Sex Like You Can't Even Imagine: "Crystal," Crack and Gay Men

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SUMMARY. The past five years have witnessed a great increase in the use of the stimulant drugs crystal methamphetamine and smoked cocaine (crack) as part of a pattern of hypersexual behavior inextricably interwoven with substance dependence. With these patients, the problems are not independent, and exist almost exclusively in the company of one another. The paper describes a framework for evaluating patients and assessing their readiness for treatment in office based individual treatment that is informed by psychoanalytic principles. Typical resistances at each stage of treatment are described, with clinical recommendations for management. Common transference and countertransference paradigms are described. The paper includes psychoanalytic exploration of the possible meanings of the experience of drug/sex addiction, abstinence and fantasies that often precede relapse. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpress inc.com> Website: <http://www.HaworthPress.com>]*

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INTRODUCTION

What is the role of substance use in the expression of sexuality? What is the role of sexuality in drug use? In my practice, I work with many gay men as they go through the difficult process of the discovery or acknowledgement of their drug/alcohol addictions, exploration of the intimate relationship that drug and alcohol use has with their sexuality and identity, the decision to change this relationship and the process of recovery. When sex and drugs are powerfully linked, abstaining from drug use inevitably brings about an exploration of sexuality in sobriety, often nostalgically haunted by memories of drug-fuelled sex. Each phase of recovery from addiction (acceptance, establishment of abstinence, relapse prevention and recovery) brings up profound experiences evoking difficult, often confounding questions. Clinical aspects of treatment to be discussed include: the patient's motivations for abstinence, relapse triggers unique to this population, exploration of sexuality in the therapeutic process, and frequent transference paradigms. This paper will not address such categorical issues as the incidence or "reasons" for addiction in the gay community as a whole. Rather, it will present an office-based clinical model for treating a particular population: gay men for whom intense, compulsive stimulant drug use combined with sex has become a problem.

Addiction in this context is most often manifested by severe affective disruption following episodes of use, loss of control of drug intake, an excess of money and time spent pursuing sex and drugs, and the constriction of other kinds of meaningful engagement in life. This treatment approach is abstinence-based, uses conventional early recovery techniques, and is informed by psychoanalytic ideas and understanding, although not "traditional" analytic treatment techniques. This paper will not offer advice about the "best" treatment modalities for certain drug addictions because these categorical recommendations (inpatient rehabilitation, intensive outpatient programs for this or that drug addiction) may not be indicated, acceptable or available to certain patients. In addition to problems of patient preference or access, many patients come to outpatient treatment unprepared for the commitment to abstinence required for initiation of programmatic (group) treatment, intensely fearful of giving up their drug/sexual experiences. Becoming ready, then making this commitment becomes the initial focus of the therapy.

HOMOSEXUALITY, PSYCHOANALYSIS AND ADDICTION: STRANGE AND ESTRANGED BEDFELLOWS

There is a long and contentious history of psychoanalytic theory and practice in the understanding and treatment of both drug addiction and homosexuality. Both areas of clinical focus historically proved to be extravagantly

unresponsive to traditional analytic approaches in terms of changing behavior explicitly defined as pathological. Because of the persistence of homosexual desire and active addiction in patients treated for these conditions while in treatment based in drive/conflict theory, analysts assigned a severe degree of psychopathology to each. This culminated in the declaration of their untreatability, with diagnosis of psychotic or severe sociopathic character pathology in both populations. At the same time, psychoanalytic approaches to addictions have long been seen as dangerous and "enabling" from the traditional addiction treatment community. John Wallace (1978) described the ways that insight and therapeutic "neutrality" supported the denial that enabled continued drinking and the inevitable progression of the addiction. He described psychotherapy itself as a betrayal of the patient, its use reflecting the clinician's lack of understanding of the principles of addiction treatment. There has, however, been a steady trickle of insightful writing on addictions by psychoanalysts. Such clinicians and writers as Edward Khantzian, Leon Wurmser, Henry Krystal and Lance Dodes have made valuable contributions to the field, and offer useful insights into working with addicted individuals in analytic settings. A concise review of their ideas can be found in Jon Morgenstern and Jeremy Leed's article, "Contemporary Psychoanalytic Theories of Substance Abuse: A Disorder in Search of a Paradigm" (Morgenstern and Leeds, 1993) and more recently, "Three Perspectives on Addiction," by Brian Johnson (1999). Some of these ideas will be introduced in the later part of this paper.

There is a long history of animosity from gay-affirmative psychotherapists toward the old guard of psychoanalysis, challenging and rejecting the psychoanalytic pathologizing of homosexuality. The misunderstanding and oppression of homosexuality by American psychoanalysis has been extensively described elsewhere (Lewes, 1988) and will not be recounted here. The readers are no doubt familiar with the slow and agonizing process by which homosexuality has been removed from our core text of psychiatric disorders, the Diagnostic and Statistical Manual. The American Psychoanalytic Association as well has changed its official position, if not the hearts and minds of all its members, regarding the designation of homosexuality per se as pathologic. Therefore, it is increasingly clear that it is not homosexuality per se that we explore analytically in work with these patients, but the function of the intense, obsessive drug/sex behavior in terms of object relations and self experience.

WHY DO GAY MEN LOVE COCAINE AND CRYSTAL METHAMPHETAMINE?

Stimulant drugs, particularly cocaine and methamphetamine ("crystal"), are particularly appealing to gay men in a highly sexualized subculture that

exists within the broader gay community. The acute physical effects of methamphetamine include an increase in sensory acuity and energy and a decrease in appetite, as well as a lowered need for sleep. Acute psychological effects include an increase in confidence, verbosity, and alertness, grandiosity, self-idealization and euphoria. There is a marked elevation in mood and sex drive, as well as a decrease in boredom, loneliness and timidity (Ling, p. 13, 1998). Cocaine initially produces a sense of increased alertness and sense of well being. It lowers anxiety and social inhibitions and heightens energy, self-esteem and the positive emotions aroused by interpersonal experiences. Wurmser (1997) states, ". . . stimulants provide a sense of mastery, control, invulnerability and grandeur . . . the amphetamine effect serves as a defense against . . . general feelings of unworthiness and weakness."

Often, the environmental response to these changes is reinforcing. The user experiences himself as more extroverted, charming and desirable, with the perception that others feel and behave differently toward him. Specifically, patients report that when they are high, other men are more attracted to them, thus confirming the sense of feeling sexier and more attractive. In this sense, both cocaine and "crystal" are drugs that must be understood in an intersubjective and interpersonal context, since their effects are perceived to be extraordinarily powerful on the subject (the user) and on the object. This impact is experienced both on internalized object representations as well as external ones, i.e., the real people in the addict's world. The impact on internalized object relations is reflected in the rapid evaporation of shame that results from critical or negating introjects, i.e., failure to live up to an ego ideal of desirable manliness and power. This transformation of self-experience is often experienced by the drug user as "making" people find him more attractive, thus reinforcing the self-experience. In simpler language, confidence, and self-assurance are attractive qualities that result in greater success in finding a partner. This interpersonal phenomenon distinguishes these drugs from opiates, for example, which tend to promote social withdrawal accompanied by an inner sense of poetic grace and warmth, obviating the need for interactions with real people.

When sex is added to the stimulant experience, its meaning and value are heightened and transformed. If a sexual experience is combined with intranasal or smoked cocaine or crystal methamphetamine, powerful and reciprocally enhancing experiences occur. Fears of rejection or overwhelming reactions to rejection are diminished. Internalized object relations that generate feelings of inadequacy or shame are eclipsed for a time, as the drug induced positive affects transiently alter internalized object relation. There emerges an internally experienced sense of approval and encouragement of the sense of entitlement. The drug-induced positive affects alter feelings regarding body adequacy, in turn increasing the drive and courage to seek sexual expe-

riences. In short, doing these drugs makes it much easier to cruise for sex and make contact with another person.

Patients using stimulants report that pre-existing sexual anxieties are absent. The ordinary time frame for sex can radically change: having sex for 6-12 hours can become a realistic and predictable event. Users frequently report that crack and "crystal" facilitate participation in uninhibited, "over the top" sex, sometimes including sadomasochism, the use of dildoes or fistfucking in ways that seem wholly inaccessible without drugs. Some are able to enjoy anal sex only when using these stimulant drugs. Orgasm may be delayed, or even impossible to achieve. While these drugs may cause impotence ("crystal dick"), sildenafil (Viagra) is sometimes utilized to facilitate maintenance of an erection.

These combined sexual and drug experiences often occur in "sleazy" settings–bathhouses, bookstores, encounters with strangers, sex-and-drug hookups through the Internet, cruising the neighborhood or a bar. For some gay men, these "sleazy" qualities may contribute to the excitement as both the drug use and "pure sex" pursuit offer a transgressive thrill, i.e., "it's fun to be bad." However, this transgressive quality is not necessarily a major aspect of the gratification. Instead, the core desired experience is the apparently magical deliverance from inhibitions brought on by shame, feelings of inadequacy, self-fragmentation, internalized homophobia, anxiety, fragile ego states or dependent/counterdependent struggles into a predictably intense, sexual trance state of extended duration. The desirability of the drug/sex experience is only heightened by its apparent controllability. Relationship problems, work related stress, fatigue, ordinary human limitations, loneliness, anxiety, depression are transiently banished and the user feels able to actually inhabit, however briefly, a grandiose self state: powerful, highly sexual, contained but uninhibited, intense, passionate, and aggressive. The drug has a profound effect on mood and behavior, which in turn alters the self-experience. There is a marked upsurge of self-idealization, feelings of omnipotence and grandiosity, self-acceptance, the expectation of acceptance by others embedded in a drug based euphoric state. There is a simultaneous experience of altered internalized object relations and an experience in the real world that (sometimes) enacts this fantasy: I am the powerful, admired, sexy man who is desired and accepted by a powerful and aroused Other/Daddy. This is not merely an internal wish, but a wish that comes true: here is a perfect stranger, confirming the "reality" of the fantasy by participating in it with me, at least for right now. This does not make the fantasy into reality, but allows for a shared illusion, dependent on drug use for its intensity and for some men, the ability to inhabit play space of the shared illusion.

Some gay men use these stimulant drugs at infrequent intervals, and this tends to preserve more of the desired response. For others, the positive effects

are so reinforcing that they are sought with increasing frequency and intake. For these men, the desired effects often become more and more elusive with continued use. As the love affair with the sex/drug experience reaches full bloom, the dark side (depression, paranoia, feeling "tweaked," compulsive, out of control use) emerges, as a result of the drugs' biologic and psychological sleight of hand. The relentless attempt to recapture the positive aspects of the experience ("chasing the high") usually leads to increased use, escalating negative consequences, physiological dependence and the stage of addiction in which use continues only to ward off the crashing despair of withdrawal. This depression is accentuated by the inevitable sadness of leaving the bathhouse, spent but lonely, ending an anonymous sexual encounter or being home alone.

DEVELOPMENTAL ISSUES

Several developmental themes emerge with frequency during the course of work with these men, which allow the therapist and ultimately the patient to appreciate the dynamic importance of the drug/sex addiction in maintaining a fragile or defective sense of self. Often, they report childhood experiences, common for some gay and proto-gay boys, of feelings of inadequacy, invisibility and difference, including an absence of athletic/physical recognition in grade school, high school and college. This commonly results in a sense of shame regarding both body and erotic feelings. Failure of parental and societal recognition and support of emerging sexuality generates self-imposed silence regarding sexual feelings and the inability to integrate sexuality into relationships and self-concept. These conditions combine to create an amalgam of shame, isolation, hopelessness, rage and sense of exclusion that is commonly labeled internalized homophobia. Even when there is compensatory narcissistic gratification through academic or professional achievements, the trauma and stigma of the invisible body, invisible self and negated sexuality remains painfully intense. This traumatic injury is felt concretely, in the body, and is experienced as factual and therefore as unhealable. The suffering is often experienced as truly being caused by insufficient muscularity, a face not handsome enough or a penis not large enough. Obsessive preoccupation with working out at the gym becomes the obvious solution with the twin hopes of becoming and attracting an idealized man. A profound sense of difference, abjection and nothingness is often coupled with interpersonal fear and self-loathing. This is "fixed" through belief in the ability to transform the self to become worthy of a relationship with a desirable Other who will mirror the grandiose, exciting, masculine self. This is concretized into (or onto) the surface and physical structure of the body. Weight training, management of body size through diet and steroid drugs and plastic surgery may become vital expressions of the drive to become visible, seen, noticed,

admired, desired. Canarelli, Cole and Rizzuto movingly depict this process in their article, "Attention vs. Acceptance: Some Dynamic Issues in Gay Male Development." They describe the possible developmental paths through which the negation of the developing gay boy's desire leads to an impoverished sense of self and an exaggerated need for attention and validation in order to heal inner deadness.

Yet even the acquisition of a better or even superb body does not "fix" the archaic, unnoticed, invisible self. Its repair appears to be achieved, albeit temporarily, by successfully attracting and having sex with a virile man who both possesses *and* recognizes the virility and sexual desirability and desire of the subject. This transaction appears to be greatly facilitated by stimulant drug use. Patients report that they not only feel sexier and more able to engage in sex when using stimulant drugs, but that strangers on the street or in the bathhouse actually see them as sexier. When abstinent, the feelings of invisibility, asexuality and irrelevance return, and are experienced as "readable" by the external world, further validating the sense of the drug's power as real. When intoxicated on stimulants, all seems transformed, or at least potentially transformed, and the social contexts in which these drugs are used often enough make "dreams come true," if only for a while. This leads to the desire to repeat the experience again and again. For a while, at least, Cinderfella does achieve transformation. He changes from an unimpressive nothing into someone who gets to go to the ball, exhibit his new gown/body and dance with many dashing princes. He knows all the while that Midnight will come, when he will have to leave the ball and face the outside world. The body remains, but the subjective sense of its adequacy may fall precipitously. However, there is always the anticipation of another ball, another set of hunky princes, another evening of hot, sweaty dancing that awaits. Crystal or cocaine is the magic dust and a drug dealer is the fairy godfather that facilitates the transformation.

THE INITIAL CLINICAL PRESENTATION

When depression and fear of loss of control become overwhelming, individuals often seek or are referred for drug treatment. A sense of panic and shame accompany the experience of being unable to control one's use of sex and drugs. However, the patient is usually not committed to abstinence at this point, and any demand for it by a therapist is greatly feared/dreaded, although it may also be met with some relief. While the decision to seek evaluation for a drug problem certainly suggests a readiness to accept help, often the patient presents rationalizations that have protected him from acknowledging the progression of his addiction. These rationalizations might include: (1) comparing one's own drug use with the drug intake of heavier users, (2) recounting previous periods of abstinence in order to demonstrate strength of will, (3) con-

demning known abstinent individuals, and (4) isolating experiences from their greater context ("So I made a mistake. Next time, I'll stop sooner or use less."). This rationalization functions defensively to help the patient maintain the idea that the recent terrible experience, with its behavioral excesses and affective eruptions, represents the *beginning* of the presence of a substance use disorder. This reflects denial of the long-standing, deep attachment to the drug-sex experience. There is an understandable wish to go back to a prior pattern of use that appeared non-problematic.

It is useful for therapists to approach this phase of treatment with a mixture of psychoeducational and cognitive therapy techniques and a detailed inquiry into the drug history and subjective experience of drug use. This technique seeks to open up the patient's direct experience in both affective and behavioral terms. A valuable guide to this approach is *Psychotherapy of Cocaine Addiction–Entering the Interpersonal World of the Cocaine Addict,* by David Mark and Jeffrey Faude.

Traditional chemical dependency treatment techniques often suggest focusing exclusively on the negative experiences of drug use, concerned that accepting "romanticized" drug memories stirs up drug craving and fosters relapse. However, intense forms of resistance appear early and many patients are alienated by efforts to transform "good" experiences into "bad" ones. There are several problems with only emphasizing the negative aspects of the drug/sex experience. It implies that the therapist believes that the patient has been engaging in costly destructive behavior for no good reason, and is therefore foolish or deeply self-destructive. It short circuits the exploration of the profoundly important role of the sex/drug experience in altering self-states or self cohesion, or their role in transiently controlling painful affective states of loneliness and rejection. The detailed inquiry into drug experiences also can provide clues of co-morbid psychiatric disorders, guiding the use of psychotropic medication. If the therapist and patient examine experiences closely, the patient's initial idealizing report will often yield a more nuanced description with elements of obsession or loss of control, as well as post-intoxication depression, despair and suicidal ideation. These core elements need to be acknowledged if the patient is to change his relationship to drugs and sexuality.

This acknowledgement is, however, avoided because it portends the appearance of an overwhelming and terrifying loss: the stabilizing role that the drugs and sex play in maintaining psychic equilibrium. It may seem paradoxical that a destabilizing experience (such as a 12-hour drug and sex binge) is experienced as stabilizing. However, it is vital to explore this contradiction with the patient. Often patients need the therapist to acknowledge how wonderful some elements of drug use can be. If the therapist doesn't "get" this, the patient may fear that the therapist will not appreciate or understand what

the impending loss will mean, that the loss is experienced as real, not illusory. As sexuality is also involved, a great deal is at stake. It is not just the affective and behavioral relationship with the drug and sex buddies that will be lost. Much worse is the threat to the patient's transient transformation into someone uninhibited and sexually successful. Patients are exquisitely sensitive to any hint of disapproval of the patterns of sexuality that they engage in, and respond with anger or withdrawal to any sense of therapist judgement. The therapist must appreciate, early on, the rigid narcissistic defenses the patient has needed and must recognize the compromised judgement and regressive defenses (denial and projection) with which the patient wards off intense shame and humiliation.

Another complication in the acknowledgement of the drug addiction is the question of sexual addiction, which patients often report with great fear and shame. The patterns are similar to those of drug addiction: loss of control, continued engagement in the behavior in spite of negative consequences, desire to stop with inability to do so, obsession with the experiences, intent to decrease frequency, etc. While the patient is in the stage of accepting the diagnosis of stimulant dependence, it is best to defer the definitive diagnosis of a sexual addiction. This is not because compulsive sexual behavior does not exist as a problem for some of these patients, but focusing on the sexual behavior distracts from the priority of this phase of treatment, the chemical addiction, and the sexual compulsivity may not persist in the state of drug abstinence. The goal of this part of the treatment is acceptance that any use of stimulants usually or invariably leads to extreme negative consequences, that sincere efforts to alter this pattern have failed, and that abstinence from stimulant drugs is necessary. It cannot be predicted that sexually compulsive behavior will persist in the context of abstinence from drugs. It often does not, although the loss of the very high level of sexual activity is usually experienced ambivalently, since sexual activity itself performs a vital function in affect management and self-stabilization. The drug induced sexual activity helps provide a grandiose sense of self, tenuously maintained in the face of poor affect tolerance and painful acknowledgement of limitations. The cognitive distortions seen in active drug addiction may lead the patient to believe that no other barrier will stand between them and overwhelming negative affects and self experiences except sex on drugs, and the threatened loss triggers a reactive protectiveness of the relationship with drugs and sex.

ESTABLISHMENT OF EARLY ABSTINENCE

The process of making a commitment to drug abstinence may take many months, and is often marked by brief episodes of abstinence alternating with return to active drug use. Just as patients dabble with drug use before becoming deeply attached to the experiences, experimentation with the thoughts and

behaviors of abstinence often occurs before acceptance of the need for a basic change in the relationship with drugs and sex, and the readiness to make that commitment. Great anxiety and protest emerge at the loss of heightened sexuality, and this presages the core struggle of ongoing abstinence and sobriety.

It is common addiction treatment practice to explore the quality of the drug experiences, with the "discovery" that they weren't so great, that losing them isn't such a great loss and that sobriety offers ample compensatory pleasures. This occurs commonly with substance dependence syndromes that do not involve sex, and the pleasures and growth available in sobriety richly reward the efforts applied. This is often not the case with patients addicted to sex and drugs. In fact, the memories of drug-heightened sex become a challenge to progress as the patients eagerly hope for restitution of the powerful psychic effects of drug and sex experiences. They seek guidance on how to have sex that matches the previous intensity, or endure sexual experimentation in the "old places," becoming dismayed or disgusted by the environments or disappointed by the sex. The memories of drug and sex experiences make it even more difficult to explore inhibitions or anxieties that impair or limit sexual/romantic pleasure and satisfaction, since drugs were such an efficient, if short-term "magical" solution. The memories (often condensed into the self-state designated as "horniness") may function as a defense mechanism (grandiose self-idealization) that keeps anxiety, shame, or depressive feelings out of consciousness. A sense of anxiety and restlessness warn of a threat to self-cohesion and breakthrough of a self-experience of emptiness or invisibility, consciously experienced as the urge for rapid restitution of the idealized and sexualized masculine self. Hints of these "signal affects" often are transformed into a perceived "need to get high and get laid" that has an urgent, peremptory quality. This is an action-oriented, alloplastic response to perceived inner deadness. Sexual longing in the exposed state of abstinence may seem both vitally important and extremely anxiety provoking, because it triggers drug craving. Without stimulants, sexual experiences themselves may seem dull, lackluster, ordinary, or even impossible. Mourning and loss often alternate with denial and bargaining to find a way to go back to earlier days when the negative aspects of drug use seemed less problematic.

DOES ABSTINENCE FROM DRUGS REQUIRE CELIBACY?

Early in sobriety, sexual behavior can sometimes trigger intense craving, so traditional addiction treatment wisdom would advise sexual abstinence during early drug recovery. The patient will usually see this stance as a moralistic, prohibitive one that offers a confusing mixed signal regarding the role of pleasure and intimate contact. Is it possible to take a neutral, non-judg-

mental stance regarding sexual experience during this period that nonetheless offers support for early recovery? It is at this point that the fusion of sex and drugs is most exposed. One must admit that "over-the-top" sexual experiences will probably be inaccessible to the patient, at least for a while. There are two reasons for this: first, the direct brain effect of stimulant drugs on sex drive and intensity is gone. Thus, an intense sexual experience is difficult to access due to the withdrawal, caused by depletion of neurotransmitters involved. The second reason is that the pre-existing affects re-emerge, exaggerated both physiologically and psychologically, inhibiting the feelings of sexual ferocity that are sought. Is it advisable to suggest to the patient that super-aroused states, previously available only through drugs, can be found in some way, in sobriety? What is the optimal time to question the "packed" or multiply determined nature of the familiar assertion of "horniness"? These recurrent clinical questions raise the inevitable labeling of "good" versus "bad" kinds of sex. It is important to separate questions of the meaning of anonymous, "recreational" sex from drug use, even though they are fused in the patient's experience. The therapist must directly acknowledge the patients "right" to pursue the type of sexuality he chooses, as these are highly valued experiences, containing important, if fragmented, archaic self-object transferences that are not easily accessed in sobriety. Often, the sexuality during drug use is experienced as highly sensual, exciting, "animalistic," and greatly satisfying in a purely physical way. Sober sex is far more invaded by fluctuating internal states and fantasies. These may be distinctly anti-erotic, or at best, a dim version of the former intensity. It is precisely the banishment of these feelings, and the evocation of a grandiose, eroticized self-state that is part of the desired drug effects.

It is common for the patient to rightly assume the therapist privileges a more related, intimate type of sexuality, while also appreciating the exuberant delights that patients frequently report when describing their drug/sex experiences. There is often a broad range of countertransference reactions to these wild and ribald stories, including envy, nostalgia, excitement, and anxiety. Sexuality in the context of greater intimacy or a relationship may or may not be a conscious goal for the patient, and even if it is, he may find many very real obstacles to it, both within himself and in his familiar social milieu. Is the possibility of a deeply exciting and passionate sober sexuality for these patients realistic, or does their positive, repetitive response to drug/sex bespeak real limitations to this ever happening, the situation being made worse, biologically and psychologically, by the rapacious chemicals? From a clinical/philosophic point of view, do we assume that the use of drugs to achieve this state somehow renders the experience less real, counterfeit, or desperately compensatory? Does it stand in the place of a more "mature" use of sexuality? These forced binaries are themselves a result of thinking that is

reductionistic. It is foolhardy to declare an experience as unreal, when the patient's direct knowledge declares otherwise. Since its occurrence, at a psychic level, requires extraordinary manipulation of affect and defense through drugs, it comes into existence through the prosthetic effects of the stimulants. It seems unlikely that an exact replica can be found in sobriety. However, the process of psychotherapy and recovery can reduce the demand for compensatory idealized self states through increased self acceptance and greater affect tolerance, which in turn lead to greater access to passion and abandon into sexuality.

THERAPEUTIC APPROACHES: TRANSFERENCE AND RESISTANCE

In early recovery, the appropriate goal is the exploration of the patient's ambivalence about abstinence, his achievement of it, and the re-establishment of abstinence in the event of relapse. It is a serious error to assume that abstinence is an unambivalent goal of the patient, even though he is knowingly in treatment that is based on it. It is a familiar, frustrating process for the therapist and patient alike when the therapist assumes the patient "knows" the "right" thing to do, then doesn't do it. Didactic approaches, moralization, gentle or combative threats or admonishments are rarely of any value. The patient may see the therapist as someone who wishes to control him and his use, punishing him for "being bad." He may overtly rebel against the sense of domination, calmly continuing to use while the therapist contains the anxiety and feeling of being out of control. The patient may alternatively submit to the therapist's "wishes," attempting to please and appease the voice of authority, all the while plotting a rebellion. The clinician's task in early recovery is to determine the type of therapeutic response that will explore these resistances and help the patient come to experience the commitment to abstinence as his own. The therapist may offer help by interpreting these resistances while demonstrating his own lack of need to control the patient.

Once the patient personally commits to abstinence, the therapist can intervene to simultaneously reduce the intensity of affects that trigger craving and relapse and support the expression and containment of emergent self-states. It is crucial to reframe these emergent states as valuable, albeit uncomfortable. It can be necessary to explicitly maintain and express the belief that a growing tolerance for these states is necessary for their transformation.

The transference/countertransference processes seen in the treatment of drug addiction are well described by Kaufman (1992) and Imhof, Hirsch and Terenzi (1984). Of particular interest is the phenomenon of the patient's use of the therapist as a drug substitute. This often shows itself first through a countertransference experience of being in a narrow or collapsed space with little therapeutic power or magic dust to sprinkle that would make things feel

better quickly. This represents the experience elicited by the patient's unconscious engagement with the therapist as a wished for drug substitute. At these times, there is intense pressure to offer hope or proof to the patient that the move from active drug use to sobriety is "worth it." The therapist becomes the spokesman for sobriety, and feels responsible for "selling it." One often sees much balancing and weighing of the positive and negative consequences of drug use compared with skepticism regarding the likelihood of "getting" anything from the sobriety that will feel good. Attempts to convince the patient of the value of sobriety are futile, since this misses the fear being expressed. It is more valuable for the therapist to hold and contain these fears, facilitating the capacity to tolerate these inner states. Verbalization of these affects and emergent self-states by the therapist, leading to the patient's experience of being held and cared for can gradually increase the tolerance for them. This occurs both for the patient and therapist, who may identify with the patient's insistent demand for results and tools as analogous to his own experience of therapeutic invisibility and lack of a tool big enough for this job.

The patient's ambivalent relationship with sobriety can be externalized into the therapist and expressed in the transference in other ways. He may see the therapist as a crusader for abstinence, a moralizing goody-goody who disapproves of drugs and wild sex. The patient then becomes the rebellious, Dionisian pleasure seeker, escaping from external demands to "be good," angrily overthrowing "the Law." In this way, the struggle with abstinence is externalized. Tension is reduced because the conflict is experienced as a struggle between the "wishes" of the therapist and the patient. Some patients feel controlled by fear of disappointing the therapist, having to endure the anticipated withdrawal, disapproval or scorn if he relapses due to lack of "will power" or inner strength, or as proof of his lack of need for help. In this situation, the drug use may function both as a rebellion against that constraint (abstaining out of fear of disapproval or loss of love) and an eraser of the guilt for the wish to destroy the therapist's perceived power or goodness. For other patients, the drug/sex relapse may function as a chemical solution for shame at failure to be "strong willed" enough to not need drugs and/or drug treatment, i.e., as a person with intense needs. Under the pressure of drug craving, the patient may perceive that he needs help (perhaps a great deal of it) in order to stay sober, but can get high on his own, thus repudiating the need for an Other and bolstering omnipotent defenses. This is a common paradox: relapse both demonstrates the failure of willpower, but chemically reinforces the illusion of self-sufficiency and omnipotence over emotional states.

Another common transference configuration is the patient's expressed belief that the therapist cannot really understand and accept the importance of sexuality to this particular patient. This dynamic is often accompanied by

fantasies of the therapist leading a tranquil, "boring" life of gay domestic tranquillity proudly enjoying "opera tickets, a two bedroom apartment and regular attendance at the 26th Street antiques market." The patient may experience a need to see the therapist in a desexualized way, and this may serve several functions. He may feel that therapeutic events need to take place in a setting devoid of sexual feelings, contributing to a feeling of safety and protection. Sessions may need to be free of the treacherous explicit competitiveness and sexuality that can evoke shame and the experience of invisibility as well as competitiveness. As well, the attribution to the therapist of a bland, desexualized life may represent a projection of the patient's fears or wishes about himself. A similar pattern is the disavowal of any sexual or sexualized aspects of the therapeutic relationship, with the wish to preserve the treatment relationship as one free of that particular danger/excitement, or at least the explicit discussion of it, as if it represents something antithetical to the psychotherapy process. This seems to point to the patient's awareness of the dissociative and essentially conservative nature of his drug fueled sexuality, and his need to maintain a split between sexuality and personal growth, intimacy, empathic engagement and safety from exploitation.

The patient may at times, desire the therapist to contain these prohibiting positions regarding sexuality, perhaps as a projective identification of internalized objects who were silent and negating of his sexuality. He may fear admitting his lack of attraction to the therapist, concerned that this will be terribly hurtful or insulting. This reveals a projected aspect of his own traumatic experience of being desexualized through denial of emergent sexuality in childhood and adolescence, and the present day feeling of being invisible in the harsh competitiveness of the gay drug/sex subculture. Alternatively, sexual attraction between the therapist and patient may interfere with the patient's feeling of trust and safety. One patient informed me that a previous therapist had revealed that he found the patient sexually attractive. The patient ended the treatment soon after, because he didn't believe anyone experiencing sexual feelings toward him could also want to help him. I was instructed not to have such feelings toward him, while simultaneously being told of years of bodybuilding, steroids, plastic surgery and self-development that he had devoted to making himself attractive to gay men. He had projected into me the conflicted boy, admonished not to get excited while being shown exciting things. In his fantasy, he struggled to possess the overt and observed sexuality. Clearly, I was not to have any, or if I did, I was supposed to suppress and contain it, as he had had to do in his childhood. This projection alternated with painful moments of experiencing himself as unattractive, thin, and invisible, anxiously asking me if I noticed subtle changes in his muscularity or facial features.

RELAPSE FANTASIES

Relapse fantasies are a common occurrence in the long-term treatment of addictive disorders. There is a growing urgency that the patient will relapse if "something isn't done." There is an experience of life and the therapy as distinctly unexciting, possessing little, if any, of the hot, powerful stuff that is available at the bathhouse or from a drug dealer. Therapy is experienced as insufficiently stimulating and frustrating in its interiority. Its explicit privileging of verbal expression of affect, especially self-experiences with painful affect, rather than narcissistic and hypomanic acting out defenses, may begin to feel unuseful or even incomprehensible to the patient. The patient may pit active drug use against sobriety in direct competition, challenging the therapist to convince him that recovery is "better." Countertransference reactions include feelings of defensiveness of psychotherapy itself, with a compensatory wish to find a way to excite the patient about the journey of self-discovery, along with anger or hopelessness in response to the patient's devaluation and concreteness. If the therapy itself is regarded as a drug substitute, an antidote to craving itself, it is seen as falling short. The persistence of this ambivalence can lead to consideration of termination. A growing weariness in the patient (and sometimes the therapist) often precedes a relapse. The patient will report increasing drug obsession, growing doubt about "changing" and boredom. The relapse, if it occurs, finally resolves the obsession about whether or not to return to active drug use.

This brings the therapy to a particular kind of dilemma. Certainly, patient, calm inquiry into the circumstances of the relapse is indicated, unless life threatening circumstances require a more active approach. Re-teaching the "how's" of abstinence is of little use here, since the problem usually lies not so much with *how* to maintain abstinence, as it does with the question of *why.* On some occasions, relapses are presented as largely unpleasant, anxiety ridden and not at all reinforcing. Most times, the period of abstinence serves to set the stage, physiologically, for a highly positive initial return to familiar territory, filled with the ecstatic, "over-the-top" experiences that were sought, even if return of obsession, loss of control and marked affective dysregulation are the price to pay. The problems inherent in active drug use seem to pose less of a problem than do those that result from living outside it. Detailed inquiry into the experience often proves to be difficult, and the sexual experiences tend to be conveyed in a stereotyped way–the hotness of the man, the hotness of the sex, its duration and the number of partners. Big, embarrassed, goofy grins and excited affect usually accompany these stories. The longing for a pure Kohutian moment of mirroring is palpable, along with fear of disapproval or shame. The internal experience remains largely unarticulated, not readily accessible for exploration, especially in regard to the use of a sexual partner as a source of transient identification, self-stabilization

against painful or frightening affect or foundering sense of self-cohesion. A common explanation that is offered is simply: "I was horny." Responding with the notion that such an explanation is lacking feels vaguely insulting and suspect to the patient. Wurmser (1997) refers to this process as "hyposymbolization," a curtailed ability to translate feelings into symbolic language, with a shift toward a more somatic or action oriented expression.

A common patient fear is that the therapist will criticize the patient's sexuality, drug use (or both), as depraved, needy, shameful. At times, there is the sense that the patient is trying to seduce the therapist. The seduction, however, is not so much into sexual arousal, but rather into believing in the validity and even the irreplaceable nature of the drug/sex experience, a kind of invitation away from the grim tasks of therapy.

It is interesting that some patients often wish for the therapist to have some experiences with the drugs in question in order to understand the difficulty of abstinence, but not too much experience. It seems important that the drug use be a part of the therapist's past, but not his present. This may be an expression of longing for the wished for gay father who can be loving, containing and understanding of intense homoerotic desire, while being available to control overstimulation and to provide safety from wishes that feel out of control or self destructive. The transference can reflect multiple identifications of the patient: the wish to be an uncloseted, confident adult gay man with "gay" desires and experiences and an excited goody-goody bystander who is intrigued by the rapacious sexual outlaw. The patient wishes for the therapist to help him integrate these disparate identities. There is pressure to show how life can be exciting in sobriety. Sobriety for the patient becomes a dreary foreign land, to which he feels exiled, sent away from the marvelous party by his own doing, and resenting the look of the new landscape. He wonders if the therapist's life is one worth identifying with.

SUMMING UP

It is particularly difficult to find a single valence for drug fueled sexuality, and to differentiate its misuse in an addiction process from its role as a response to the internalized homophobic and antisexual biases we are all subject to. Certainly, there are many ways to live as a gay man, but if drug use is experienced as vital to the uninhibited expression of one's "true" gay identity, can abstinence occur without a profound revision of such an identity? Is there a stable abstinence from drugs that is not coupled with the privileging of calmer, safer, cozier sexuality? Certainly, in theory, but it's not an easy place to get to when anxiety, feelings of invisibility and disappointing sexual experiences become overwhelming. Some patients in recovery from drug addiction find a profound positive change in their capacity for intimacy and their ability to maintain a relationship. Yet they may still have moments

of nostalgic longing for their "basic (old) program: get drunk, get high, get laid." A stable path toward sustained abstinence occurs when multiple aspects of a patient's life improve so clearly as a result of recovery that the idea of returning to drug use is not a realistic consideration, even under the pressure of euphoric recall of drug/sex experiences. These improvements are usually both in the personal, relational world as well as the world of work and avocations. In this situation, changes in sexuality are usually accepted and explored, with some ambivalent nostalgia. Commonly, patients say they don't regret having had a drug/sex addiction, but are grateful that they've escaped from it with most of their life intact.

There are several important processes that significantly contribute to positive outcomes in the treatment of these men. The establishment of a stable, containing treatment setting in which to examine the relationship with stimulant drugs and sex can lead to the reduction in defenses against awareness of the negative consequences of the addiction. This stabilizes recovery. Clarification and explication of the defenses of denial, minimization, projection, splitting, *as applied to the relationship with the drug itself*, can lead to greater persistence of the experienced need for abstinence and thus the patient is able to withstand greater storms of craving and longing. Patients also find in sobriety, inevitably, a greater acceptance of their interior world, regardless of the kind of character structure that underlay the heightened receptivity to the drug experience in the first place. Abstinence and recovery in these patients is almost always accompanied by a moving sense of reacquaintance or rediscovery of their former self, however troubled it may have felt. The strengths of the pre-addiction self are recognized and reappreciated once outside the invisible grasp of the addictive process. And the sex? Well, each man returns to his own world, returned to the more ordinary struggles for intimacy and sexual expression that have challenged us for millennia.

REFERENCES

Canarelli, Joseph, Cole, Gilbert and Rizzuto, Charles (1998), Attention vs. Acceptance: Some Dynamic Issues in Gay Male Development. *Gender and Psychoanalysis: An Interdisciplinary Journal*, Vol. 4: No. 1: 47-70.

Dodes, Lance (1990), Addiction, Helplessness and Narcissistic Rage. *Psychoanalytic Quarterly*, LIX: 398-419.

Imhof, John, Hirsch, Robert and Terenzi, Richard (1984), Countertransferential and Attitudinal Considerations in the Treatment of Drug Abuse and Addiction. *The Journal of Substance Abuse Treatment*, Vol. 1: 21-30.

Johnson, Brian (1999), Three Perspectives on Addiction. *Journal of the American Psychoanalytic Association*, Vol. 47: 3, pp. 791-815.

Khantzian, Edward (1995), Self-Regulation Vulnerabilities in Substance Abusers: Treatment Implications. In *The Psychology and Treatment of Addictive Behavior*, ed. Scott Dowling. Madison: International Universities Press, pp. 17-41.

Khantzian, Edward (1997), The Self-Medication Hypotheses of Addictive Disorders: Focus on Heroin and Cocaine Dependence. In *Essential Papers On Addiction*, ed. Daniel Yalisove. New York: New York University Press, pp. 429-440.

Kaufman, Edward (1992), Countertransference and Other Mutually Interactive Aspects of Psychotherapy with Substance Abusers. *The American Journal on Addictions*, Vol.1: No. 3: pp. 185-202.

Krystal, Henry (1997), Self-Representation and the Capacity for Self-Care. In *Essential Papers on Addiction*, ed. Daniel Yalisove. New York: New York University Press, pp. 109-146.

Ling, Walter, Los Angeles Addiction Research Consortium (1998), Proceedings of Ninth Annual Meeting and Symposium of the American Academy of Addiction Psychiatry, p. 13.

Mark, David and Faude, Jeffrey (1997), *Psychotherapy of Cocaine Addiction: Entering the Interpersonal World of the Cocaine Addict*. Northvale, New Jersey: Jason Aronson, Inc.

Morgenstern, Leeds (1993), Contemporary Psychoanalytic Theories of Substance Abuse: A Disorder in Search of a Paradigm," *Psychotherapy*, Vol. 30, No. 2, pp. 194-206.

Wallace, John (1978), The Dangers of Psychotherapy in the Treatment of Alcoholism. In *Practical Approaches to Alcoholism Psychotherapy*, ed. Zimberg, Sheldon, Wallace, John and Blume, Sheila G., New York: Plenum Press.

Wurmser, Leon (1995), Compulsiveness and Conflict: The Distinction between Description and Explanation in the Treatment of Addictive Behavior. In *The Psychology and Treatment of Addictive Behavior*, ed. Scott Dowling, Madison: International University Press, pp. 43-64.

Wurmser, Leon (1997), Psychoanalytic Considerations of the Etiology of Compulsive Drug Use. In *Essential Papers on Addiction*, ed. Daniel Yalisove, New York City: New York University Press, pp. 87-108.

Wurmser, Leon (1987), Flight from Conscience: Experiences with the Psychoanalytic Treatment of Compulsive Drug Abusers: Part One: Dynamic Sequences Underlying Compulsive Drug Use; Part Two: Dynamic and Therapeutic Conclusions from the Experiences with Psychoanalysis of Drug Users. *Journal of Substance Abuse Treatment*, Vol. 4. pp. 157-179.

Zimberg, Sheldon, Wallace, John and Blume, Sheila G. (1978), *Practical Approaches to Alcoholism Psychotherapy*, New York: Plenum Press.