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SHOULD MEN TREAT COUPLES? TRANSFERENCE, COUNTERTRANSFERENCE, AND SOCIOPOLITICAL CONSIDERATIONS

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While gender issues in the therapy process have recently received considerable attention, very little has been explored about the gender complications which arise in couples therapy. Couples therapy is seen here as a conversation and an experience which are significantly different for each member of the couple when the therapist is a male. Couples therapy differs profoundly from individual therapy in that couples therapy involves three people, two of whom will share the same gender, resulting in an inherent imbalance with important transference and countertransference consequences and dilemmas. This imbalance and the transference–countertransference constellations that result are explored. Recommendations concerning gender-sensitivity are made to the therapist to promote appropriate treatment.

> How is it possible to conduct therapy with . . . couples in and out of marriage . . . without understanding how this process constructs many of the problems, relationships, and conflicts that we encounter in our offices? How can we make *therapeutic* interventions . . . and not be sensitive to the profoundly different meanings our words, tasks, and metaphors will have for men and for women as a result of their gender experiences? And how can we not but be aware that in a patriarchal culture life experience will be defined largely within a male frame of reference? M. Walters (1990)

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Currently, gender issues in the therapy process have taken center stage (Bograd, 1991; Goldner, 1985; Goodrich et al., 1988; Hare-Mustin, 1987; Luepnitz, 1988; Meth & Pasick, 1990; Mirkin, 1990; Mogul, 1982; Walters et al., 1988) after a relatively lengthy period of little attention. While there has been a growing body of literature regarding gender concerns in individual therapy, e.g., the process of men treating women (Chesler, 1971; Heatherington, Stets, & Mazzarella, 1986; Kaplan, 1984), women treating men (Bernardez, 1982; Bograd, 1990; 1991; Gornick, 1986); men treating men (Ipsaro, 1986; Levant, 1990; Osherson & Krugman, 1990; Pollack, 1990), and women treating women (Bernstein, 1991; Goz, 1973; Person, 1983), very little has been explored about the complications that exist in couples therapy. Consider these clinical situations, each involving a male therapist:

Tearfully, the wife describes her husband's rejection of her surprise dinner for his birthday. The therapist, a male, empathizes with her distress. The husband, feeling misunderstood, interrupts the therapist and says, "Wait a minute. Sure she wanted to support me by making a special surprise dinner, but then she served buckwheat pancakes. Buckwheat pancakes! A man isn't going to eat buckwheat pancakes. Would you eat them?"

In a second couple, the wife declares angrily that her fiance pays little attention to her when the Celtics are on television. She adds, "I've talked to my women friends about it, and we agree that all men will abandon you for the Celtics or Judge Wapner." The male therapist had himself watched the Celtics game the night before this session.

After two years in couples therapy, a wife revealed to her husband that she had never really enjoyed sex. A month later, in therapy, this conservative, religious woman discussed with her husband for the first time a shameful experience she had endured at age 5, in which she had been caught and punished by her mother for masturbating. As she discussed this, and her subsequent masturbation history, stating that she felt very comfortable with the therapist, the husband kept stealing glances at the the therapist for his reaction.

The perspective taken here is that psychotherapy, whether individual therapy or couples therapy or family therapy, is a conversation and an experience. These clinical examples highlight situations in which the very nature of the conversation and of the experience may be determined more by the therapist's gender than by his theory. What is the nature of the conversation and experience of the male and female in the couple in the situations that I've described? And what is the experience of the therapist? How might these situations occur differently, if at all, if the therapist were a female? How are the conversation and experience different, and is this difference helpful or destructive? Are there particular dilemmas that result when the couples therapist is a male?

From a gender perspective, the treatment of couples is profoundly different than that of individuals because couples therapy involves three people, with the inherent imbalance of one same-gender pairing and one cross-gender pairing. While it will be argued here that this "unstable triad" (Lamb & Hare-Mustin, 1990) leads inevitably to interesting and complicating transference and countertransference situations, there is a paucity of attention in the literature to such situations. Many recent volumes on couples therapy make virtually no mention of such considerations, as though they have little significant impact on treatment. In this paper, I will examine some of these considerations in the context of the treatment of one particular type of couple frequently seen by therapists. I will suggest that there are very specific difficulties that arise when the therapist is a male, raising the question in the title: Should men treat couples? I will also suggest some specific advantages. As I discuss whether men should treat couples, a subtext question, perhaps as significant, might be *Are male therapists really men*?

The "Typical" Couple in Conflict

While there is surely a wide range of couples that come for treatment, in terms of presenting problems, depth of pathology, and availability of psychological resources, there does seem to be, for the sake of examination, a typical couple configuration. This, indeed, should come as no surprise to those who believe in the central importance of gender socialization, because each member of this typical couple is clearly a member of the culture in which we all live.

This quintessential couple is composed of the woman who strives for intimacy and the man who strives for distance. The woman is interested in connection, community, and cooperation while the man is focused on autonomy, isolation, and competition (Bowen, 1978; Fogarty, 1976; Jordan et al., 1991; Low, 1990; Scarf, 1987; Stiver, 1984; Tannen, 1990; Walters, 1990; Walters et al., 1988).

Two psychiatrists (Martin & Bird, 1959) described in detail, albeit quite pejorative detail for the woman, this "most difficult psychotherapeutic problem" (p. 245). In 14 couples, they saw repeatedly the pattern of the dependent, clinging, infantile, "lovesick" wife, married to and blaming of the intelligent, competent, and rational, "cold, sick" husband.

This type of marriage, which continued to draw attention in the 1960s and 1970s, was thought of as "*the* marriage syndrome," (Ryder, 1970), where the wife is frustrated and distressed in her efforts to spark some life from husband, and the husband acts deliberately calm and reasonable in an effort to pacify his wife" (p. 53). Other authors have also described similar interaction patterns (DuPont & Grunebaum, 1968, discussing paranoid women; Sampson, Messinger, & Towne, 1964, discussing schizophrenic women).

Then, the classic article on this subject was written (Barnett, 1971), entitled "Narcissism and dependency in the obsessional-hysteric marriage." Using the ancient notion that opposites attract, Barnett described the marriage between the obsessional neurotic and hysteric neurotic: "The hysteric sees the obsessional as the strong silent man, profound, organized, and successful, while the obsessional views the hysteric as being warm, vital, loving, and fun." (pp. 75-76).

> The hysteric, in her dependent craving for contact and care, threatens the obsessional, whose fears of exposure and whose shame and self-contempt cause him to perceive tenderness and intimacy as risks he cannot afford. His response to this threat is to avoid intimacy, to withdraw and create emotional distance, to inhibit affect and action. The hysteric, her anaclitic needs thwarted, responds to his avoidance by feeling unloved and rejected and by frantically attacking the passivity and withdrawal of her mate. The obsessional views this response as criticism, rejection, and scorn and reacts with further retaliatory withdrawal and distantiation (p. 77).

Even if we avoid the diagnostic name-calling attached to such couples, they should be recognizable to the seasoned clinician. It is also readily

recognizable that this couple is not infrequently brought to the therapist by the dissatisfied woman who pressures the reluctant man, sometimes "blackmailing" him (Gordon & Allen, 1990; Low, 1990; O'Brien, 1990) with the threat of separation or divorce.

Transference and Countertransference Prior to Therapy

One day, the couple calls for an appointment. The position suggested here is that the moment the appointment is made with the male therapist, transference and countertransference reactions are activated. The projection factory begins to hum. For purposes of discussion, I will divide these transference and countertransference reactions into two time periods, specifically, the period before therapy begins, and the period of therapy itself.

A Priori Transference Reactions

By transference, I am referring to the "special illusion" (Sandler, Dare, & Holder, 1970) which the patient develops about the other person, whether the therapist or the partner, which represents a repetition of feelings, drives, attitudes, fantasies, and defenses originating in earlier experiences of life with significant persons and unconsciously displaced onto figures in the present. I am also broadening the concept of transference to include present affective responses that are structured by the individual's earlier immersion in a particular sociocultural milieu more than by the specific personal attributes of the figure in the present toward whom they are made. From an object-relations perspective, I am concerned here with the affective experience associated with internalized object representations and projections of internalized self-representations. What I am actually describing here is the patient's a priori "working model" of who the therapist will be.

A brief digression about relationships is necessary to elaborate on this latter point. The assumption here is that each member of a couple enters the relationship with a "working model" (Bowlby, 1982; Israelstam, 1989; Shay, 1990) of what he/she, the partner, and the relationship will be like. This working model is based on current perceptions that have emerged from earlier life experiences with males, females, and relationships, both in the family of origin and in the larger context of the sociocultural milieu. The effects of this omnipresent sociocultural milieu, organized along such dimensions as gender, power, and hierarchy, cannot be escaped and, as such, exert a profound, if relatively silent, influence on each individual's presumably unique working model. When this working model includes "illusions," distortions, or misrepresentations based on the past, it can be thought of as transference-based or transference-influenced. Such transference influences often occur between members of the couple, and of course, toward the therapist as well.

Returning now to transference toward the therapist, the reader is reminded that all transference reactions can be placed into one of two categories, namely, positive and negative transference. I would like to be more specific, however, and redefine the categories as *Affiliation Transferences* and *Disconnection Transferences*. Positive, affiliation transferences can include idealizing, dependency, parental authority, mirroring, and narcissistic self-object transferences. Negative, disconnection transferences can include devaluing, aggressive, competitive, shame, and sadomasochistic tranferences.

When the initial appointment is made, each member of the couple, then, has certain predisposing thoughts, feelings, and anticipations, that is, a working model of therapy and the male therapist. While these reactions vary along a wide continuum, certain expectable reactions can be predicted based on each member's growth and socialization in their families of origin which are inevitably and inextricably located in a particular sociocultural milieu. Relevant to the discussion below is the ubiquitous and critical pattern of socialization described by Chodorow (1978), namely, the pattern of children being reared primarily by their mothers, with resulting affiliation imperatives central for girls, and separation imperatives central for boys. This pattern is so embedded in the current organization of society, has so penetrated the marrow of daily interaction, that it may deserve to be considered, with apologies to Jung, as the "cultural unconscious."

Because the transference reactions activated here occur before therapy actually begins, I have called them *a priori transferences*.

In our culture, therapy, as an experience of affiliation, is primarily a woman's domain, calling upon familiar abilities for a woman such as acknowledgement of difficulties, expression of

affect, experience with intimate sharing, and comfort with dependency needs (Gilligan, 1982; Goldner, 1985; Heatherington et al., 1986; Jordan et al., 1991; Stiver, 1984). As a result, women who are about to enter couples therapy with a male therapist often begin with *a priori* transferences along the affiliation spectrum, such as positive, idealizing, dependency, and authority transferences. Often, however, women fear that they will not be understood as well by a man, in the context of individualized paternal transference expectations, as well as deeply embedded sociocultural expectations which inhere in a patriarchal society, for example, the expectation that men, just like the boys in elementary school, bond against women to protect their status and power. Does the woman fear that the therapist, in the first meeting, will greet the man with a secret handshake and whisper "Semper Fi"? Is the very use of this Marine metaphor elusive or troubling, and is that reflective of a man's potential misunderstanding of women?

Men, on the other hand, who are less willing to acknowledge difficulties, less comfortable with intimacy, and more restricted emotionally, are notoriously reluctant to enter treatment, "the refuge of the weak" (Scher, 1990) whether with a male or female (Balswick, 1982; Ipsaro, 1986; Levant, 1990; O'Neil, 1982; Oshershon & Krugman, 1990; Pollack, 1990; Skovholt, 1978; Toomer, 1978). Richman (1982) expresses this well when he articulates the first commandment of masculinity: *Thou shalt not cry or expose feelings of emotion, fear, weakness, symptoms, empathy or involvement before thy neighbor* (p. 103).

Consequently, a priori transference reactions for men more often range along the disconnection spectrum, such as shame, devaluing, aggressive, and competitive transferences. Again, this is especially true for those men who are being dragged to therapy against their will. When the male learns that the therapist is a man, he may initially feel relieved, because he does not have to face the "double shame" (Gornick, 1986) of being a patient and being subordinate to a woman. But he may also feel threatened and vulnerable, recognizing that he is about to enter an alien land (Ettkin, 1981; Oshershon & Krugman, 1990; Tannen, 1990) with another male who is almost certainly more like Alan Alda than like Donald Trump. His reactions may also include jealousy, expectation of competition, and homophobic anxiety which are signally different than typical reactions toward a female therapist.

It is further threatening that the therapist may actually do a better job of responding to the woman's needs, thus "raising the curve" for the man and underlining his inadequacies. Indeed, the very nature of couples therapy, with its emphasis on open communication, expression of affect, and the development of intimacy, may be inherently threatening and humiliating when a male therapist so easily offers that which the woman has unsuccessfully tried to get her man to provide.

A Priori Countertransference Reactions

While the members of the couple are busily anticipating therapy with a male, the therapist has his own countertransference expectations, that is, his own working model of the couple. (I am using here the totalistic definition of countertransference as including all of the therapist's affective experiences of and assumptions about the patient.) We may call these *a priori countertransference reactions*. Once again, in object-relations terms, the therapist, too, has a host of affective experiences associated with internalized object and self-representations.

Rather than present these countertransference reactions in general, I would like to confess some of my personal reactions which I believe are representative for male therapists, since we all participate in roughly the same sociocultural arrangements. My thesis is that there is an inextricable relationship between the way we, as couples therapists, grow up in and participate in the social arrangements of society, and the way we experience and develop countertransference reactions to the partners in couples therapy. (Please recognize that I am not defending these reactions, but trying to be honest about them.)

First, in the phone conversation with the woman, I typically experience an affiliative countertransference, anticipating that the woman is initiating the treatment, is willing to change, will welcome my understanding and empathic support, will keep her partner coming to treatment even after the insurance expires, and will tolerate my periodic siding with her partner since she intuitively knows he needs this to remain in treatment. I also do not expect her to be competitive or devaluing. In short, I expect to like the woman, and to have her like me. I also expect

that at some point in the treatment I may experience sexual feelings toward her ranging from brief sexual curiosity to erotic wishes. (I am less reluctant to acknowledge these feelings because of a courageous article by Bograd (1989) discussing this taboo area of the therapist's experience.)

Despite these generally affiliative feelings, I also anticipate that I will periodically miss connecting with the woman, because there are some experiences I cannot share. These vary from obvious experiences such as pregnancy and menstrual periods, to more subtle ones related to growing up as a female in this society. While obvious to women, certain experiences may escape a man's consciousness. Can a man genuinely appreciate, for example, the woman's experience of living her entire life in a society in which there has never been a female President, in which the best known female in the country is Madonna, in which the fear of rape is a pervasive and sometimes debilitating reality?

In contrast to my generally affiliative reaction to the woman, my a priori reaction is less affiliative and more disconnected from the man, even though I know from experience that we will share much in common, such as an interest in achievement, autonomy, sports, and sex. While I hope we will also share an interest in self-reflection and the capacity to express vulnerability, I do not expect this, certainly not initially in therapy. Moreover, I expect that the difficulties in the relationship will not break down in a 50–50 manner, even though my training is systemic as well as psychodynamic. Rather, I anticipate uncomfortably that I will have to struggle with the man about recognizing the severity of the difficulties in the relationship, feel competitive with him for the affections of his partner, and have more difficulty in allowing myself to become as intimate with him as with his partner.

While I expect that I will also come to like the man, especially if I meet with him individually once or twice, I do not anticipate thinking about him in a sexual way, although this does on occasion happen for me. I also anticipate that I will support the woman in criticizing her partner, causing him shame, which will then cause me to feel guilty and ashamed of myself. I have learned that my ability to tolerate a man's vulnerability is less than my ability to tolerate it in a woman. I have also learned that this is often the woman's experience as well.

There are, of course, advantages to sharing gender, centering around a familiarity with a common socialization process which has shaped both of us. I am familiar with the male epistemology, that is, I know how a man makes meaning of the world. I can appreciate his striving for success, his competitive nature, his drive to accompany his testosterone for an outing to the movies, and his ability to purchase an entire wardrobe in less time than this presentation. I can also resonate with his deep, often hidden, need for intimacy and connection and his anxiety about expressing underlying vulnerabilities. Also, I know these can be explored if I can provide a "holding environment" which is increasingly less threatening.

Transference Considerations

Next, having made the appointment, the couple enters the office, accompanied by transference and greeted by countertransference. Concerning transference, it is common that the couples' a priori transference experiences will develop into powerful transference reactions in treatment, typically along the same affiliation or disconnection spectrum that characterized the a priori reactions. Having described these transference possibilities earlier, they will not be repeated here. However, two problematic aspects of transference in couples therapy deserve to be highlighted.

First, in contrast to individual therapy, there is an added dimension to transference in couples therapy, which I call Newton's First Law of Transference, namely: In couples therapy, for every male transference experience, there is an equal and *correlated* female transference experience, and vice versa. In other words, each member of the couple reacts to the therapist in a particular transferential way, but has this reaction in the *presence* of the partner who has a correlated reaction. There is a kind of symmetry or complementarity to many transference experiences, although often taking a complex rather than a simple form. These "triangular transference transactions" have been described in the literature primarily by psychoanalytic theorists (Giovacchini, 1965; Greene & Solomon, 1963; Guttman, 1982; Sonne, 1981; Willi, 1984).

Second, not infrequently a triangular transference dilemma is presented when the woman develops an eroticized transference. Whether conscious, unconscious, or preconscious, the male

therapist can become "the other man" (Lamb & Hare-Mustin, 1990) for the woman, whether by virtue of sheer transference experience, or because the male therapist has seemed to favor the woman and perhaps even been flirtatious with her. Even if not flirtatious, the therapist must remember that empathy can be extremely seductive, especially when offered to an empathy-starved wife. Not surprisingly, the withholding husband is not excited by this "affair," if he discerns it, and predictably may experience jealousy, competition, and humiliation. Her rescuer has become his adversary.

Unless recognized by the therapist and handled with sensitivity, the outcome of this transference development can be premature termination of therapy. Such recognition by the therapist is enhanced by an appreciation of his own countertransference.

Countertransference Considerations

In treating couples, as in treating individuals, powerful countertransference reactions are unavoidable. This brings us to Newton's Second Law of Transference, namely: In couples therapy, for every intense transference there is an equal and correlated countertransference. That is, intense transference begets intense countertransference. Sometimes it is less clear about what begets what. Common clinical lore suggests that "seductive patients are those who can't resist us and hostile patients are those who don't admire us" (Lamb & Hare-Mustin, 1990, p. 272).

While some of our countertransference experiences will cut across individual and couples treatment, many will be significantly different because of the particular nature of couples therapy and the particular working model of relationships which the therapist brings to the work. Most therapists have been reared by couples whose marriage has remained intact at least long enough for the therapist to have developed a working model of marriage. Whatever the working model, whether of underlying harmony, intermittent volatility, or chronic conflict, this model will be juxtaposed in some way with the couples relationship in the office, for example with the stormy couple (Shay, 1990). A therapist whose parents fought vociferously and constantly and then divorced will have a different model and a different countertransference reaction than a therapist raised, for example, by Dr. Carl Rogers and his wife, or Mr. Fred Rogers and his wife.

There are some countertransference experiences deriving from personal history which are typical for both male and female couples therapists, including: overidentification or siding with the member of the couple most like an idealized parent or different from a devalued parent; too great or too little tolerance for heated exchanges in the office; premature attempts at peacemaking and problem-solving; childlike immobilization; and profound urges to withdraw from conflictual situations. While some of these reactions promote affiliation and others disconnection, they do not seem to be primarily gender-based.

Although the male therapist affiliates at times with each partner, and, *ideally*, with both at once, nonetheless, there are countertransference patterns which are clearly problematic for the therapy, namely, those in which affiliation with one partner risks disconnection with the other. As a simple illustration, the male therapist may experience the wife as victim and overidentify with the transference attribution of the rescuer. The wife, seen by the therapist as victim, may relate to the therapist as her hero, as he attempts to rescue her prematurely from the villain who is victimizing her. (I exclude here those couples situations in which battering or sexual abuse is occurring, in which the need for rapid and clear-cut action is necessary to protect the safety of the victim.)

Countertransference Edge to the Woman

In general, affiliation countertransferences are more common toward the woman of the couple, because, as noted above, she is more likely to speak the language of therapy. She is also more likely to stroke the male therapist's narcissism through affiliative, idealizing, and dependency transferences, such as those described earlier. As if these magnetic attractions were not sufficient, the male therapist's particular disconnections from the man also result in greater affiliation with the woman.

While some of these countertransference disconnections may develop from earlier family experiences of the male therapist (such as experiences with his father, brother, or son), in a larger sense they derive from the male's participation in the social arrangements of society, which I have earlier referred to as the "cultural unconscious." Elsewhere (Shay, 1992), I have argued that, from this perspective, countertransference does not begin in the office; it begins at birth.

Earlier, I noted some of the difficulties male transferences experience in utilizing therapy deriving from gender sterotypes about masculinity. Male patients are males before they are patients; male therapists are males before they are therapists. As Ettkin writes, "No matter how much a male therapist may feel that he has gone beyond the traditional limits of gender-role stereotypes, the therapist is still part of the culture and is directly and indirectly influenced by it" (cited in Ipsaro, 1986, p. 263).

In consequence, the male therapist, too, may have a culturally embedded difficulty in feeling intimate with another man. Moreover, the male therapist is not immune from shame about vulnerability, difficulty acknowledging inadequacy, restrictive emotionality, or homophobia. In addition, "male therapists may be made uneasy by experiencing the sense of male inadequacy" from patients (Ipsaro, 1986, p. 263), for it may resonate too closely with aspects of ourselves that we have heretofore been able to ward off or deny. In a couple in which the husband, an unemployed engineer, had extreme difficulty in recognizing or sharing feelings, he began to talk for the first time of his deep pain in having to consider taking a job which would demean him. "Do you want me to take a job as a clerk in the bagel store?," he asked his wife. Turning to me, she said, "There's a new bagel store opening up in Belmont Center." "Really?," I said. "Where exactly is it?" As the wife began to answer, the husband exclaimed, "Wait a minute! Don't you want to hear about my *feelings* instead of the bagel store?" Unconsciously, collusively, we did not.

The male therapist may also be a competitive person who has difficulty avoiding a competitive struggle with the man in the couple, thereby implicitly tilting toward the woman. Overidentifying with an idealizing transference as "the expert," "knowing the answer" may also be "a subtle form of competition that is also a barrier to intimacy and maintains an unequal and authoritarian therapeutic relationship" (Solomon, 1982, p. 269). In this way, idealization by the male patient can result in shame, especially with the female observing this process, resulting in consequent devaluation of the therapist.

Another pitfall arising from this type of transference–countertransference matrix is described by Ipsaro (1986) who warns of the dangers of parentification and infantilization: "The male therapist may discover some of his own issues as a father with the male client; or, at the other end of the continuum, his own issues as son may be seen in his male client's responses to him as an authority figure or father figure" (p. 264).

Countertransference difficulties ensue, as well, when the therapist has worked to dis-identify with stereotypic gender roles. The therapist may be angry or impatient with the male who glorifies the stereotype (Ipsaro, 1986), or may devalue the male who, in businesslike fashion, is "seeking instrumental solutions to affective problems" (Osherson & Krugman, 1990, p. 337), or may feel fearful in the presence of an angry male. By devaluing stereotypic masculinity and instrumentality, and admiring expressivity, the therapist again tilts toward the female.

These latter countertransference reactions are particularly interesting in couples therapy because of the presumably ongoing process of projective identification between the couple. Projective identification is a process by which an intrapsychic tension becomes an interpersonal conflict, as the partners trade disavowed aspects of themselves and enact the other's disavowed aspect. When the therapist disavows certain "masculine" traits such as aggressivity, he may be stepping in the middle of the couple's projective identification process, accepting the disavowed aggressivity from the wife, but immediately "passing" it to the husband in trade for the husband's disavowed passivity. By adding his weight to that of one partner, in this case the wife, the therapist creates a powerful imbalance in which there is a magnification of the process already existing between the pair, with particular disavowed attributes hurled at the husband. This is, if you will, an example of "projectile identification." (A more complicated analysis of this point is beyond the scope of this paper, but would include Racker's [1957] concepts of complementary and concordant identification. Moreover, the intrapsychic tension described above may be argued to originate, not in the individual, but in the sociocultural imperatives that promote such polarization of attributes.)

Countertransference Edge to the Man

While the woman may be seen to have the edge in many respects, there are particular advantages for the man as well which result in greater affiliation. As a result of being male, both therapist and husband share certain cultural loadings, although, to be sure, male therapists may downplay these.

What we share has very early roots. In one couples therapy session, after the husband said to the therapist, "We aim to please," the therapist disclosed his loose association to bathroom grafitti when in junior high school: "We aim to please; you aim too, please." The therapist and husband talked about bathroom grafitti for a moment, and the therapist said to the wife, "One experience I've never had is reading the grafitti in a girl's bathroom. I don't know what girls write." The husband blurted out, "Recipes!" All three laughed, the men perhaps more heartily than the wife.

This facetious example reflects the more serious point that a body of experiences shared by men make possible a kind of primal bonding, which is powerful and exclusionary. These experiences include an emphasis on bonding through power, achievement, autonomy, and humor. From bathroom to back yard to baseball diamond to bar room to board room, men bond by teasing, by grabbing at each other's testicles, by competing to win, by sexist asides, by demonstrating grit, and by denying the need to bond. This is our secret club for which we need no decoder ring or secret handshake to belong.

From the opposite direction, women share many experiences that the male therapist has little hope of understanding with the depth of empathy necessary to comprehend the experience. The most obvious are biological: pregnancy, childbirth, breastfeeding, and menstrual periods. Less obvious to men are women's experience of sexuality (for example, in relation to differences in sexual desire or initiation of sex), the wish for intimate talk ("rapport talk" vs. men's "report talk," Tannen, 1990), and the willingness to tolerate abusive situations. In each of these areas, the woman in couples therapy may be at a disadvantage with a male therapist who can better empathize with the man's failure of empathy.

At a more subtle level, it has been argued that all men, including therapists, blame women because men see mothers "through the eyes of the eternally angry child within, no matter what our age, sex or parental status. . . . [S]ince virtually every adult was raised by a woman, all of us are likely to retain exaggerated images of an all-powerful, fearsome, and enticing figure, who rendered us helpless merely by contrast" (Goldner, 1985, p. 39). This can lead the unconsciously blaming therapist in couples therapy to "some sadistic act masquerading as an unfortunate, but necessary, clinical maneuver" (Goldner, 1985, p. 40).

A Word About Power

Having discussed the centrality of gender as a major factor in the treatment of couples, it is important to highlight the inextricable relationship between gender and power. It is critically important to recognize that in this society, *gender travels with power* (Perelberg & Miller, 1990). In the analysis above, there are certain clear references to this power dimension. For example, issues of competition, "expertness," and shame between the men involve power. Issues of idealization, vulnerability, and blame between the therapist and the woman involve power. There are less obvious issues as well, however, which raise interesting questions. What does it mean to the wife that it takes a man to "change" her man? Is the empowerment of the male therapist by its very nature disempowering of her? What does it mean to the husband that his wife is seeking help from another man, metacommunicatively a more powerful man? What does it mean to both that the power relationship in the therapy (namely, that the male therapist carries more power) repeats the dominant cultural pattern, even while striving to equalize the power imbalance between the couple? Does the very use of psychodynamic language, e.g., paternal transference, maternal countertransference, etc., no matter how tied to sociocultural roots, *interfere* with our understanding, because it maintains the centrality of individual analysis while skirting perhaps a more essential sociopolitical analysis of gender arrangements?

Conclusions

Having offered these ideas, what conclusions can be drawn concerning the question Should Men Treat Couples? First, the simple answer is: yes, men are clearly capable of treating couples and helping them to grow. The more complex answer is: yes, but only with great sensitivity to gender issues, within each member of the couple, within the couple itself, and within the therapist.

As I have tried to emphasize, the therapist's gender-sensitivity will help him better appreciate his own *a priori* ideology and also that of the members of the couple. It will as well maintain his consciousness that there are powerful and inescapable consequences of being a male therapist

with a heterosexual couple, centering around the same-gender/cross-gender pairings.

Suggestions for the therapist, male and female, that derive from these considerations and summarize the major points of this paper include the following:

1. Remember the "obvious," namely, that neither you nor the couple leave your gender in the waiting room.
2. Try to isolate the "gender messages" you have internalized from your family, from the culture, and from your training. (Black & Piercy, 1991; Coleman, Avis, & Turin, 1990; Hare-Mustin & Maracek, 1986; Roberts, 1991).
3. Take time to discover the *a priori* and continuing transference perceptions of each member of the couple.
4. Attend to your countertransference experience toward each member of the couple, and recognize that your experience toward one may well impact the other.
5. Appreciate that your "working model" of men, women, relationships, and treatment may well place one of the members of the couple at a genuine disadvantage in the treatment.
6. Strive to utilize the particular advantages of being a gendered therapist, e.g., as a male therapist, providing for the man a model of empathic attunement and intimacy; operating for the woman as a guide to the foreign terrain of the man's psyche; serving for both as an interpreter when they are speaking different tongues.
7. Inform yourself about feminist critiques of exploitative therapeutic interventions.
8. Remember that feminism strives for equality between men and women, and that men can be feminists too. We too can join, even without a decoder ring or a secret handshake.

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