologies, more fixed practice principles and less unanswered questions would have emerged, but at the cost of limiting the conceptual complexity relevant to work with male couples. Instead, encountering why feminists, queer theorists and gay and lesbian academics are increasingly positioning ideas about gender, sexuality, and sexual orientation in a social constructed context (Goldner, 2003), phenomenologically diverse practice models best reflect the push and pull of biopsychosocial, legal, and cultural power plays that disperse throug hout the entire relational core of the couples studied.

Inherent in the acceptance of this more unpredictable style of practice development is the inclusion of a "queer" practice wisdom, which as much as it develops knowledge and bridges theoretical techniques and styles, also enables a clinician to embrace an open ended search for potential therapeutic challenges. Therefore, more and varied educational opportunities that include both social constructionist and queer theories into the fundamental paradigms of practice seem a necessary next step. Only then will disciplines that train psychotherapists help their students not only to understand

why these ideas originated, but also help them to more readily and consciously integrate them into other theoretical frameworks.

With that said, there are endless areas of ongoing negotiation and investigation, ripe for prospective inquiries. Future research would do well to continue to question the complexities of working within and outside one's own minority status, since early on in conceptualizing this research it became clear thatmale couples visit both gay identified and heterosexually identified clinicians (Green, 2000; Kurdek, 1998; Laird & Green, 1996). Because these interviews and this study did not focus specifically on the differences in these two groups, and there was not a balanced sample related to size, or potentially contaminating variables like years of experience as a therapist, educational degress, theoretical orientations, etc., the complexity of these methodological, conceptual and clinical concerns warrants further inquiry. Also, quantitative methodology could take into account the potential strengths and limitations of matching not only sexual orientation, but also other potential matchingfac tors, including, gender, personalities, cultural backgrounds, class, religion, ideological priorities, and racebetween therapists and clients.

As compelling as statements by non-gay therapists, like Paul, may be about the freedom he feels when working with gay men, comments like his raise other questions about working with gay men for heterosexually identified therapists. Does it free up competitive strivings, and give space to a desire for a different sort of male connection for the male therapist? Does it allow for a different experience of men for the non-gay women and a different experience of heterosexual men and women for the couples? These types of questions suggest future studies that might look at the direct impact of

working with same-sex couples on the self-image, gender beliefs and practice expectations of heterosexual therapists and their gay clients.

Clearly, there is much left to understand when working within ones own minority group. Inquiries about self-image and the complexity of working with men like oneself are also needed to better understand the processes of gay therapists. A qualitative evaluation could compare directly how gay therapists with different theoretical orientations deal with and remain open to various aspects, both conventional and unconventional, of male relationships. This research could explore, in depth, if and how some gay therapists' desire to be part of the "inside," established, more legitimized world of psychoanalysis impacts their work. Another study could take case examples and examine how clients who have significantly different experiences and perspectives about being gay and/or in a couple than their therapists, affect either the couple's sense of the work or the therapists, or both.

Research has established the effectiveness of couple therapy with heterosexual couples and indicates that therapy increases relational satisfaction (Christensen & Heavey, 1999). At a time when many believe male couples are appearing more like non-gay couples, some of these more quantitative research designs might be applied or redesigned to demonstrate the degree of effectiveness of couple therapy with contemporary male couples (Johnson & Lebow, 2000). Data from this research will not only help other clinicians to notice, name and normalize varied coupling models, but also alert researchers to find other than heteronormative constructs to evaluate intimacy. Measuring such content specific areas such as stigma, homophobia, perceived social supports, adaptation, and emotional fidelity before and after couples therapy might not

only provide an evaluation of the effectiveness of this type of work for male couples, but also lead to other ways of creating research and instruments geared directly to the needs of this population.

Much of the uncertainty throughout thedata analysis in this study was contained in still unanswered questions about both the effectiveness of certain psychotherapeutic interventions and styles of working with male couples. A more exploratory study that mirrored the qualitative design of this study could solicit from male couples what they thought was most effective about their treatment. It would be interesting to administer a standardized test of effectiveness to couples who have completed treatment, trying to control for the theoretical orientation of the therapist, in order to evaluate and compare outcomes. And as per the suggestions about blending essentialist and social constructionist viewpoints, if a large enough sample could be reached, it would be helpful to measure how this blend actually impacts perceived support and effectiveness.

Research that explores and deepens specific concerns, like sexual neutralization among male couples, the impact of drug acceptance in the gay community, the significance of commitment ceremonies and/or having children, all would lend to a fuller picture of male coupling. However, these few suggestions represent the proverbial tip of the iceberg for therapeutic practice. Most importantly, it is hoped that the questions and suggestions that emerge from this data stimulate more research that unpacks the presupposed values in theoretical orientations, that describes the usefulness of practice wisdom in creating other self-reflective and self-critical processes, that helps therapists incorporate a social constructionist view of couples therapy, and thatseeks a more in -

depth understanding of how to work with the concerns that cause distressfor this population.

In addition, the few research designs that include any sort of follow-up evaluations for couples show a trend of diminishing effects over time, especially beyond the first year after treatment (Christensen & Heavey, 1999). Because of the impact of these studies and the moderate success of psychotherapy to stop ever increasing divorce rates, the literature indicates that the field of couple therapy is increasingly accepting relationship preparation and crisis prevention as an integral part of its overall mission (Christensen & Heavey, 1999; Donavan, 1999). However, there is little if any published literature on applying any similar type of prevention work to same-sex couples (Wood, unpublished). Even though it seems clear thatmore work has to be done with regard to measuring the effectiveness of all types of couples therapy, this gap, in conjunction with the often varied and diverse redefinitions of intimate relationship thatgay men attempt to handle without even basic relationship skills, strongly supports the development of more research and programs focusing on prevention interventions geared specifically toward male couples.

Summation

Just as gay men and women are entitled to the same civil liberties as all other citizens--to have equal legal, financial and cultural rights--they are also entitled to find mental health professionals and programs that are well versed in the particular challenges that bring this population into treatment. This study argues for an ongoing critical and deconstructive process, both in the consultation room and outside of it, thatrequi res that

therapists stay sensitized to male couples' unique waysof defining their relationships and the impact of the pervasive lack of societal supports they still encounter. Otherwise, the therapeutic process may inadvertently reinforce stigma by prescribing limited and/or heterosexist visions of relationships based upon theoretical presumptions and political assumptions about social equality that do not necessarily apply to gay men.

The data from this study strongly suggests that adhering to one, particular theoretical approach when treating gay male couples results in inadequate and frequently misattuned intervention strategies. Neither do efforts to apply generic models of integrated theories successfully address the particularities of each couple's psychosocial reality. Rather, as is true of all competent clinicians, practitioners working with gay male couples must entwine their theoretical understanding of human behavior with the specific relational experiences of the particular couple in treatment. Therapist and couple join forces in a socially constructed process that both responds to and often breaks with social and therapeutic convention. The art of a successful intimate relationship requires a couple to be flexible with individual and dyadic boundaries. Similarly, the art of psychotherapy with gay male couples seems to center on knowing when to work inside, outside, or across the lines of dominant clinical theories, therapeutic processes, and socially constructed beliefs about what makes healthy and satisfying relationships.

TABLE I
DEMOGRAPHIC PROFILES

NAME	AGE	GENDER	SEXUAL ORIENTATION	DEGREE	THEORETICAL ORIENTATION
Robert	38	Male	Gay	Social work	Eclectic
Bill	53	Male	Gay	Psychology	Systemic Relational
Henry	52	Male	Gay	Social work	Family systems
Jill	43	Female	Non-gay	Psychology	Integrative
Paul	44	Male	Non-gay	Psychology	Systemic
Frank	54	Male	Non-gay	Social work	Interpersonal
Arthur	44	Male	Gay	Social work	Analytic
Mark	40	Male	Non-gay	Social work	Psychodynamic
Ellen	42	Female	Gay	Social work	Psychodynamic
Carlos	48	Male	Gay	Social work	Self-psychology
David	47	Male	Gay	Social work	Psychoanalytic
Barry	38	Male	Gay	Social work	Interpersonal Integrative
Michael	53	Male	Non-gay	Psychologist	Relational Experiential
Marietta	61	Female	Non-gay	Psychologist	Systems/Dynamic
John	45	Male	Gay	Social work	Psychoanalytic
Margo	51	Female	Gay	Social work	Relational
Mary	48	Female	Non-gay	Social work	Relational
Edna	55	Female	Non-gay	Social work	Eclectic
Eric	46	Male	Gay	Social work	Analytic Interpersonal
Irwin	62	Male	Non-gay	Social work	Integrative

APPENDIX 1

INTERVIEW GUIDE

OPENING STATEMENT:

With a goal of self-reflection in mind, today I want to interview you about how you developed what is referred to in the social work literature as practice wisdom. Practice wisdom is defined as knowledge that emerges directly out of your ongoing experiences with a specific population, in this case male couples.

It is the purpose of this research to describe what experienced clinicians report as the practice principles most helpful when working with male couples. In addition, this project will attempt to document the concerns of contemporary male couples who attend therapy. What will be most helpful is that you speak directly from your personal and practice experiences, and whenever possible support your ideas with experiences from your clinical work. All your responses will be kept confidential and your anonymity will be protected from everyone. With your permission, I will tape record our interview.

TOPIC: Pre-existing knowledge

1). What most prepared you for your work with male couples? (How did this help?)

PROMPTS: your graduate education, post graduate training, workshops, supervision, your own therapy, influence of your sexual orientation, your own experiences of being single and coupled, influence of generational issues or your age, gender, ethnicity

2). If a colleague asked you to describe your theoretical orientation in regard to male couples, how would you describe it? What are its strengths and limitations?

PROMPTS: Integrative, systems, gay affirmative, etc. other approaches, expectations, most useful aspects

3.) When you first started working with male couples, what, if anything got in the way of treating these couple as effectively as you could have?

PROMPTS: own experience, your practice approach, over or under identification, value judgments, theories that informed your work and how you utilized them, conflicts with your clinical education, ideals versus reality, rigidity, exmapl;es

TOPIC: Discovering gaps in the knowledge base

4). Think of a couple, or a particular moment in your work, when a therapeutic impasse related to the couple being gay men forced you to discover a new way of working or apply different knowledge. Describe the circumstances and what happened.

PROMPTS: what was the failure or gap in knowledge base, countertransferential obstacles, limited beliefs, preparation, training,

supervision, personal experience, theoretical gaps and modifications, specific interventions

5). Over time, how did you correct this?

PROMPTS: specific interventions, new thought process, imagination, trial and error, other theories, mini- hypotheses, value shifts finding similarities, differences with other couples, types of couples, stages of couples, value shifts

6). As you reflect on this case, what did you learn that might have translated into intervention strategies or beliefs about male couples that you utilized or generalized in future cases?

PROMPTS: structuring sessions, use of theory, ideas about male couples, types of couples, stages about couples, specific needs based on ages or stages of life of the men , power differentials

TOPIC: Bridging subjective experiences with objective knowledge

7). Choose another couple, or a particular moment in your work, when your knowledge or experience related to the couple being gay men felt insufficient for effective work. Again, describe the circumstances and what felt ineffective?

8). Over time, what did you learn from this gap in your knowledge base and how are you applying it now?

PROMPTS: specific interventions, new thought process, imagination, trial and error, other theories, mini- hypotheses, value shifts, finding similarities, differences with other couples, types of couples, stages of coupling

9). Utilizing these two cases, or any others you believe are relevant examples from your practice, identify other aspects of your knowledge base or practice principles that you have learned through direct clinical experience and not necessarily through your education or training.

PROMPTS: hypotheses about male couples, interventions, style of working countertransferential obstacles, cultural needs, revision in concepts, practice principles, ideas about relationships in general, values

TOPIC: Beliefs about male coupling

10.) Based on your practice experiences, what do you believe are some of the essential common characteristics of male couples?

PROMPTS: impact of homophobia, lack of social, political and familial supports, impact of gay community, gender norms erotic concerns, loss of sexual desire, HIV, others

11). Again, based on your practice experience, what are the most challenging issues facing today's male couples?

PROMPTS: How long has this been true? All or some couples? Details

12.) What are your observations about the way male couples have changed since you started to practice?

PROMPTS: sexual arrangements, social and/or political climate, visibility, AIDS epidemics, HIV status, the increased possibilities of children, etc,

13) How have these changes affected how you work?

TOPIC: Differences between working with male couples and straight couples

14). Based on your practice experiences, how are male couples similar to and different from straight couples?

PROMPTS: sexual arrangements, children, family, stigma, inter-cultural needs, rituals, assimilation, legal, financial

15). What do you believe are some of the significant differences between working with gay male couples and straight couples?

TOPIC: Self- Reflection; Emerging theories

16). What have you learned from the male couples you have worked with?

17). What advice would you give to other clinicians working with male couples?

Appendix 2

Demographic Face Sheet

(Mailed out with consent form after the initial phone consent to participate)

1) **Your degree/ discipline?**

   a. **Social work b) Psychology c) Psychiatrist d) Other**

2) **Years in practice?**_____

3) **Major theoretical focus of your training/education?**_____

4) **Gender?** _____

5) **Age?**_____

6) **Ethnicity?**_____

7) **Race?**_____

8) **How would you describe your present theoretical orientation?**

   _____

9) **Approximate percentage of couples you see that are male couples?**

Name_____ **Date**_____

Signature_____

Appendix 3

Preparation for the Interview

To help the interview process move along, it would be helpful to think of at least two male couples you have worked with (or gay men with relationship concerns) that might help you respond to the following types of questions:

1). Recall a couple, or a particular moment in you work with a male relationship, when your knowledge or experience felt insufficient for effective work?

2). How did you deal with this "gap" in your knowledge base?

3). Think about another couple you have worked with where you experienced a gap in your knowledge or had difficulty intervening particularly because they were two gay men? Again, describe the circumstances and what felt difficult?

4). Over time, what did you learn from this gap in your knowledge base/ difficulty and how are you applying this experience now?

5). Utilizing these two cases, or any others you believe are relevant examples from your practice, identify aspects of your knowledge base that you have learned through experience and not through your training?

Appendix 4
Consent Form

Steven Ball is a doctoral student at Hunter College School of Social Work (CUNY) conducting research that will describe what clinicians report as the practice wisdom they find most helpful when working clinically with contemporary male couples. The study is part of his doctoral requirements to complete his PhD and might be used in the future for other scholarly endeavors. You are being asked to share your experiences and self-reflection as a clinician who has worked with gay male couples. It is anticipated at this time that 20 subjects will be needed to complete the data collection process.

You will gain little direct benefit from the study. It may afford the opportunity to articulate your own evolving practice principles in regard to male couples. However, even if there is no direct benefit to you, it could benefit other clinicians with an emergent knowledge base that further documents the unique concerns of doing therapy with contemporary male couples.

The study will involve a structured, one-hour, interview. This interview will include questions on your perspectives on treatment with male couples. You will be able to meet or talk in a private place, wherever it is most convenient for you. With your consent, the interview will be audio taped, so that the researcher can be as efficient as possible and have a clear record of your answers. This will be accomplished without having your name on the audio track or written on the tape, and no one will hear the tape but the transcriber/researcher, who will transcribe the tape and discard it after transcription. If you are uncomfortable being taped, you can sign below and still be interviewed and recorded with hand-written process notes.

The only foreseeable risk in participating would be anxiety over volunteering time for the interview and/or reflecting on a particular question. You can skip any questions that elicit discomfort and you are free to withdraw from this study at any point without penalties of any sort. It is highly unlikely that the study will raise any painful or upsetting issues, but

in the event of upset or concern at any time in the process you can contact the researcher or the doctoral chairperson, Professor Irwin Epstein at 212-452-7030. Understand, in the unlikely event that the interview reveals a need to report the potential to harm others, or yourself, the limits of confidentiality apply.

You understand participation is voluntary and no one but the researcher/interviewer will know of your participation in this study. Your identity will remain completely confidential and no identifying information will be used in the reporting of the data. Findings will be in aggregated form and reported in such a way to mask any characteristics that might tend to identify your answers, your clients or you. All materials will be kept in a locked file to which only the researcher has access. The researcher will keep the data for three years. After that, all materials will be discarded. If you would like a summary of the data results please initial the area below.

If you have any further questions about this study you can contact Steven Ball, (212)-691-5396 or his faculty advisor, Irwin Epstein at 212-452-7030. If you have questions about your rights as a subject or if you feel you have experienced a research-related injury, please contact the Hunter College Office of Research Administration, (212) 772-4020.

Sign below, and the audio release form, if you *agree* to be audio taped

_____

Sign here if you do *not* want to be audio taped_____

I understand the purpose and procedures of this project and the predictable discomfort, risks and benefits that might result have been explained to me. I have had an opportunity to discuss this with the researcher and all of my questions have been answered. I agree to participate as a volunteer in this research, understand my rights as a subject in this project and hereby give my consent to participate.

Please Sign_____, Date_____

Receive summary of results (Initial)_____

Researcher's signature_____, Date_____

References

Abramowitz, S. I. & Murray, J. (1983). Race effect in psychotherapy. In J. Murray & P. Abramson (Eds.), Bias in Psychotherapy. (pp. 215- 255). New York: Praeger.

Adler, P. & Adler, P. (1994). Observational techniques. In N. Denzin & Lincoln (Eds.) Handbook of Qualitative Research. (pp. 45- 65). Newbury Park, CA: Sage.

Advocate. (1997, May). National Sex Survey, 6, 1-2.

Alexander. C. (1997a). Factors contributing to the termination of long-term gay male relationships. R. Berger & Kelly (Eds.) . Journal of Gay and Lesbian Social Services , 7(1), 1-12 .

Alexander, C. (1997 b) Growth and intimacy for gay men: A work book. New York: The Haworth Press.

Allen, K. & Demo, D. (1995). The families of lesbians and gay men: A new frontier in family research. Journal of Marriage and the Family, 57, 1-17.

Appleby, G. A. & Anastas, J. W. (1998). Not just a passing phase: Social work with gay, lesbian and bisexual people. New York: Colombia University Press.

Appleby, G. A. (2001). Working class gay and bisexual men. Journal of Gay and Lesbian Social Services, 12, 3/4, 5-45.

Ayers, I & Brown, P. (1999). The essential guide to lesbian and gay weddings. San Francisco: Harper Books.

Ball, S. (1966). HIV-Negative gay men: Individual and community needs. In M. Shernoff (Ed.), Human services for gay people: Clinical and community social service needs. (pp. 25-400). New York: Haworth Press.

Ball. S. (1998). The HIV-Negative Gay Man: Developing strategies for survival and emotional well-being. New York: Haworth Press.

Ball, S, & Lipton, B. (1996). Group work with gay men. In G. Grief & P. Ephross (Eds.), Group work with populations at risk. (pp. 259-277). New York: Oxford Press.

Bateson, G. (1958). Naven (2nd ed.). Stanford, CA: Stanford University Press

Bawer, B. (1993). A place at the table. New York: Poseidan Press.

Bayer, R. (1987) Homosexuality and American psychiatry: The politics of diagnosis. Princeton, NJ: Princeton University Press.

Becker, H. (1986). Doing things together. Evaston, Illinois: Northwestern University Press.

Becvar, D. S. & Becvar, R. J. (1996). Family systems: A systemic integrations, Boston: Allyn and Bacon.

Beiber, I. (1962). Homosexuality : A psychoanalytic study. New York: Basic Books.

Bell, A. & Weinberg, M. (1978). Homosexualities: A study of diversity among men and women. New York: Simon & Schuster.

Bebko, C, & Johnson, T. (2000). Gay and lesbian couples therapy: Perspectives for the contemporary family therapist. Journal of Marital and Family Therapy, 26, 4, 409-419.

Beren, S. E., Hayden, H. A., Wilfey, D. E., & Grilo, C.M. (1996). The influence of sexual orientation on body dissatisfaction in adult men and women. International Journal of Eating Disorders, 20, 135-11.

Berger. R. (1990). Men together: understanding the gay couple. Journal of Homosexuality, 19(3), New York: Haworth Press.

Bergin, A. E. & Garfield. S. L. (1994). Handbook of psychotherapy and behavior change. New York: John Wiley and Sons, Inc.

Bernstein, A. (2000). Straight therapist working with lesbians and gays in family therapy. Journal of Marital and Family Therapy, 26, 443-454.

Berzoff, J. &Melano Flanagan, L, & Hertz, P. (1996) Inside out and outside in: Psychodynamic clinical theory and practice in contemporary multicultural contexts. New Jersey: Jason Aronson, Inc.

Berzon, B. (1996). The intimacy dance: A guide to long-term success in gay and lesbian relationships. New York: Dutton.

Berube, A. (1990). Out under fire: The history of gay men and women in World War 11. New York: The Free Press.

Beutler, L. E. & Machado, P.P. and Neufeldt, S. A. (1994). Therapist variables. In A. Bergin & S. Garfield, (Eds.) , Handbook of psychotherapy and behavior change. (pp. 229-269). New York: John Wiley and Sons, Inc.

Blair, R. (1975). Counseling and homosexuality: Keynote address of the 1975 national conference series of the Homosexual Counseling Journal. Homosexual Counseling Journal, (2), 94-106.

Blasband D. & Peplau L. (1985). Sexual exclusivity versus openness in gay male couples, Archives of Sexual Behavior, 14, 395-412.

Blumenfeld, W.J. & Raymond, D. (1993). Looking at gay and lesbian life. Berkeley: Celestial Arts.

Blumstein, P. & Schwartz, P. (1983). American Couples: Money, work and sex. New York: Pocketbooks.

Bogdan R. & Biklen, S. (1982). Qualitative research for education: An introduction to theory and methods. Boston, MA: Allyn & Bacon.

Bohan, J. S. & Russell, G. M. (1999). Conversation about Psychology and Sexual Orientation. New York: New York University Press.

Bowen, M. (1978). Family therapy in clinical practice. Northvlae, NJ:Arosnon.

Bowman, P. (1982). An analog study with beginning therapist suggesting bias against 'activity" in women. Psychotherapy: Theory, Research and Practice, 19, 318-324.

Brown, L. S. (1989). New voices, new vision: Toward a lesbian /gay paradigm for psychology. Psychology of Women Quarterly, 13, 445-456.

Brown, L. S. & Zimmer, D. (1986). Therapy issues of lesbian and gay couples. In N. Jacobson, &.A. Gurman, (Eds.) Clinical handbook of marital therapy. (pp. 228-268). New York: The Guilford Press.

Browning F. (1993). The culture of desire: paradox and perversity in gay lives today. New York: Crown.

Bryant A. S. & Demian (1994). Relationship Characteristics of American Gay and Lesbian couples: Findings from a National Survey. Journal of Gay and Lesbian Social Services, 1, (2), 101-117.

Bumiller, E. (2003, November 23). What partisans embrace, politician s fear. The New York Times, pp.4.1, 4.4.

Butler, D. (1997). Ceremonies of the Heart. Seattle: Sea Press.

Butler, J. (1990). Gender trouble: Feminism and the subversion of identity. London: Routledge.

Butlers, H., Davis, I. & Kukkonen, R. (1979). The logic of case comparison. Social work Research and Abstracts, 3, 3-11.

Cabaj, R. (1991). Overidentification with a patient. In C. Silverstein (Ed.). Gays and lesbians and their therapy. (pp. 31-39). New York: Norton.

Cabaj, R. & Pucell, D. (1998). On the road to same-sex marriage. San Francisco; Josey- Bass Publishers.

Cain, R. (1991). Stigma management and gay identity development. Social Work, 3(1), 67-73.

Cardell, M., Finn, S. & Marecek, J. (1981). Sex-role identity, sex role behavior and satisfaction in heterosexual lesbian and gay male couples. Psychology of Women Quarterly, 5, 488-496.

Cass, V. (1979). Homosexual identify formation: a theoretical model. Journal of Homosexuality, 4, 219-235.

Champagne, J. (1993) Seven speculations of queers and class. Journal of Homosexuality, 26, 159-174.

Chauncey, G. (1994). Gay New York: Gender, urban culture and the making of the gay world 1890-1940. New York; Basic Books.

Chodorow, N. J. (1978). The reproduction of mothering: Psychoanalysis and the Society of Gender. Berkeley: University of California Press.

Christensen A. & Heavey C. (1999). Interventions for couples. Annual Review of Psychology, 50, 165-190.

Clunis, D & Green, G. (1988). Lesbian Couples. Seattle: Seal Press.

Cochran, S. & Mays, V. (1994). Depressive distress among homosexuality active African American men and women. American Journal of Psychiatry, 151, 524-529.

Cohen, F. & Farell, D. (1984). Models of the mind. In H. Goldman (Ed.) Review of general psychiatry. Los Altos, CA: Lange Medical Publications.

Cole, S. (1992). Making science; between nature and society. Cambridge, MA: Harvard University Press.

Coleman, E. (1985). Developmental stages of the coming out process. In J. Gonsiorek (Ed.) A guide to psychotherapy with gay and lesbian clients.(pp. 31-43). New York: Harrington Park Press.

Cornett, C. (1995). Reclining the authentic self: psychotherapy with gay men. Northvale, NJ: Jason Aronson, Inc.

Council on Social Work Education, (1994). Curriculum policy statement: Handbook of accreditation standards and procedures. Alexandria: Commission on Accreditation, Council of Social work Education.

Cox, E O. & Gallois, C. (1996) Gay and lesbian identity development: A social identity perspective. Journal of Homosexuality, 30 (4), 1-30.

Cramer, E. (1997). Strategies for reducing social work student's homophobia. In J. Sears & W. Williams (Eds.) Overcoming heterosexism and homophobia. (pp.272-287). New York: Colombia University Press.

Dank, B. M. (1973). The homosexual. In D. Spiegel & P. Keith-Spiegal (Eds.) Outsiders, USA: Original essays of 24 outgroups in American society. (pp. 85-99 . New York: Rinehart.

Decker, R. J. (1988). Effective psychotherapy: The silent dialogue. New York: Hemisphere Books

Decrescenzo, T. (1984). Homophobia: A study of attitudes of mental health professions toward homosexuality. Journal of Social Work and Homosexuality,2, 115-136.

Deenen, A. & Gijs, L. & Naerssen, A. (1994). Intimacy and sexuality in gay male couples. Archives of Sexual Behavior, 23, (4), 421-431.

Deitz, S. M. (1978). Current status of applied behavior analysis: Science versus technology. American Psychologist, 33, 805-813.

D'Emilio, J. & Freedman, E. B. (1988). Intimate matters: A history of sexuality in America. New York: Harper and Row.

De Roos, Y. (1990). The development of practice wisdom through human problem-solving process. Social Service Review. June, 1990, 276-287.

De Simone, M. (2000). The aesthetics of self-disclosure: Countertransference as deep play. The Clinician, 31, 7-9.

Deyton, B. & Lear, W. (1988). A brief history of gay/lesbian health movement in the USA. In M. Shernoff & W. Scott (Eds.) The sourcebook of lesbian/gay healthcare. (pp. 15-19) Washington DC: National Lesbian/Gay Health Foundation.

Doherty, W. J. & Simmons, D. S. (1996). Clinical practice patterns of marriage and family therapists: A national survey of therapist and their clients. Journal of Marital and Family Therapy, 22, 9-25.

Donovan, J. (1999). Brief couple therapy: Lessons form the history of brief individual treatment. Psychotherapy, 35 (1), 116-129.

Doyal, L. (1979). The political economy of health. London: Boston: South End Press, 1-46.

Drescher, J, (1998). Psychoanalytic therapy and the gay man. Hillside, N.J.: The Analytic Press.

Duberman. M. (1991). Cures. New York: Dutton.

Du Bois, B. (1983). Passionate scholarship: Notes on values, knowing and method in feminist social science. In G, Bowles and R. Klein (Eds.) Theories of women's studies. (pp.105-116). London & Boston: Routeldge & K. Paul.

Easton. M. (1986). The effect on unrealistic expectations on satisfaction and duration in male couples. unpublished doctoral dissertation, Hofstra University, 1986.

Ekstrand, M.L., Stall, R.D., Paul, J.P, Osmond, D.H., Paul, J. & Stall, R.D. (1999). Gay men report high rates of unprotected anal sex with partners of unknown or serodiscordant status, AIDS, 12, 1525-1533.

Ely, M., Anzul, M., Freidman, T., Garner, D., and Steimetz, A. M., (1991). Doing qualitative research: Circles within circles. New York: The Falmer Press

Epstein, L. (1992), Brief treatment and a new look at the task-centered approach. (pp. 321-330). New York: Mc Millan.

Erickson, M. H. & Rossi, E. L. (1980). TheFebruary man: Facilitating a new identity in hypnotherapy. In E. Rossi (Ed.), The collected papers of Milton Erickson on hypnosis, IV, Innovative hypnotherapy. (pp. 212-223). New York: Irvington.

Eskridge, W. N. (2002). Equality practice: Civil Unions and the future of gay rights. New York: Rutledge.

Excerpts from ruling on gay marriage. (2004, February 15). New York Times, p. A 27.

Finchman, F. (1993). Communicating in relationships. Champaign :Research Press.

Forstein, M. (1986). Psychodynamic psychotherapy with gay make couples. In T. Stein & C. Cohen (Eds.) Psychotherapy with lesbians and gay men. (pp. 103-137). New York: Plenum Publishing Co.

Forstein, M. (1994). Psychotherapy with gay male couples: Loving in the time of AIDS. In Cadwell, Burnham & Forstein, (Eds.) Therapists of the front line: Psychotherapy with gay men in the age of AIDS. (pp. 52-71) Washington, D. C. American Psychiatric Press, Inc.

Foucault, M. (1978). The History of sexuality Volume 1: An Introduction. translated by R. Hurley. New York: Pantheon. (Originally published in 1976)

Fraenkel, P. (1982). Systems approach to couple therapy. In K.Halford and H., Markman, (Eds.) Clinical Handbook of Marriage and Couple Interventions (pp. 134-155). Chichester, England: John Wiley and Sons.

Freud, S. (1963). Further recommendations in the technique of psychoanalysis: Observations on transference-love. In P. Rieff (Ed.), Freud: Therapy and technique. (pp. 167-180). New York: Collier Books.

Freud S, (1905/1962). Three essays on the theory of sexuality. New York: Harper Collins Publishers.

Freud, S, (1951). Clinical observations on the treatment of male homosexuality, Psychoanalytic Quarterly, Vol.20, 337-339.

Friedman, E. (1991). Bowen theory and therapy. In A. Gurman & D. Kniskern (Eds.) The handbook of family therapy :Vol. 2. (pp. 143-170). New York: Bruner & Mazel.

Friedman, R. C. (1988.) Male homosexuality: A contemporary psychoanalytic perspective. New Haven: Yale University Press.

Frommer. M. (1995). Countertransference obscurity in the psychoanalytic treatment of homosexual patients. In T. Domenici, T. & R. C. Lesser (Eds.), Disorienting sexuality: psychoanalytic reappraisal of sexual identities. (pp. 134-163). New York and London: Routledge.

Fuss, D. (1991). Inside/out: Lesbian theories: Gay theories. New York: Routledge Press.

Garfield, S. L. (1980). Psychotherapy: An eclectic approach. New York: Wiley.

Gilgun, J. F. (1992) Hypothesis generation in social work research. Journal of Social Service Research, 15(3/4), 112-135.

Gilgun. J. F. (1994). Hand in glove: The grounded theory approach and social work research. In E. Sherman and W. Reid (Eds.). Qualitative research in social work. (pp. 115-125). New York: Colombia University Press,.

Giligan, C. (1982). In a Different Voice: Psychological theory and Women's' Development. Cambridge, Mass. Harvard University Press.

Glaser B. & Strauss, A. (1967). Discovery of grounded theory: Strategies of qualitative research. Chicago: Aldine Publishing Co.

Goldfried, M. R. & M. R. Newman, C. F. (1992). A history of psychotherapy integration. In J C. Nocross & M. R. Goldfried (Eds.) Handbook of psychotherapy integration . (pp. 502-532). New York: Basic Books.

Goldner V. (1985) Feminism and family therapy. Family Process, 24, 31-47.

Goldner, V. (1995). Toward a critical relational theory of gender, Psychoanalytic Dialogues, 1, 249-272.

Goldner, V. (2003). Ironic gender/Authentic sex. Studies in Gender and Sexuality (4), 1. 113-139.

Gonsiorek J. (1982). Homosexuality : the end of a mental illness, Special issue of American Behavioral Scientist, March/April Vol. 25, number 4.

Gonsiorek, J. (1985). A guide to psychotherapy with gay and lesbian clients. New York: Harrington Park Press.

Gonsiorek, J. (1988). Current and future directions in gay/lesbian affirmative mental health practice. In M. Shernoff, M. & W. Scott, (Eds.) The sourcebook on lesbian/gay health care, second edition. (pp. 107-113).Washington D.C.: National Lesbian/gay health foundation.

Goodrich, T. J., Rampage, C. Ellman B. & Halstead, K. (1988). Feminist family therapy: A casebook. New York: Norton & Co.

Goransson, L. (1998). International trends in same-sex marriage. In R. B. Cabaj & D. W. Purcell (Eds.) On the road to same-sex marriage. San Francisco: Josey-Bass Publishers.

Green, R.; Bettinger, M.; Zacks, E. (1996). Are lesbian couples fused and gay male couples disengaged? In (Eds.) Laird, J. & Green, R. Lesbians and gays in couples and families: A handbook for therapists . (pp.185-230). San Francisco: Jossey-Bass Publishers.

Green. R. (2000) Introduction to special section: Lesbian, gay and bisexual issues in family therapy, Journal of Marital and Family Therapy. 26, 407-408.

Greene, B. (1995). Addressing, racism, sexism, and heterosexism in psychoanalytic psychotherapy, In (Eds.) J, M. Glassgold & Iasenza, S. Lesbians and psychoanalysis: Revolutions in theory and practice. (pp.145-159). New York: Free Press.

Greenson, R. R. (1974). Loving, hating and indifferences towards the patients, International Review of Psychoanalysis, 1, 259-266.

Griffiths, D. (1984). The sexual relationships of established gay male couples. Unpublished doctoral dissertation, Boston University School of Education.

Grosssman, C. M. (1965) Transference, countertransference and being in love. Psychoanalytic Quarterly, 34, 249-256.

Guba, E. & Lincoln, Y. (1994). Competing paradigms in qualitative research. In (Ed.) Denzin and Lincoln. Handbook of qualitative research.(pp. 43-56) .Newberry, CA: Sage.

Gurman, A. S., Kniskern, D. P., & Pinsof, W. M. (1986). Research of the process and outcome of marital therapy and family therapy. In S. L. Garfiled & A. E. Bergin (Eds.), Handbook pf psychotherapy and behavior change. (pp. 565-624). New York: Wiley.

Halkitis, P.N. & Wilton, L. (1999). Beyond complacency: The effects of treatment advances on HIV transmission. Focus: A guided to AIDS research and counseling, 14(5), 1-5.

Hare-Mustin, R. Y. (1987). The problem of gender in family therapy theory. Family Process, 26, 15-67.

Hare-Mustin & Marecek (1998). The meaning of difference: Gender theory, postmodernism, and psychology. In B. M. Clinchy & J. K. Norem (Eds.), The gender and psychology reader. New York: New York University Press

Harper, A. (1963). Psychological aspects of homosexuality. In H. G. Beiger (Ed.) Advances in sex research. (pp. 197-197). New York: Harper,

Harry, J. & DeVall, W. (1978). The social organization of gay males. New York: Praeger.

Harry, J. & Lovely, R. (1979). Gay marriages and communities of sexual orientation. Alternative Lifestyles, #2, 117-200.

Hartmann, A. (1992). In search of subjugated knowledge. Social Work ,37(2), 483-484.

Hendrix, H. (1992). Keeping the love you find. New York: Pocket Books.

Herek, G. (1984). Beyond homophobia: A social psychological perspective on attitudes towards gays and lesbians. Journal of Homosexuality, 10(1), 1-18.

Herek, G. (1991). Stigma, prejudice and violence against lesbians and *gays*. In J. Gonsiorek J, & M. Weinrich, (Eds.) Homosexually: Research findings for public policy. (pp. 60-80). Newbury Park, California: Sage,

Herek, G. (1991). Myths and sexual orientation; A lawyer's guide to social science research. Law and sexuality: A review of Lesbian and gay legal issues 133-172.

Herek, G. (1995). Psychological heterosexism in the United States. In D'Augelli and C. Patteron (Eds.) Lesbian and gay, and bisexual identities over the lifespan. (pp. 321-346). New York: Oxford Press.

Hodges, A. & Hutter, D. (1974). Downcast gays. London: Pomegrante Press.

Hoffman, M., (1968), The gay world: Male homosexuality and the social creation of evil. New York: Basic Books

Hooker, E. A, (1957). The adjustment of the male overt homosexual. Journal of Projective Techniques. 21, 17-31.

Hooker, E. (1965). Male homosexuals in their world. In J. Marmour (Ed.). Sexual Inversion. (pp. 121-134). New York: Basic Books

Horney. K. (1967). The flight from womanhood. Feminine Psychology. New York: Norton, 54-70.

Horowitz, L. (2000). Resisting amnesia in the countertransference: A clinical strategy for working with lesbian patients. Clinical Social Work Journal, 28, 55-70.

Imre, R. W. (1984). The nature of knowledge in social work. Social Work, 29, 41-44.

Isay, R. (1989). Being homosexual; gay men and their development. New York: Farrar, Straus and Giroux.

Jacobson, N. S., & Gurman, A.S. (1995). Clinical handbook of couple therapy. New York: Guiford.

Janesick, V. (1994). The dance of qualitative research design: Metaphor, methodolatry and meaning. In (Eds.) Denzin & Lincoln, Handbook of qualitative research. (pp. 209-219). Newbury Park, CA:Sage.

Jick, T. (1983). Mixing qualitative and quantitative methods:Triangulalton in Action In (Ed.) Van Maanan, Qualitative Methodology.(pp.602-941). Newbury, CA:Sage.

Johnson, S. & Lebow, J. (2000). The "coming of age" of couple therapy: A decade review. Journal of Marital and Family Therapy, 26 (1), 23-38.

Johnson T. W. and Keren, M. S. (1996). Creating and maintaining boundaries in male couples. In (Eds.) Laird, J. & Green, R. Lesbians and Gays in couples and families: A handbook for therapists .(pp. 231-249).San Francisco: Jossey-Bass Publishers.

Julian, D. & Chartrand, E., & Begin, J. (1996). Male couples' dyadic adjustment and the use of safer sex with and outside of primary relationships. Journal of Family Psychology, 10, 89-96.

Kanuha, V. K. (2000). 'Being native' versus "going native": Conducting social work research as an insider. Social Work, 45, 439-447.

Kaplan, J. A. (2000). Introduction. Clinical Social Work Journal, 28(4), 413-416.

Karpel, M (1994). Evaluating couples: A handbook for practitioners. New York: W. & W. Norton & Co.

Katz, N. (1983). The treatment of homosexuals in colonial America . Gay/Lesbian Almanac. (pp. 23-133). New York: Colombia Press.

Keller, E. F. (1989.) Holding the center of feminist theory. Women's Studies International Forum, 12(3), 313-18.

Kinsey. A.C., Pomeroy, W.; Martin, C. & Gebhard, P. (1948). Sexual behavior in the human male. Philadelphia: W.B. Saunders.

Klein, W.C. & Bloom, M. (1995). Practice wisdom. Social Work, 40 (6), 799-807.

Kottler, J. A. (1991). The Compleat Therapist. San Francisco: Jossey -Bass.

Kurdek L A. & Schmitt, J. P. (1986). " Relationship quality of gay men in closed and open relationships. In J. Cecco (Ed.) Gay relationships. (pp. 85-99). Haworth Press, New York.

Kurdek, L.A. & Schmitt. J. P. (1986) Relationship quality of partners in heterosexual married, heterosexual cohabitating, and gay and lesbian relationships. Journal of personality and social psychology, 51, 711-720.

Kurdek, L.A. & Schmitt, J. P. (1987) Perceived emotional support from family and friends of homosexual, married, heterosexual cohabitating couples. Journal of Homosexuality, 14, 57-68.

Kurdek, L. A. (1995). Lesbian and gay couples. In A. R. D'Augelli & C. J. Patterson (Eds.) Lesbian, gay and bisexual identities over the lifespan: Psychological perspectives (pp. 243-261). New York: Oxford Press.

Kurdek, L. (1998). Relationship outcome and their predictors: Longitudinal evidence from heterosexual married, gay cohabitating, and lesbian cohabitating couples. Journal of Marriage and Family, 60, 553-568.

Laird, J. (1993). Lesbian and gay families, In F. Walsh (Ed.) Normal family processes.(pp. 282-328). New York: Guilford.

Laird, J. & Green, R.J. (Eds.) (1996). Lesbian and gays in couples and families: A handbook for therapists. San Francisco: Jossey-Bass.

Lange, R. J. (1982). Countertransference and the process of cure. In S. Slipp (Ed.), Curative factors of dynamic psychotherapy.(pp. 127-152)> New York: McGraw – Hill.

La Sala, M.C. (2000). Lesbian, gay, men and their parents: Family therapy for the coming-out crisis. Family Process, 39, 67-81.

La Sala, M. C. (2001). Monogamous or not: Understanding and counseling gay male couples. Families in Society: The Journal of Contemporary Humans Services, 82, (6), 605-611.

La Sala, M. C. (2003). When interviewing "family": Maximizing the insider advantage in the qualitative study of lesbians and gay men. Journal of Gay and Lesbian Social Services, 15,15-30.

Lebolt, J. (1999). Gay affirmative psychotherapy: A phenomenological study. Clinical Journal of Homosexuality (10), 401-418.

Lee, J. A. (1976). Forbidden colors of love: Patterns of gay love and gay liberation. Journal of Homosexuality (10), 401-418.

Lee J. (1991). An annotated bibliography of gay and lesbian readings. New York: Cummings & Hathaway.

Lefley, H. P. (1985). Mental health training across cultures. In P. Pedersen (Ed.) Handbook of cross-cultural counseling and therapy.(pp. 259-266).Westport CT: Greenwood Press.

Lehman. A. & Salovey, P. (1990). Psychotherapist orientation and expectation for liked and disliked patients, Professional Psychology Research and Practice, 21, 385-391.

Levy, J. & Koff, B. (2001). "Gay-positive" therapy is not good enough. In the Family. (7) 2, 9-11

Light, Jr. D. (1983). Surface and deep structure: observing the organization of professional training. In (Ed.) J. Maanan, Qualitative methodology. (pp. 56-71) Newberry Park, CA:Sage.

Lipton, B. (1996). Opening doors responding to the mental health needs of gay and bisexual students. In M. Shernoff (Ed). Human serices for gay people . (pp. 7-24). New York: Harrington Park Press,

Lipton, B. (2001). Exploring the psychosocial experiences of gay men living with non-HIV chronic illness. Unpublished paper. Doctoral Dissertation seminar, NYU.

Lofland, J. & Lofland, L. (1984). Analyzing social settings. Belmont, CA:Wadsworth..

Lopez, S. R. (1989). Patient variable biases in clinical judgment: Conceptual overview and methodological considerations. Psychological bulletin, 106, 184-203.

Lowentahl, M. (1997). Gay men at the millennium. New York; Penguin Putnam Inc.

Mann, K. (1997). Love's labour lost: Countertransference with a terminating relationship. In M. Solomon and J. Siegel (Eds.), Countertransference in couple's therapy. (pp, 101-113). New York: W. W. Norton and Co.

McGoldrick, M. (1996). Foreword . In J.Laird, &R. Green (Eds.) Lesbians and gays in couples and families: A handbook for therapists. (pp.2-21). San Francisco: Jossey-Bass.

McWhirter, D. P. & Mattison, A. M. (1984). The male couple: How relationships develop. Englewood Cliffs, NJ: Prentice Hall.

Marcus, E. (1998). Together forever: Gay and lesbian marriage. New York; Anchor Books.

Marmor, J. (1980). Epilogue: Homosexuality and the issue of mental illness, In J, Marmor (Ed.) Homosexual behavior: A modern reappraisal. (pp.3-22), New York: Basic Books.

Mattison, A. & Mc Whirter, D. (1994). Serodiscordant male couples. Journal of Gay and Lesbian Social Services, (1), 2, New York: Haworth Press, 83-99.

Mays, V. M. & Albee, G. W. (1992). Psychotherapy and ethnic minorities. In D. K. Friedman (Ed.) History of psychotherapy: A century of change. (pp. 552-570). Washington, DC: American Psychological Association.

Mendola, M. (1980). The Mendola report. New York: Crown.

Miles , M. B. & Huberman, A. B. (1994). Qualitative data analysis. Thousand Oaks, California: Sage Publications.

Minuchin, S. (1974). Families and family therapy. Cambridge, MA :Harvard Press.

Mitchell, S. (1978). The psychoanalytic treatment of homosexuality. International Revue of Psychoanalysis, 8, 63-80.

Mitchell, S. (1996). Gender and sexual orientation in the age of postmodernism: The plight of the perplexed clinician. Gender & psychoanalysis, 1, (1), 45-72.

Mitchell, S. (2002). Can love last: The fate of romance over time. New York: W.W. Norton & Co.

Modrcin, M. J. & Wyers, N. L. (1990). Lesbian and gay couples: Where they turn when they need help. Journal of Gay and Lesbian Psychotherapy, 1(3), 89-104

Morin, S. (1977). Heterosexual bias in research on lesbianism and male homosexuality. American Psychologist, 32, 629-637.

Morin, J. (1995). The Erotic Mind. New York: Harper Perennial.

Morin, J. (1999). When hot monogamy isn't happening, consider plan B. In the Family, 4, (4), 12-27.

Morin S. & Charles, K. A. (1983) Heterosexual bias in psychotherapy. In J. Murray & P. R. Abramson (Eds.) Bias in psychotherapy. (pp. 309-338). New York: Praeger.

Moultrop, D. (1990). Husbands, wives and lovers: The emotional system of the extramarital affair. New York: Guilford.

Murphy. B. (1994). Differences and diversity: Gay and lesbian couples. In (Ed.) Kurdek, L. Social services for gay and lesbian couples, 1(2) Haworth Press: New York, 5-31.

National Institute of Drug Abuse (1999, December 2). Club drugs take center stage to new national educational and prevention initiative by NIDA and national partners, Bethesda, MD. U. S. Department of Health and Human Services.

Newman, P. (1998). Discursive condoms in the age of AIDS: Queer(y)ing HIV prevention. In S. Ball (Ed.). The HIV negative gay man: Developing strategies for survival and emotional well-being. (pp. 83-101) Binghampton, NY: Harrington Park Press.

Nichols, S. E. (1986). Psychotherapy and AIDS. In T. Stein & C. J. Cohen (Eds.). Contemporary perspectives on psychotherapy wih gays and lesbian clients. (pp. 209-239). New York: Harrington Park Press.

Nicoslosi, J. & Freeman, L. (1995). Healing Homosexuality: Case studies of reparative therapy. Northvale, NJ: Aronson

Nimmons, D. (2002). The soul beneath the skin: The unseen hears and habits of gay men. New York: St. Martin's Press.

Norcross, J. & Wogan, M. (1987). Values in psychotherapy: A survey of practitioner's belief. Professional psychology research and practice, 18, 5-7.

Odets, W. (1997). Gay male couples: Opening speech at the annual symposium of the gay and lesbian medical association, San Francisco, August, 23, 1997.

O'Hanlon, P. & O'Hanlon, W. (1991. Rewriting Love stories: Brief marital therapy. New York: Norton.

Olson, D., McCubbin, H., Barnes, H., Larsen, A., Muxen, M., Wilson, M. (1982). Family inventories. St. Paul: University of Minnesota.

Paulsen, J. (1988). *Preface* In M. Ross (Ed.), The treatment of homosexuals with mental disorders. (pp. 1-5). Haworth Press, New York,.

Payne, M. (1997). Modern social work theory. Chicago: Lyceum Books.

Pelligrini, A. (1992). *Shifting the terms of hetero/sexism; Gender, power, homophobia*In W. J. Blumenfeld (Ed.), Homophobia: How we all pay the price. (pp. 39-56). Boston: Bacon Press.

Peplau, & Cocchran, S. (1981). Value orientation in the intimate relationships of gay men. Journal of Homosexuality, 6(3), 1-19.

Peplau, L. & Gordon, S. (1982). The intimate relationships of lesbians and gay men. In Allegier & McCormick (Eds.). Gender roles and sexual behavior. (pp. 36-45). Palo Alto, CA: Mayfield.

Peplau, L. & Cochran, S, & Mays, V. (1998), A national survey of intimate relationship of a African American lesbian and gay men: A look at commitment, satisfaction, sexual behavior, and HIV Disease. (pp.11-38). Diversity among lesbian and gays. New York Random House.

Peplau, L. (1991). Lesbian and gay relationship. In J. Gonsiorek & J. Weinrich (Eds.), Homosexuality: Research implications for public policy. (pp.77-196.) Newbury Park: Sage.

Peplau, L. A. (1993). Lesbian and gay relationships. In L. D. Garnets & D. C. Kimmel (Eds.), Psychological perspectives on lesbian and gay male experiences. (pp. 11-38). New York: Colombia University Press.

Pelligrini, A. (1992). Shifting the terms of hetero/sexism: Gender, power, and homophobia. In (Ed.) W. Blumenfeld. Homophobia: How we all pay the price. (pp. 39-56). Boston: Bacon Press

Pinderhughes, E. (1989). Understanding race, ethnicity and power. New York: The Free Press.

Perez Foster. R. M. (1998). The clinical countertransference :The psychodynamic of culturally competent practice. Clinical Social Work Journal, 26(3), 253-270.

Pharr, S. (1988) Homophobia: A weapon of sexism. Little Rock, AR: Chardon Press.

Pittman, F. (1989). Private lies: Infidelity and the betrayal of intimacy. New York: Norton.

Polkinghorne, D. E. (1988). Narrative knowing and the human sciences. Albany State University of New York Press.

Racker, H. (1957). The meanings and use of countertransference. Psychoanalytic Quarterly, 26, 303-357.

Real, T. (2001). Complexity of gender and sexuality: Keynote address. The 32nd annual conference of the New York Society for Clinical Social Work, May 12, New York.

Reich, A. (1951). On countertransference. International journal of psychoanalysis, 32, 25-31.

Ramafedi, G. (1988). Preventing the sexual transmission of AIDS during adolescence. Journal of Adolescent Health Care, 9, 139-143.

Rampage, C. R. (1989). Revolution and resistance: A comment on Witkin. Journal of Family Psychology, 2 (4), 447-450.

Reid, W. J. (1994). Reframing the epistemological debate. In E. Sherman & W. Reid (Eds.) Qualitative research in social work. (pp. 464-481). New York: Colombia University Press.

Rein, M. & White, S. H. (1981). Knowledge for practice. Social Service Review, 55(1), 1-41.

Ridley, C. R. (1984). Clinical treatment of the nondisclosing Black client: A therapeutic paradox. American Psychologist, 39, 1234-1244.

Ritter, K. Y. & Terndrup, A. I. (2002.)Handbook of affirmative psychotherapy with lesbians and gay men. New York: The Guilford Press.

Robbins,S. (1999). Theory, knowledge and social work practice: Ongoing debates and fresh perspectives. Families in Society: The Journal of contemporary human services, 80(4), 325-326.

Rofes, E. (1996). Reviving the tribe. Harrington Park Press: Binghampton, NY.

Roland, A. (1996). Cultural pluralism and psychoanalysis. New York: Routledge.

Rubin, G. (1984). Thinking sex: Notes for a radical theory of the politics of sexuality. In R. Vance (Ed.). Pleasure and danger: exploring female sexuality. (pp. 269-319). Boston: Rotledge & Kegan .

Sadownick, D. (1996). Sex between Men; An intimate history of the sex lives of gay men postwar to present. San Francisco: Harper Collins.

Saleeby, D. (1989). The estrangement of knowing and doing: Professions in crisis. Social Casework, 70, 556-563.

Sayers, S. Kohn, C. & Heavey, C. (1998). Prevention of marital dysfunction: Behavioral approaches and beyond, Clinical Psychology Review, 18 (6), 713-744.

Scharff, D. & Scharff, J. (1995). Object relations couple therapy. New Jersey; Jason Aronson, Inc.

Schon, D. (1990). The reflexive practitioner: How professionals think in action. New York: Basic Books.

Schon, D. A. (1995). Reflexive inquiry in social work practice. In P. M. Hess & E. J. Mullen (Eds.) Practitioner-researcher partnerships: Building knowledge from in, and for practice. (pp. 31-55). Washington, DC: NASW Press.

Schulz, D. (1976). The changing family: Its function and future. Englewood Cliff's, NJ: Prentice Hall.

Scott, D. (1990). Practice wisdom: The neglected source of practice research. Social Work, (35), 6, 564-568.

Sears, J. T. & Williams, W. L (1997). Overcoming heterosexism and homophobia: Strategies that work. New York: Columbia University Press.

Sedgewick. E. K. (1990). Epistemology of the closet. Berkeley, CA: University of California Press.

Seigel, S. & Walker, G. (1996). Conversations between a gay therapist and a straight therapist. J. Laird & R. J, Green, (Eds.), Lesbian and gays in couples and families: A handbook for therapists. (pp. 28-68). San Francisco: Jossey-Bass.

Schatzman, L. & Strauss, A. (1973). Field research: Strategies for a natural sociology. Englewood Cliffs NJ:Prentice-Hall.

Sherman, E, & Reid, W., J. (1994). Introduction: Coming of age in social work-The emergence of qualitative research. Qualitative research in social work. (pp. 1-14). New York: Colombia University Press.

Shernoff, M. (1995). Male couples and their relationship styles. Journal of Gay and Lesbian Social Services , 2, (2),43-58.

Shimerlink, S. (1999). Personal communication. Ackerman Institute for couples and families, New York, New York.

Sibeon, R. (1990). Comments on the structure and form of social work knowledge. Social Work and Social Sciences Review, 1 (1), 29-44.

Signorile, M. (1997). The Signorile report on gay men: Sex, drugs, muscles and the passages of life. New York: Harper Collins.

Silverstein, C. (1981). Man to man. New York: William Morrow & Co.

Silverstein, C. (1991). Gays, lesbians and their therapists. New York: W. W. Norton & Co.

Simerly, T. (1996). Longtime companions: Gay couples in the era of AIDS. Transactional Analysis Journal, 26 (1), 8-14.

Simon, W. (1996). Postmodern sexualities. New York: Routledge.

Socarides, C. W. (1968). The overt homosexual. New York: Grune & Stratton.

Socarides, C. W. (1995). Homosexuality: A freedom too far. Phoenix, AZ.: Adam Margrave Books.

Solomon. M. & Siegel, J. (1997.) Countertransference in couples therapy. New York: Norton.

Spanier, G. (1976). Measuring dyadic adjustment: New scales for assessing the qualities of marriage and other similar dyads. Journal of Marriage and Family, 38, 15-28.

Stein, T. S. (1996). The essentialist/ constructionist debate about homosexuality and it relevance to psychotherapy. In R. P. Cuba & T. S. Stein (Eds.) *Textbook of Homosexuality and Mental Health.* (pp. 83-99).Washington D.C.: American Psychiatric Press.

Stern, S. (1994). Commentary: Social work evaluation and research. In E. Sherman and W. Reid (Eds.). Qualitative research in social work. (pp. 285-290). New York: Colombia University Press.

Sternberg,R. J. (1986). A Triangular theory of love. Psychological Review 9(3), 119-135.

Strauss, A. L. & Corbin, J. (1990). Basic of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Stulberg, I. & Smith, M. (1988). Psychosocial impact of AIDS on the lives of gay men. Social Work, 33(3), 277-281.

Sue, S. Zane, N. & Young, K. (1994). Research of psychotherapy with culturally diverse populations. In (Eds.) Bergin, A. & Garfield, S. Handbook of Psychotherapy and Behavior Change.(pp. 783-817). New York: John Wiley & Sons, Inc.

Thompson, N. (1993). Anti-Discriminatory Practice. London:MacMillan.

Tower, L. E. ((1956). Countertransference. Journal of the American Psychoanalytic Association, 4, 224-255.

Turner, H., Hays, R. , Coaters, T. (1993). Determinants of social supports among gay men: The context of AIDS. Journal of Health and Social Behavior, 34, 35-37.

Ussher, J. M. (1990). Couples therapy with gay clients: Issues facing counselors. Counseling Psychology Quarterly, 3(1), 109-116.

Ussher, J. M. (1991). Family and couples therapy with he gay and lesbian client: Acknowledging the forgotten minority. Journal of Family Therapy 13 (2), 131-148.

Valllliantos, C. (2001). Cultural competence standards are issued. NASW News 46(8), 1.

Vargo, M. (1998). Acts of disclosure: The coming out process. Haworth Press: New York.

Walby, S. (1990). Theorizing patriarchy. Oxford: Basic Blackwell.

Weeks, J. (1977). Coming out: Homosexual politics in Britain from the nineteenth century to the present. Oxford Press: London.

Weinberg, G. (1972). Society and the healthy homosexual. New York: St. Martin's.

Weingarten , K. (1991). The discourse of intimacy: Adding a social constructionist and feminist view. Family Process, 30, 285-305.

Weiss, R. S. (1994). Learning form strangers: The art and method of qualitative interview studies. New York: Free press.

Westfall, A. (1989). Extramarital sex: The treatment of the couple. In G. Weeks (Ed.), Treating couples: The intersystem model of the Marriage Council of Philadelphia.(pp.159-171). New York: Brunner/Mazel.

Weston, K. (1991). Families we choose: Lesbians, gays, kinship. New York: Columbia University Press.

Wethington, E. & Kessler, R. (1986). Perceived support: Received support and adjustment to stressful life events. Journal of Health and Social Behavior, 27, 78-89.

Whitbourne, S. & Ebmeyer, J. (1990). Identity and intimacy in marriage: A study of couples, New York: Springer-Verlnag.

White, M & Epston, D. (1990). Narrative means to therapeutic ends. New York: W. W. Norton.

Winicott, D. (1949). Hate in counter transference. International Journal of Psychoanalysis, 30, 69-75.

Witkin, S. L. (1989). Responding to sexism in marital researcher and therapy: Is awareness enough? Journal of Family Psychology, 3(1), 82-85.

Wolcott, H. F. (1994). Transforming qualitative data: Description, analysis, Iinterpretation. Thousand Oaks: Sage.

Wood, K. M. (1990). Epistemological issues in the development of social work practice knowledge. In L Videka- Sherman and W. J. Reid (Eds.), Advances in clinical social work research. (pp.373-390). Silver Springs, Maryland: NASW Press.

Wood. M. (2002). Liberating gay and lesbian relationships: Social work praxis and same-sex couples. Comprehensive Integrative Paper. Unpublished manuscript, NYU University.

Wood, M. (in press). The gay male gaze: Body image disturbance and gender oppression among gay men. In B. Lipton (Ed.) From crisis to crossroads: Gay men living with chronic illnesses and disabilities. Special Edition of Journal of Gay and Lesbian Social Services. (pp. 72-96). Binghamton, NY: Haworth Press.

Young, L. (1985). The effects of obesity on the clinical judgments of mental health professionals. Journal of Health and Social Behavior, 26, 233-246.

Zeira, A. & Rosen, A. (2000). Unraveling "tacit knowledge": what social workers do and why they do it. Social Service Review, 74(1), 103-123.