Homosexuality in the First Three Decades of Transactional Analysis: A Study of Theory in the Practice of Transactional Analysis Psychotherapy

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Abstract
Eric Berne, in the 1950s and 1960s, constructed a theory that brought about its own psychopathology of homosexuality, leading to the virtual disappearance from the transactional analysis literature of the concepts of the homosexual and homosexuality. Berne’s colleagues (and others) continued developing his ideas using life script theory to explain homosexuality as a psychopathology caused by a script. However, in the 1970s there were some gay contributors who began the work of removing homosexuality as a transactional analytic psychopathology and increasing visibility in the vicinity of the transactional analysis closet, although they left unchanged the mesh of theoretically intertwined but consistent concepts that produced the psychopathology. This essay describes how the psychotherapy of the homosexual patient generates theory, the theory creates the psychopathology of homosexuality, and, in turn, the psychopathology of homosexuality produces new theory. Also discussed are Berne’s writings on homosexuality, which demonstrate that theory comes before the psychotherapy and the psychotherapy precedes the psychopathology.

“I could have cured him the same way I’ve cured myself.”
“And that is …”
“By convincing him he wasn’t sick.”

[From Corydon by André Gide (1925/1985, pp. 16-17), in which Corydon explains to a friend what he would do now to help a young man of their acquaintance who, in despair over his sexuality, had committed suicide]

Soon after the publication of Eric Berne’s (1972) last major book, American psychiatry deleted homosexuality from its list of psychiatric disorders (Bayer, 1981) thanks to politically and socially active and intellectually engaged lesbians and gay men. Since then, attitudes and public policy toward lesbians and gay males have continued changing in many places, often for the better. What, then, might be the relevance of a scholarly study of Berne’s theory of homosexuality and of the transactional analysis conceptualizations of homosexuality in the first three decades of transactional analysis? One reason is that Berne’s theory is still in use, and its heterosexist assumptions cannot be dismissed—and neither can his theory’s lack of sensitivity to lesbians, gay men, and bisexual women and men.

The purpose of this essay is to present evidence for two claims: The first is that Berne’s theory produced and configured its own psychopathology of homosexuality. The second is that his theory denied the legitimacy of same-sex desire and behavior. In fact, it obliterated from transactional analysis the concept of the homosexual through a transformation of concepts. Berne constructed the concept of the homosexual differently than had anyone before him: He transformed it into the concept of the Child ego state and construed the homosexual as a child and thus as an ego state. Another purpose of this essay is to trace the virtual disappearance of the idea of homosexuality from the transactional analysis literature of the 1970s and to discuss the role of the concept of life script in shaping the transactional analysis psychopathology of homosexuality. I also evaluate the three gay contributions to transactional analysis in the 1970s and the efforts by other theorists to remove homosexuality as a transactional analysis psychopathology.
Some of the material I use here comes from my study of theory-centered psychotherapy using transactional analysis as my case (Barnes, 2002a). For that study I analyzed everything Berne published, some of his unpublished material, and all of the transactional analysis literature up to 1980 for references and possible relevance to three examples of psychotherapy bringing about psychopathology, one of which was homosexuality.

This essay interacts strikingly with my own personal narrative, making what I say here especially poignant for me. Berne’s theory and transactional analysis became a “plan of action” that shaped my development as a psychotherapist and an individual. Berne’s theory of homosexuality demanded what Sedgwick (1991, p. 3) called the “vicinity of the closet,” with all the secrecy and duplicity implied in that notion. Locating individuals in the vicinity of the closet silences them and makes them invisible. Gay individuals also retreat to the closet for privacy and to protect themselves from abuse (see Simerly, 2003). Sedgwick explained, “For many gay people [the closet] is still the fundamental feature of social life; and there can be few gay people, however courageous and forthright by habit, however fortunate in the support of their immediate communities, in whose lives the closet is not still a shaping presence” (p. 68).

Does theory make any difference to practice? My answer is that theory is already practice. In this essay I discuss how what I have learned from experience might have some validity for others by showing, in fact, what theory does to practice, using homosexuality as an example and transactional analysis as a case of a theory-centered psychotherapy. I let transactional analysis speak for itself, showing its own distortions and maltreatments of the narratives of gay individuals.

While transactional analysis created its unique psychopathology of homosexuality, other theory-centered styles of psychotherapy made their own assertions and claims about homosexuality. What they all share is what Foucault (1978) called the medicalization of homosexuality, first by medicine and then by psychiatry. According to Foucault, before the nineteenth century, “sodomy was a category of forbidden acts” (p. 43). Then, “the nineteenth-century homosexual became a personage, a past, a case history, and a childhood, in addition to being a type of life, a life form, and a morphology, with an indiscreet anatomy and possibly a mysterious physiology” (p. 43). Medicine and psychiatry constituted homosexuality as a psychological, psychiatric, medical category. “Homosexuality appeared as one of the forms of sexuality when it was transposed from the practice of sodomy onto a kind of interior androgyny, a hermaphrodisism of the soul. The sodomite had been a temporary aberration; the homosexual was now a species” (p. 43).

Therefore, the empirical material for this essay could have come from almost any of many theory-centered approaches—from psychoanalysis to even more recent psychotherapy vintages—to demonstrate the circular arrangement of theory-psychotherapy-psychopathology. It just so happens that transactional analysis is the theory-centered approach that I know most thoroughly as practitioner, supervisor, teacher, and theorist. In addition, I have devoted many years to a scholarly study of it.

This essay is presented in three parts. Part I sets forth the central argument by explaining the circularity of theory and psychotherapy and of theory-psychotherapy and psychopathology.

Part II begins with an analysis of Berne’s (1952) unpublished notes, excerpting his comments about his work with a male patient. This analysis shows the constructive process at work—of theory-centered psychotherapy bringing about the psychopathology of homosexuality. I then consider Berne’s published work on intuition and discuss the case of Ned. These two cases, especially the case of Ned, are the background for discussing the psychopathology of homosexuality that Berne’s psychotherapy proposed. I describe how Berne’s construction of the Child ego state obliterated the concept of the homosexual, with the concept of the Child ego state replacing the concept of the homosexual as a grown-up individual. This section con-
cludes with a discussion of reflexivity, which is missing in Berne’s description of Ned’s theory, arguing that homosexuality as a ps
lays bare the underlying assumptions and say also “queers” psychotherapy; that is, it con
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school’s theory and prototype case are discussed in the third part of this essay, and a review of the references to homosexuality in the other transactional literature during the 1970s is presented. In an earlier study (Barnes, 2002a) I presented a more comprehensive discussion of this material, including a critique of reparenting, the other predominant school of the 1970s. There I offered an analysis of the paradigm case for reparenting as presented by its founder, J. L. Schiff (Schiff, 1969; Schiff with Day, 1970). This case demonstrated how Schiff’s reparenting theory was unmistakably heterosexist and homophobic (or homorevulsive in White’s [1999, p. 79] refinement.

PART I: THEORY AND PRACTICE
Gay studies and constructionism, constructivism, American pragmatism, and second-order cybernetics are employed here to show the interaction of theory, psychotherapy, and psychopathology in relation to the concepts of the homosexual and homosexuality.

This essay fits within constructionist lesbian and gay studies (Stein, 1992, 1999; see also Doan, 1997, for the distinctions between constructionist and constructivist ). This essay also “queers” psychotherapy; that is, it lays bare the underlying assumptions and ways of working of transactional analysis theory, arguing that homosexuality as a psy-

chopathology is the psychopathology, not of gay individuals, but of the psychotherapy and its theory.

My beginning point is with the psychotherapy itself, that is, with turning the psychotherapy on itself (Barnes, 1994, 1999a, 1999b, 1999c, 2000). As part of this process, I turn script theory on itself and on transactional analysis as a whole, showing what it does where it acts reflexively. I turn to script theory to analyze transactional analysis by studying how transactional analysis theory and practice shaped the concepts of homosexual and homosexuality from the 1940s to 1980, delineating how theory-practice related itself to the experiences of gay people.

I propose that a theory works in psychotherapy like a script. The theory becomes a fixed program, leading psychotherapists to assume, for example, that patients have an invariant set of states. It also programs therapists through their training and their own transactional analysis psychotherapy. And the psychotherapists, in turn, transmit the program to their patients—often without being aware that they are doing so. Similarly, they may be unaware that by drawing diagrams of ego states and talking about a patient’s ego states, they might be attributing theoretical concepts as injunctions.

Psychotherapy seems to work when patients become highly receptive to suggestions, metaphors, hunches, images, analogies, and stories their psychotherapists offer. Any of these (and other rhetorical forms) can become injunctions, especially when trust develops. In fact, love, respect, and care may be vehicles by which injunctions are transmitted. It may be assumed that psychotherapists transmit injunctions to patients just as script theory claims parents transmit them to children. Ideas that constitute an injunction depend on the recipient’s interpretation and understanding of the ideas, not only on the intentions of the speaker or the content of the ideas. I believe that psychotherapy is trance inducing and that not infrequently patients spontaneously go into hypnosis during treatment, regardless of the psychotherapy style or approach (Barnes, 2002b). (Observers of the diagnostic rhetoric of psychopathology know its persuasiveness.) Holby (1973),
drawing on Laing, described the transmission of injunctions as taking the form of hypnotic suggestion. Thus, I claim that in theory-centered psychotherapy, the application of the theory in clinical practice acts as the script of the psychotherapy through the psychotherapist’s application of the concepts of the theory.

The transactional analysis style of theory making, like other theory-centered styles, involves a circular relationship between psychotherapy and theory and psychopathology and theory. In this circular relationship, the psychotherapy of the homosexual patient generates theory, the theory creates the psychopathology of homosexuality, and, in turn, the psychopathology of homosexuality produces new theory. Berne’s writings on homosexuality demonstrate that theory comes before the psychotherapy and the psychotherapy precedes the psychopathology.

Figure 1 illustrates the circular relationship between psychopathology and the theory of psychotherapy in the context of a psychotherapist applying a theory in a conversation with a patient. Theory (T) creates psychotherapy (Pt) just as psychotherapy makes theory; psychotherapy-theory (Pt – T) brings forth psychopathology (Pp) just as psychopathology gives rise to psychotherapy-theory (Pt – T).

Accordingly, there is no psychopathology until a psychotherapy is invented to generate it; the invention of a psychotherapy leads to the naming of a psychopathology; and every theory-centered psychotherapy names its own psychopathologies, which in turn define their own worlds of psychotherapy (Barnes, 1994; see also Baute, 1980, for a content analysis of Transactional Analysis Journal [TAJ] articles published in the 1970s, with results demonstrating the circularity described in this essay).

**PART II: BERNE’S THEORY OF HOMOSEXUALITY**

Treat . . . according to the principle, “Remember she is a child, writhing with embarrassment,” rather than, “Remember the homosexual and anal conflicts.”

Eric Berne (1957/1977a, p. 104)

**The Case of Mr. D**

The case of Mr. D documents Berne’s treatment of a male patient in group psychotherapy and provides data on theory-centered psychotherapy constructing the psychopathology of homosexuality. Mr. D’s reason for being in psychotherapy was homosexuality—and he was suicidal. In addition to group therapy with Berne, Mr. D had been seeing a psychiatrist for individual psychotherapy for 4 years.

The case of Mr. D as described here is derived from Berne’s (1952) notes, which he wrote himself or dictated. Copies of these unpublished notes and manuscripts were generously made available to me by the Jorgensen, authors of a thoroughly researched biography of Berne (Jorgensen & Jorgensen, 1984). These notes are summaries of Berne’s reconstructed conversations of his weekly sessions with one of his therapy groups in 1952. I did not have access to all of his notes from these group sessions, and I do not know if they are extant, but those I did see covered 13 months and comprised 177 typewritten, double-spaced pages. They begin on 22 January 1952 and run through 20 January 1953. I analyzed notes from 17 group meetings, and the dates of the sessions and page numbers from the typescript are used for references in this essay. Of these group sessions, five contained approximately 45 explicit uses of the
words “homosexual” or “homosexuality.” A female professional was Berne’s assistant therapist, and he usually included in his notes a summary of his discussions with her following each group. She was also seeing some group members for individual psychotherapy. I will refer to her here as Ms. P (not the initial Berne used).

My purpose for discussing Mr. D’s case is to distinguish Berne’s concept of homosexuality by relating it to his overall theory, the development of transactional analysis, and the development of the theory and psychopathology of homosexuality in transactional analysis. Since readers are unlikely to have access to Berne’s notes, I have quoted several revealing passages verbatim, hoping to communicate the sentiments Berne’s text conveys as well as its conceptualization of the psychopathology of homosexuality.

Overview of Berne’s Notes on Mr. D

The themes of Berne’s notes from the May 13 group session are death and sex. Mr. D discussed his feelings about death, saying, “I don’t see much in life anyway. You just go on living and there is nothing to it” (p. 2). A corpse does not bother him. It “is just an inanimate object” (p. 5). He reluctantly went to his father’s funeral and started crying. He thought it was “self-pity.” Berne disagreed: “Calling it self-pity is a defense against feeling the grief” (p. 7).

Berne also discussed sexual feelings, telling a patient that his problem was that two men could not exist side by side in one place and that perhaps Mr. D’s “problem is the same.” Mr. D disagreed, “My problem is sex.” “The same thing applies to sex,” replied Berne. “It could be two men in one bedroom. It’s either him or me, the same as with [another patient, Mr.] Ws now—it’s either him or me. I think they will both be all right when they can see that several people can exist side by side and not get in each other’s way too much” (p. 10).

Berne’s notes for 20 May begin with Mr. D, who “started the discussion immediately upon entering, stating that his condition had suddenly grown worse.” Mr. D was afraid that one of his professors, who had “made him very uneasy,” was homosexual. Mr. D was required to attend his classes, but he was afraid to go. His feelings were becoming impossible for him to tolerate. “He realized now that it was not the professor’s fault but due to something in him,” Berne wrote. “It had to do with homosexuality, especially his being homosexual, although previously he had thought it was the professor.” Berne noted that Mr. D “was in acute misery.” Mr. D said he was unable to study: “I can’t think of anything else but these feelings I have in that classroom and my fears about homosexuality” (p. 1). Berne wrote that in this session Mr. D’s manner was different from previous sessions. He was “diffident, listened to what everyone said, even the people he had formerly attacked and had expressed contempt for.” While Mr. D was talking, Berne noticed “how frightened Ms. P looked as it was obvious to her which way D was headed” (p. 2). Mr. D told about having climbed up on a dam and he said that “people must have thought I was going to commit suicide”; seeing people stare at him, he came down (pp. 2-3).

Mr. D asked on 27 May, “Why do people go on living anyway? I wonder why you people go on living?” And later he said, “My moods are going to recur all my life, and I don’t see that it’s worthwhile to go on living” (p. 1). Later in the session Berne said he was “against suicide.” The main reason is “that none of you in your idea are really committing suicide. In other words, it fits very well with the idea that it is impossible to imagine one’s death” (p. 3). Mr. D challenged Berne: “Is it really?” Berne replied, “I believe so. You see if we go over your ideas about suicide, you see you are not really killing yourself, you are killing something in yourself and then you are still around to see what happens.” After illustrating his point from what people in the group had said, Berne stated that “none of you is really dead when you commit suicide” (p. 3). Mr. D replied, “Well, I still don’t know why anyone would go on
living, especially if they have been rejected.” He asked Berne if “psychiatry could help such a person.” Berne’s answer was theoretical: “You can go back to birth and reform someone’s character.” Mr. D objected: “No. It is like a twisted finger. Who can straighten it out?” Another member of the group asked him, “D, are you that child?” He answered, “No,” adding, “I don’t think psychiatry can help.” Berne answered, “Well, it has been done. It is amazing how people can be straightened out even when they were so-called rejected at a very early age” (p. 4).

On 10 June Mr. D asked, “What’s the use of living?” (p. 5) and “Do you think I will be back in September?” (p. 6). At the end of this session Berne shook hands with Mr. D and said, “Good luck, D. Write me a letter. Either write it privately or if you feel I can read it to the group, please put on it ‘This letter can be read to the group.’ ” Mr. D replied, “Thank you. I’ll do that. You know, I guess you people really do help me.” Another patient said, “We will look forward to seeing you in September.” And then another: “Yes. We want you in the group and we hope you come back” (pp. 10-11).

On 23 September, the first meeting after Berne’s vacation, Mr. D returned to the group, reporting that his condition was “very serious” and that he had been “thrown out of college.”

On 7 October Berne told Ms. P during their post-session discussion that he was “glad that D is Dr. A’s patient. I think it is a matter of week to week that we carry him through.” Berne said he could “only hope” that Mr. D “will find some libidinal satisfaction in the group that will keep him coming back indefinitely.” He asked Ms. P, “Did you notice how he sat with his finger near his temple?” (p. 7).

Mr. D was absent on 14 October when the group discussed whether he was really suicidal. One patient said he could not say what he wanted to say to him because he might commit suicide, but maybe he “was just talking about this to get sympathy to control the group” (p. 5). Berne agreed with the group members who said they should not criticize Mr. D (pp. 5-6).

Mr. D said on 3 November, “I don’t know how much longer I can last without committing suicide. I am very lonely. At work the other day the girls were talking to me normally, and they suddenly began to imitate queers and that made me very uneasy. Then I was transferred to another department. The men were all right until they began to imitate queers and that made me uneasy. I feel helpless. I don’t know any good reason for living. I am angry at psychiatry” (p. 3). Later in the session he said, “I don’t feel suicidal right now, but people sure bother me” (p. 7). After the session Berne wondered about “how long D is going to last” (p. 8).

The next week, 11 November, Mr. D told about getting “the man who cleans the rooms” fired. He explained that this man “was talking to me as though he knew I was a homosexual.” He asked Mr. D, “Is there anything I can do for you?” Mr. D threw him out of his room, knowing “the boy in the next room could hear him.” He demanded that the manager fire the man: “Either he goes or I go” (p. 4). Berne said Mr. D and another patient, Mr. G, have the same problem, but Mr. D’s “problems are more urgent” than G’s and “less precise.” Mr. D’s problem is, “People will think I am homosexual.” Mr. D “actually has two problems, and the one that makes him suicidal can be taken care of by drugs” (p. 6). Mr. D wanted to know what Berne meant. “Well, you see,” Berne answered, “G can have the same idea and it doesn’t really bother him. He can live with it ten or twenty years. You feel an urgency to settle it. It is this urgency which is the problem.” Again, Mr. D asked, “What do you mean?” Berne said, “I mean it is not the content of the question, ‘Do they think I am homosexual’ but it is the feeling around it, the feeling of urgency which makes you want to settle it by suicide. And this feeling of urgency can be dissolved by a drug.” “Oh, I see now,” said Mr. D (p. 6).

Berne told Mr. D on 20 May that the
group, not psychiatry, could help him. Since Mr. D admitted that he did not know when others were talking about him, and since it was important for Mr. D to know when he was “distorting, misinterpreting, or exaggerating,” and since “it would be very dangerous for you to do that,” what the group can do is keep him “in touch with reality.” Berne was careful to note that he meant the reality of feelings: “Tell us your feelings and we will tell you how we feel about them, and this will help you to understand your feelings better and to know the reality of them.” Berne added, “This is a service that we can perform as we are doing it tonight. I think it keeps you much more in touch with what is really going on inside yourself, so that you avoid misinterpreting, exaggerating, and distorting” (p. 5). Later in the session Berne said that homosexuality “is not the real issue.” Just as earlier Mr. D had used aggression to attract everyone’s attention, “Now what you are worrying about again is that you are attracting everyone’s attention, so whether this is done by being aggressive or by worrying about being a homosexual, the real reason is what people call self-consciousness but what I would call too much consciousness about other people. And that is really the problem” (p. 7).

On 21 October Mr. D reported, “Everybody’s afraid of me now.” Berne explained that Mr. D was “still on the axis of fear. It is whether you are afraid of them or they are afraid of you. Of course, the real progress would be if you could just be at ease with them.” Mr. D replied, “Yes, I think you may be right. I can see that” (p. 4). Berne answered, “Yes, and now that you can control the situation by making them afraid of you, you may gradually come to feel more at ease with them” (pp. 4-5). On 28 October Mr. D touched another male’s foot and “he had a homosexual feeling; that means he felt someone would think he was homosexual” (p. 1). Berne reflected on this session that after Mr. D and yet another male (Mr. G) talked about homosexuality, Berne saw “them smiling at each other in an intimate way.” Berne remarked to Ms. P, “Did you notice how D and G looked at each other, as though to say ‘I know you’ to each other?” (pp. 6-7). During the session Mr. D and Mr. G agreed that their feelings were normal, but another group member disagreed, saying that made him abnormal (p. 1). Berne noted on 3 November that “last week D felt uneasy because he had touched W and felt W might think he was homosexual. His solution for that—what was it, D?” Mr. D answered, “I avoid people for that reason.” Berne said that others had the same problem. “You people avoid people because you are afraid of something in connection with homosexuality” (p. 4).

Following the group meeting on 11 November, Berne and Ms. P argued over who was the “sickest” man in the group. Berne held out for Mr. D, offering as proof that Mr. D “has to lash out at everybody.” Ms. P did not agree. Berne explained, “If he hadn’t been coming here, he would have lashed out [at the manager]. That’s what he did during the summer when he wasn’t coming here. . . . In reality D is the sickest. After all, psychosis is a practical concept” (p. 10).

On 25 November Mr. D said he was “worse since coming to a psychiatrist” but then reversed himself, saying, “No, I’m exaggerating; it’s not really that bad” (p. 2). Berne told Mr. D and others that they had talked “about looking and being looked at” (p. 4). Following the session, Berne told Ms. P his concern about Mr. D, that if he “ever became paranoid about them, it might be very tragic and disastrous.” Berne “was actually figuring out the possibilities of D coming in and shooting the place up.” He hoped that Mr. D had “enough libidinous investment not to do that.” Next time he would “get D to talk a little about his paranoia to see how he was doing” (pp. 5-6).

Major Themes

For explication I have extrapolated four major themes about homosexuality and homosexuals from Berne’s notes on his work with Mr. D. These themes often showed up in the arguments by American psychiatrists in the 1950s and 1960s to support their claim for the psychopathology of homosexuality (see Lewes, 1988; Marmor, 1965).
1. Homosexuals have to overcome their hostility and fear of women and come to see them as real people. Finding the right woman will restore heterosexual potency.

2. Homosexuality is related to patterns of early childhood. Children are born "normal," but some parents program their children at an early age to be homosexuals.

3. People have to control their sexual feelings.


There are themes relevant to Mr. D’s case that I do not spell out here. One is a relationship in Berne’s theory between homosexuality and paranoia. Another theme is Berne’s conviction that psychotherapy can cure homosexuality—if homosexuals want to be cured—and cure means being free of sexual activities with other males. Berne (1947/1968) asserted that “homosexuals” have to want to be cured, but most homosexuals do not want to be cured. It is what they should want, but “most homosexuals who come to a psychiatrist, however, do not want to be made heterosexual, but want to be relieved of the symptoms which often occur among homosexuals, such as headaches, diarrhea, and palpitation” (p. 253).

In the following paragraphs, I cite vignettes from Berne’s notes of his discussions with Mr. D that spell out each of the four major themes. I also draw from Berne’s published work statements that corroborate or delineate these particular themes.

**Theme 1:** Homosexuals have to overcome their hostility and fear of women and come to see them as real people. Finding the right woman will restore heterosexual potency.

Berne said to the group (20 May),

If certain men are afraid of women, then they run away from them and have to express their sexual impulses in some other way and they may get interested in men. But it is not a question of homosexuality, it is a question of emphasis. Furthermore, D’s interest in men may not be as sexual as he thinks it is; it may be something else entirely which has the appearance of sex. (p. 11)

Berne (3 November) insisted that separating sex from other activities is necessary if one wants to enjoy people. “As for homosexuality, I don’t believe there is any such thing” (p. 5). He explained why “so-called” homosexuality does not exist:

It’s a good word for us to use here, but it always boils down to something very specific. To start off with, all people of both sexes have hormones of both sexes. . . . These hormones have some psychological effect, but usually people can repress the effect of hormones of the opposite sex. But if we add to this the psychological problem, namely a fear of the genitals of the opposite sex, then we have trouble. I think each of you here has that problem. . . . If you are afraid of them and you feel sexy, then you can’t think of the opposite sex, so you think of the same sex, and this is homosexuality so called. But you see the problem is really a very concrete one. It is not a matter of words or theory. (p. 5)

On 11 November Mr. D said, “If I had a good relationship with women, I wouldn’t be interested in homosexuality. I have a date with a girl for next Saturday” (p. 4). Berne’s response was that Mr. D’s problem was that people will think he is homosexual. Berne addressed the group members: “It is now clear that each of you feels his problem would be solved if he had normal relationships with women. . . . D has said so explicitly tonight, and I agree” (p. 6). Berne continued by describing “normal” sex as “genital relationships with the opposite sex,” explaining that “this is considered the most satisfying in our society” (p. 7). He continued:

Now the point is that your difficulty is first, not getting along with the opposite sex but secondly, the thing you go back to has a strange fascination for you. . . . D turns to homosexuality—whatever that means in his case. Although he is the most urgent, he is the least specific. Actually, we know least about what he means. (p. 7)

Later in the same session, Mr. D said, “I am looking forward to going out with this girl.” Berne proposed to Mr. D to “use this date as an experiment. I would observe how you feel about her, how she feels about you, and what happens” (p. 11). Both Berne and Ms. P wondered (25 November) if Mr. D “shouldn’t try
the experiment of not talking about homosexuality, since his problem is probably really women” (p. 2).

Theme 2: Homosexuality is related to patterns of early childhood. Children are born “normal,” but some parents program their children at an early age to be homosexuals. On 11 November Berne told the group: You were all born normally, and . . . you reacted in a perfectly normal way to the abnormal things that happened to you. Therefore, there is nothing essentially abnormal. It is the abnormal things that happened to you that turned you from the track of normality. If you could trace this back to the beginning and get back to the time when you were normal, you could complete your normal growth. (p. 7; also 20 May, p. 3)

On 7 October Berne discussed Mr. D’s “childhood patterns which made the script” (p. 6). Berne also associated Mr. D’s homosexuality with his childhood incest experiences. On 11 November another patient asked Mr. D, “What is your cultural attitude toward homosexuality? Why did you feel guilty?” Mr. D replied, “Well, I felt guilty because I had had homosexual ideas.” The other patient continued questioning Mr. D, asking if there was any homosexuality where he was reared. Mr. D denied ever hearing of it. Berne reminded Mr. D that “there was something interesting sexually where you were brought up. What was it?” “Oh, yes. Incest,” Mr. D said, explaining that he and all his siblings from the age of 6 on “had some sort of intercourse with their brothers and sisters.” Then he allowed that “there was some homosexuality,” adding, “if I had a good relationship with women, I wouldn’t be interested in homosexuality” (p. 4).

Theme 3: People have to control their sexual feelings. Berne said to the group on 20 May that “the real problem in life is to find out how to control one’s sexual feelings and thoughts so that one can go about one’s everyday business.” He added that “psychiatry is . . . to help you control your sexual feelings because all of you are efficient enough when you are in good shape” (pp. 8-9). In reply to the patient’s question, “How do you control your sexuality?” Berne talked about getting sexual feelings under control to use that “energy” for other things. You are able to get your sexual feelings under control so that energy can be used for other things temporarily, but as soon as you are under an emotional strain, such as an examination, which would be as a sexual examination, the integration of your sexual feelings falls apart and begins to trouble you again. . . . [Things that are called homosexuality] turn out to be something else. For example, a homosexual is generally thought of as one who is interested in a person of the same sex. (p. 10)

Theme 4: Homosexuality is a problem of identity. Berne told Mr. D on 20 May that his basic problems have something to do with his impending examination. Berne explained that an examination in mathematics that Mr. D was worried about was not the examination he was really worrying about and that what he was trying to study is “on the surface” (p. 5). Underneath, Mr. D is “worrying about another kind of examination, a primitive one, which is . . . the first examination anybody ever has.” Berne said the first examination everybody undergoes is the examination to find out whether they are a boy or a girl. And I think this is why D is unable to study. You see, he is trying to find out whether he is homosexual or not, that is, how much of a man or a woman he is. He is not sure of his masculinity and he acts as though the examination would be that kind of examination. That’s why he can’t study. His conscious mind says, “You must study mathematics,” whereas his unconscious mind, the part which he is not aware of where these primitive fears are hidden, is saying “‘Don’t waste your time doing that. The problem is to find out how much of a man you are before you take that examination. You are not too sure of your masculinity.” This does not come about by accident. Perhaps your parents wanted a girl and somehow they conveyed this to you so that you were never sure of your sex in some very primitive part of your mind. (p. 6)

That reminded Mr. D that “up until the age of
two I had long curls, and then my mother cut them off.” Berne reported that “everyone seemed to agree” with him that in the 1920s “it was rather unusual to let a boy go with long curls until the age of two. Like a girl” (p. 6). Mr. D volunteered later that his “confusion must go back to a very early period” (p. 9). Berne said one basic problem “is the question of losing one’s penis or testicles if one talks about sex. . . . The real problem is to prove one’s masculinity or femininity, and this is how doubts creep in” (pp. 9-10).

**Discussion**

What is missing in Berne’s notes is a sympathetic tone regarding Mr. D’s suffering and his despair about homosexuality, feelings that seemed to be pushing this patient toward suicide. Berne may have thought that Mr. D’s having “normal” (male-female) sex would cure his homosexuality. In fact, he told Mr. D that medication could stop his thoughts of suicide. Today we can only be amazed by the aura of professional insensitivity to Mr. D’s kind of pain and suffering that these notes appear to reveal.

After 4 years, psychotherapy had not cured Mr. D of the psychopathology of homosexuality. Although he hoped it would help him change his sexual behavior, it had not changed his sexual desire—and his emotional condition was worsening as he fell deeper into despair. Mr. D had come to see himself as psychiatry saw him. He agreed with Berne that finding the right woman would make him “normal” and that he needed to engage in male-female sexual activities to get well. Mr. D wanted to be cured of his homosexuality, so he was learning to dance and getting dates with women. However, nothing he did was helping because his problem was that psychotherapy could not cure the psychopathology of homosexuality that it had imposed on him. He seemed to be, like others in his situation, on the way to committing suicide, disavowing life and finding it meaningless.

Reading Berne’s notes left me feeling that not only had Mr. D not received help in developing either the self-understanding or the self-confidence he needed to overcome his self-hatred and shame, but treatment had instead added to both his self-hatred and his shame. It seems he was coming to see himself as even more of a freak he feared he was. He became an object of disgust, not desire. When he left the group on 10 June, he found out the group members cared for him, and he might have hoped that after the summer things would be different. So he went back, although he received the same treatment.

Berne assumed that gay men are hostile toward and fear women. He took this assumption from Ferenczi, who was Berne’s (1944; 1970, p. 248) preferred theorist on several sex-related themes, including homosexuality. Ferenczi (as cited in Lewes, 1988) wanted to abate “their hostility toward women, to help control their sexual urgency, and to restore their heterosexual potency with women” (p. 67). Berne also believed, following Ferenczi, that a gay male’s finding the right woman and engaging in male-female sex would make him “heterosexual” and “restore” his “normal” heterosexual potency. In *Sex in Human Loving*, for example, Berne (1970, p. 132) wrote that the ideal sexual mate for a man is the right woman who will turn him on. The book is about male-female sex (e.g., pp. 48, 79, 86), and in it he wrote nothing positive about female-female sex or male-male sex. In fact, what he did say was either pejorative or silly (e.g., p. 216).

The women who populate the “script world” of the “male homosexual,” according to Berne (1972), are “either dangerous and hateful schemers, or else innocent and occasionally amiable weirdos” (p. 351). According to Berne, gay men have come to see women as real people when they make them the object of sexual desire and have sex with them. Berne did not “believe there is any such thing” as homosexuality (3 November, p. 5)—which means there is no such thing as legitimate (healthy) male-male or female-female sex. This belief is encoded into Berne’s theory. Thus the idea of homosexuality was eliminated just as Berne’s theory would obliterate the idea of the homosexual. In Mr. D’s case, this meant that, according to Berne, Mr. D did not really desire men.

Berne also relied on Ferenczi’s authority to give credibility to his idea that homosexuals were born “normal.” Ferenczi did not believe in “innate homosexuality” and grounded “homosexual object choice in an ‘excessively powerful heterosexual’ (intolerable to the
ego’” (as cited in Lewes, 1988, p. 55). Berne’s discussion of “normal” seems to be a definition of what he later called “OKness,” which is the state before parental scripting takes effect. (Berne makes an essentialist statement, saying each individual is born “essentially” normal.) With regard to Mr. D, as a patient he was asking psychiatry to help him accept himself as being different. He did not need to hear that he was born “normal” if he had never experienced what Berne called “normal,” especially if he lacked that capacity.

Berne’s 1947 book The Mind in Action, an introduction to psychiatry, anticipated a position that he later worked out in the script theory of homosexuality: The individual “who has taken this direction since childhood is the most difficult to treat” (p. 204). In the 1968 revised edition of the same book, now titled A Layman’s Guide to Psychiatry and Psychoanalysis, he added to the paragraph on treatment, “If a homosexual wants to be ‘cured,’ it is possible with enough treatment” (p. 253). This statement implies (1) that homosexuality is a psychopathology that needs to be cured and (2) cure can be effected with enough treatment. Later, he (Berne, 1970) wrote that homosexuality is “programmed in by the parents in most cases” (p. 197), and in his final book, he claimed, “The most important factor here is the parents’ scripts. Does Jeder fit in, or is he the wrong sex, or badly timed?” (Berne, 1972, p. 71). It is the script that is responsible for homosexuality, and that is why Berne did not consider same-sex relationships game free and script free.

The third topic—people controlling their sexual feelings—presented Mr. D with a dual temptation. He had to control his sexual urges (as did the others in the group), and in Berne’s view he had to switch from male-male sexual desire to male-female desire and thus to control the sexual object of his desire. Controlling sexual feelings is a theme that runs through almost everything Berne wrote about sex. In fact, he wrote as if he was compartmentalizing sex, separating it from the rest of living.

Berne did not believe that friendship between people could endure if it involved a sexual relationship. Specifically, he (Berne, 1970, p. 198) never supported the notion that gay people can sustain friendship within male-male or female-female sexual relationships. He thought that, even if homosexuals stop playing their games, they are still deviants, and they are deviants because of their psychopathology of homosexuality. Berne (1966) insisted that sexual “deviation should be separated from the overlying games” (p. 353). He distinguished homosexual sex from “playing Homosexual,” allowing, however, that “a game-free homosexual can lead quite a different life from one who insists on exploiting the game aspects of the situation” (p. 353). He thus implied that homosexuality ipso facto creates situations in which games are played, the reason being that it originates in a script.

After Berne developed a consistent (and complete) theory of ego states, games, and script, he (Berne, 1970) advised homosexuals to give up their “gamey behavior” because as game players they are “using their sexuality for bait as well as for pleasure,” satisfying “both their hang-ups and their desires and thus keep themselves reasonably contented—on their way to lonely Loserville” (p. 191). By believing that homosexuals can change from being the victims of their parental programs and their own childhood decisions, he supported the idea that homosexuality is a psychopathology caused by parental instructions and childhood decisions. The cure is to become heterosexual, becoming what “biology” intended lesbians and gay men to be, according to the theory of biology Berne was using.

Berne (1947/1968) claimed that many gay males “are ‘over-sexed,’ and cannot resist the temptation to ‘cruise’ and pick up anybody they can at any time and in any place” (p. 253). He (1964a) went on to claim that “the psychiatric conception of homosexuality . . . is heavily skewed, because the more aggressive and successful [game] ‘players’ do not often come for psychiatric treatment, and the available material mostly concerns the passive partners” (p. 123). The logic of this argument should be that the psychiatric conception of homosexuality is heavily skewed because it is the more aggressive and successful players who do not need treatment (and perhaps their passive partners did not need or seek treatment either for their passiv-
ity or for their homosexuality). In fact, Hooker’s (1965) research, which challenged the view that homosexuals were sick, showed that gay men were not as psychiatry described them. Her groundbreaking study of nonpatient gay men, which began in the early 1950s, was the first not to focus on clinical populations. She matched her gay target groups with a heterosexual group, proposing to find out (1) if the homosexuals revealed higher levels of psychopathology than the heterosexuals and (2) if the matched pairs of homosexuals and heterosexuals could be distinguished from each other and thereby show evidence for the psychopathology of homosexuality. She found that gay males differed as much from each other as did heterosexuals. The conclusion to be drawn from her work is that the diagnostic label of homosexuality is itself pathogenic (see Bayer, 1981, pp. 49-53).

In the context of describing the antithesis of the game of “Perversion,” Berne (1964a) noted that “the game of ‘Homosexuality’ has become elaborated into a subculture in many countries, just as it is ritualized in others. Many of the disabilities which result from homosexuality arise from making it into a game” (p. 125). He proposed subjecting the provocative behavior that gives rise to other games to “social control, which reduces the handicaps to a minimum,” adding,

The “professional homosexual” wastes a large amount of time and energy which could be applied to other ends. Analysis of his games may help him establish a quiet ménage which will leave him free to enjoy the benefits that bourgeois society offers, instead of devoting himself to playing his own variation of “Ain’t It Awful!” (p. 125)

Conversely, “One of the most unfortunate and acute forms of Third-Degree ‘Rapo’ occurs relatively frequently between homosexual strangers, who in a matter of an hour or so may bring the game to a point of homicide” (p. 127).

Berne did not connect Mr. D’s threats of suicide with the homophobia and social oppression of gay people in American society in 1952 Cory (1951) put forward the novel idea that homosexuals were an oppressed minority. Berne, like others in his profession in the 1950s, was not listening. He, and they, lived in a heteronormative society, breathing its homophobia, where homosexuality was illegal, police entrapment of gay men was common, and there existed a “public paranoia that homosexuals represented an invisible enemy” (Alwood, 1996, p. 65). The fact is that Berne (1960) was not sympathetic to the idea of anything causing psychosocial problems other than early childhood influences:

“The doctrine that people are victims of their environments is a doubtful ortho-psychiatric position” (p. 1060). Therefore, in the case of Mr. D, he was convinced that his patient’s problems were caused by parental and early childhood influences. Regardless of what theory Berne used, it could not cure the psychopathology of Mr. D’s homosexuality—not even the one imposed by Berne’s theory—because homosexuality is not a disease or a result of faulty development. Rather, it is a psychopathology that exists in theories, not in people before the psychotherapy plants the psychopathology on them. At best, a theory (and theory-centered psychotherapy) can only cure itself of making psychopathology (Barnes, 1994, p. 137).

Sadly, it seems Mr. D did not even receive help for his ulcer and headaches let alone his suicidal ideation. According to Berne’s theory, Mr. D’s reason for being in psychotherapy was to get relief from his symptoms, not to be cured of his homosexuality. Or, as Berne (1972) wrote in his major work on script theory, homosexuals come to therapy “to find out how to be more comfortable living in [their] script,” not to leave their script world (p. 351). Berne made other assumptions about gay men: They do not seek psychotherapy to change, meaning to change their psychopathology of homosexuality. They seek psychotherapy to play their games with their [male] psychotherapists, advancing the Child’s “script through transactions with the therapis” (p. 352). In his view, rather than play games with male homosexual patients, the psychotherapist needs to confront them:

If a homosexual man sits with his legs wide apart to exhibit his basket, the therapist can say: “Tremendous basket you’ve got there. Well, to get back to your diarrhea . . .” etc. If the patient re-
plies “Fuck you!” the answer is “Not me. I’m here to cure you. What about the diarrheaa?” (p. 353)

In my view, Berne let himself get by too easily with his confrontation of the gay man’s “basket.” He would not have done so if he had included himself in his theory and in what he was saying, noting, for example, the seduction in his calling attention to the “tremendous basket.”

The Case of Ned

The case of Ned—the prototype case of Berne’s theory—is one of three published cases (the others being Diana and Alice Triss) that further exemplify the thesis of this essay. Ned, alias Mr. Segundo (Berne, 1961), was a socially popular 35-year-old family man whom Berne, to ensure his patient’s anonymity, misidentified as “a court-room lawyer of high repute” (p. 33) (he actually practiced medicine). Berne (1973) said later that transactional analysis “started” when Ned said to him, “I have a little boy inside of me” (p. 63). Instead of attributing to that remark the orthodox psychoanalytic interpretation of an introjected penis, Berne thought maybe his patient was actually saying something significant and that “maybe [it] means something” (p. 63). Berne and Ned decided that “he did have a little boy inside of him,” and when Ned talked, Berne asked him, “Who is talking?” (p. 63). At times Ned would ask Berne (1957/1977b), “Are you talking to the lawyer or to the little boy?” (p. 122). In this way Berne split Ned’s personality into two parts, the little boy and the grown-up professional.

Berne (1961, pp. 33-34, 143-150; 1957/1977a, pp. 99-101, 116; 1957/1977b, pp. 121-122, 126-129) described Ned as sexually confused and as an impulsive bisexual, a gambler with a latent psychosis who referred to himself socially as “us girls.” At parties Ned would remark, “Us girls have got to be careful not to drink too much” (1957/1977a, p. 101; 1957/1977b, p. 126), which Berne understood as an indication of sexual confusion. However, Ned changed his mode of living after months of psychotherapy, confining his questionable behavior to weekend sprees at his cabin in the mountains away from his family. He moved his whiskey bottle, lewd pictures, guns, and morphine to this weekend hideout. After 4 years of treatment, he threw away the morphine, put aside the whiskey bottle, and brought his “private perversion . . . under much better control” (1957/1977b, p. 122). Berne credited structural analysis of Ned’s ego states with saving him from a “social and psychological calamity, and perhaps suicide” (p. 129).

Berne (1957/1977b) described Ned’s Child as “hostile, easily panicked, sexually confused, and afraid that something would be taken away from him” (p. 128). Berne claimed that it is in the Child where “the actual psychopathology for the most part resides” (p. 128). The theory set the terms for how the psychotherapy would work: “The problem was to ally the ‘child’s anxiety’ and ‘unconfuse him’ ” (p. 129). What was Berne’s goal for doing that? The “child” “would contribute . . . masculinity to the total personality” (p. 129). Berne diagnosed Ned’s Adult as “intelligent and realistic” and his Parent as weak and sentimental (p. 129). The eventual outcome of the psychotherapy was a change in the patient’s perception of himself, and Berne did that by helping Ned do the constructive work so that “he could actually perceive, as psychological realities, the three ego states which were in conflict inside of him” (p. 130).

Here is how Berne (1957/1977b) described the results:

After the boundary between his “adult” and his “child” became well-defined, he reported that he had had the following thoughts at a party: “If I were a girl (but I’m not a girl) I wouldn’t drink too much (but I don’t intend to make remarks about it aloud in any case).” The phrases in parentheses are the “adult’s” gloss on the “child’s” wisdom, and saved him from regret, from embarrassment, and from adding another item to the dangerously mounting gossip about him in the community. In the old days, the contaminated “adult” . . . would say: “Us girls [have got to be careful not to drink too much]” . . . etc. Now the masculine, sensible, purified “adult” distinguished himself from the bisexual impulsive “child.” When the “child” thought: “Us girls . . . ” etc., the adult was no longer
taken in, and made the two realistic objections given in the parentheses. (p. 126)

Berne (1957/1977a) discussed Ned in the context of characterizing patients who were “severe latent homosexuals” or “latent paranoid schizophrenics” (p. 101). Such patients aroused in Berne a primal image that let to what he called his primal judgment: “This man is concerned about buggery” (p. 102). Berne’s intuitive image was: “This man feels as though he were a very young child, standing naked and sexually excited before a group of elders, blushing furiously and writhing with almost unbearable embarrassment” (p. 102). Thus Berne’s primal image of buggery was transformed into an image of a writhing child. I infer from this that Berne transformed his concept of the homosexual into his concept of the Child ego state.

Berne’s (1962/1977c) view was that “intuitions may be used as instruments for satisfaction at any level of psychosexual development” (p. 160). He noted, “Perhaps the commonest example is the ability of homosexuals to spot one another quickly” (p. 160). This statement helps to explicate the connection between Berne’s concepts of intuition and homosexuality. His concept of intuition became his mechanism for transforming the homosexual into the Child ego state.

The Case of Diana

Berne’s (1957/1977a) first article on Ned also introduced another patient, Diana. Berne treated her using what he called his primal judgment: “This is a woman with strong homosexual conflicts and strong anal strivings” (p. 103). He treated Diana for 5 years according to this principle, encouraging “her hetero-sexual genital attitudes . . . but this was not enough” (p. 103). During the next 5 years of Diana’s treatment, Berne formed this “intuitive ego image of her”: “Remember she is a child, writhing with embarrassment” (p. 104). As a result, Berne reported that she was able to carry on her work and studies, “even during periods when she was engaged in an acute struggle with her paranoia” (p. 104). Berne added this footnote about Diana: “At the time of going to press, the patient has been married for six months and is functioning happily as a housewife” (p. 105).

Thus Berne (1957/1977a) described two stages in the development of his theory. In stage one, Berne’s perception was shaped by what he called a primal image: “Remember the homosexual and anal conflicts” (p. 104). When Berne perceived his patient’s conflicts as homosexual and anal, he encouraged “her heterosexual genital attitudes” (p. 103). In the second stage, Berne changed his perception from his primal image to the patient’s ego states. To do that he formed an ego image of the patient as a child, seeing the patient as “a child, writhing with embarrassment” (p. 104).

Berne painted a striking picture. Through his interest in intuitive processes he was able to isolate a mechanism for his constructive process, which he called intuition. He then distinguished between primal images and intuitive images, between primal judgments and ego states. He continued with perception of primal images, giving him primal judgments, but in psychotherapy he worked with the ego images and thus with ego states.

Sexual confusion and sexual conflicts led Berne to construct ego images and what he took to be actual ego states. His conceptualization of the homosexual was of someone else. Just as paranoia might be keeping passive homosexual yearnings from becoming conscious (as in Freud’s theory), or just as homosexuality was masking paranoia in Berne’s view, for Berne the homosexual was hiding the Child ego state.

Thus, what happened in the two stages of Berne’s psychotherapy was that in stage two, the idea of homosexuality began to disappear. What homosexuality was covering—paranoia—might still have to be struggled with, but homosexuality itself had been annulled, and with it bisexuality, latent homosexuality, and buggery. With the erasure of the idea of homosexuality, something else disappeared: the idea of the homosexual, which was replaced by Berne’s idea of the Child ego state.

Theory-Centered Psychotherapy Brings about Psychopathology

The case of Ned is not as straightforward as Berne tells it. Even if Ned contributed to developing the theory, there is something missing in the story. This case shows that psychotherapy brings forth theory, and it
demonstrates what happens with the introduction of theory into psychotherapy. That is, applying theory in psychotherapy brings about the psychopathology that is implicit in the logic of the psychotherapy. For example, Berne’s theory of ego states proposed the psychopathology of ego states (Berne, 1964b; see also Steiner, 1968). And then the psychopathology adds further to the theory, making up what Hacking (1992, 1999) calls “its own kinds of people.”

To return to the case of Ned, his psychotherapy led to the identification of his “psychopathology.” The psychopathology added to the complexity of Berne’s theory with a resulting loss of flexibility in the psychotherapy. In fact, in Ned’s case, the psychotherapy reduced his flexibility by ensuring that he would become a kind of social conformist and adjust to established social norms (Barnes, 2002b). As far as we know, there was nothing untoward about Ned’s psychotherapy. His story had a satisfactory outcome as Berne attested and as an independent interview with the patient years after Berne’s death confirmed (Jorgensen & Jorgensen, 1984). However, others who were exposed to the full-fledged theory in their own psychotherapy were not always as fortunate.

**Disappearance of the Idea of the Homosexual**

The psychopathology of homosexuality did not disappear from Berne’s theory and from transactional analysis. The concept of the homosexual as standing for same-sex desires and activities by gay persons, however, did disappear, reappearing in the guise of the psychopathology proposed by Berne’s theory. Berne’s construction of the Child ego state deleted the idea of the homosexual that his theory constructed, replacing the gay individual with the theoretical homosexual, which, in turn, was obliterated. It became, instead, “a child writhing with embarrassment.”

The idea of the homosexual construed in Berne’s theory of psychopathology was transformed through his theory of intuition from a primal image of a seductive homosexual wanting buggery to an ego image of a “writhing child standing naked before adults.” The grown individual was seen not only as possessing the ego states of a grown-up—Berne’s Adult and Parent ego states—but also as a child and possessing a Child ego state. Thus, in Berne’s theory the homosexual individual is not a grown-up but a Child. With this the identity of the person as a homosexual individual (i.e., a lesbian or gay male) ceases to be legitimate, and the problem of identity is solved. The theory came to conceptualize the homosexual individual as the product of (1) Parental injunctions, specifically of the injunction “Don’t be the sex you are” directed from the Child ego state of the parent to the developing child’s ego state and (2) early Child decisions, which means that the decision can be reversed. Thus, in Berne’s theory the idea of the homosexual disappears and also the idea of homosexuality.

Berne’s theory might have taken a route more sympathetic to the suffering and despair of lesbians and gay men if he had jumped to another level of abstraction. If, as I have argued, the theory obliterates the idea of the homosexual by transforming the homosexual into the Child ego state, why not take the next step and obliterate the psychopathology of homosexuality that Berne’s theory constructed?

The concepts “homosexual” and “Child ego state” are abstractions. Berne’s (1961) claim that ego states “are not concepts . . . but phenomenological realities” (pp. 24, 34) mistakes abstractions for concrete realities, committing what Whitehead (1925/1967) called the “fallacy of misplaced concreteness.” Berne’s claim also confuses logical typing (Whitehead & Russell, 1927/1980) by not recognizing that the name is not the thing named (see Bateson, 1972/2000). Kuhn (1970) noted that if scientists talk about an object long enough, they may actually invent it and be able to see it. They may, however, forget that what they are seeing is their own invention. So it is with psychotherapists when they apply theory in psychotherapy.

**Reflexivity Missing**

Who was the little boy that Ned had inside himself? Berne (1973) said the little boy was one of Ned’s selves (p. 68). If the little boy was one of Ned’s selves, and if a self proposes another person—the self and the other
proposing and requiring each other—by what social process did Ned get his little boy self? I direct a question to Berne’s text: Was Berne that little boy? This question turns Berne’s theory on itself. Ned never disclaimed having a little boy inside himself, but what if he had? What is missing in Berne’s theory is what is missing in Berne’s description of Ned’s psychotherapy. At no point did Ned turn to him and say, “Dr. Berne, if ever I thought I had a little boy inside me, I now know better.”

Let us listen in on an imaginary conversation between Berne and Ned. Berne (1973, p. 63) now believes that Ned really does have a little boy inside, as he will tell the story years later at a conference in Vienna. But in our imaginary story, Ned performs a reflexive act on his psychotherapy and his psychotherapist. Ned sees that his psychotherapist has accepted his psychic way of thinking about having a little boy in his head. Ned has to bring his psychotherapist out of the psychosis he has shared with him: “I have deceived you. I don’t have a little boy in me. I never did. The little boy you’ve been talking to was all made up. It was a useful way to talk for a while.”

Since we are creating our own fantasy, let us take the imaginary story further. Let us suppose that Ned’s reflexive act works and that his admission alerts Berne—perhaps even shocks Berne—into recognizing that he has substituted the metaphorical introjected penis of psychoanalysis with the metaphorical introjected little boy of his theory of ego states. He might even realize that he has substituted the little boy ego state for something else. Is it too far-fetched to imagine that Berne might have grasped then and there that his concept of the Child ego state was a substitute for the concept of the homosexual?

Imagine that: The notion of the patient therapeutically treating the psychotherapist’s theory after the patient had successfully completed his own psychotherapy. Such a process brings into focus the reflexiveness of a psychotherapy that plays itself out by turning the theory into the psychopathology and, with that turn, concluding the patient’s psychotherapy.

PART III: HOMOSEXUALITY IN THE LITERATURE OF TRANSACTIONAL ANALYSIS UP TO 1980

Who cares to call it love or not?
Laurence Collinson (1985b, p. 22)

There were gay men and lesbians who became transactional analysts, including a few who were colleagues of Berne. I know of no extant record of their agreement or disagreement with Berne’s theory of homosexuality. In general their lot was the silence and invisibility of the transactional analysis closet.

Perhaps the police raids on 28 June 1969 on a gay bar in New York City known as the Stonewall Inn, in which gay men and drag queens resisted arrest and rioted over the next few days, became the symbol and turning point for attitude change within transactional analysis as well as the wider culture (Alwood, 1996, pp. 82-90; Duberman, 1993). In December 1973, three years after Berne’s death, the American Psychiatric Association (APA) decided that “by itself, homosexuality does not meet the criteria for being a psychiatric disorder” (see Alwood, 1996, pp. 127-131, and Bayer, 1981, for a comprehensive study of the politics within the APA). Duberman (1996), a distinguished gay historian, described the 1970s as producing gains, but they “remained tentative, incomplete, and . . . of marginal significance or none at all” (p. 69). He explained:

Even in liberal straight circles, homosexuality could be accommodated only when seen as a pale shadow of the superior heterosexual way. Any suggestion that homosexuals, with their special historical experience, had a unique and valuable perspective to contribute—especially in regard to nonconformist gender roles—was perceived (accurately) as a threat to the established psycho-sexual order and treated, at best, with uneasy, patronizing scorn. (pp. 69-70)

By the mid-1970s, a few gay transactional analysts were overtly and openly questioning Berne’s theory of the psychopathology of homosexuality. There were other transactional analysts who challenged the notion of homosexuality as psychopathology. These challenges, however, did not reflect in-depth efforts to rework Berne’s theory or its epis-
temology of the closet.

As late as 1977, almost every transactional analyst who wrote anything about homosexuality connected it with the Don’t Be You injunction. Other than the three gay contributors to changing transactional analysis—Karakashian (1973), Collinson (1975), and Aiken (1976)—the exceptions were Beattie and Erskine (1976), McCormick (1971), and Allen and Allen (1978).

Homosexuality as a Transactional Analysis Psychopathology

In this section I cite representative transactional conceptualizations that were current in the 1970s. With few exceptions, transactional analysts in the 1970s viewed homosexuality as a psychopathology and conceptualized it as a script issue: Homosexuality was caused by a Parental Don’t Be You (the sex you are) injunction given in early childhood (Abell & Abell, 1976; Goulding & Goulding, 1978; Orlando, 1974; Roberts, 1975; Steiner, 1971), thus making it an issue of identity (Erikson, 1950). In transactional analysis, the crisis of identity was framed in gender terms as the result of script. The injunctions were axiomatic: It was believed that patients’ histories would show that the psychopathology of homosexuality they exhibited in adulthood extended back into their childhood, that the Parental injunction of Don’t Be You (the sex you are) altered their sexual and/or gender identity.

Steiner. Claude Steiner (1971) classified homosexuality as a psychopathology (along with alcoholism, depression, and schizophrenia). These psychopathologies “often represent a script, that is, they are the result of consciously made childhood decisions” (p. 158).

Steiner (1971) assumed that psychopathology (including the psychopathology of homosexuality) existed prior to script theory. He gave the example of “one young homosexual” who satisfied his mother by becoming her “good little boy,” with his “boyish behavior” receiving no support from his father. The script was as follows: “The decision had affected his sex life, in that he practiced a sort of depersonalized sex as a homosexual, which was an adaptation to his mother’s injunctions” (p. 35).

Steiner (1971) identified childhood decision as “the crux of psychopathology” (p. 36). For him homosexuality was still a diagnostic category, a psychopathology, caused by decisions in childhood or adolescence. Steiner (1967) claimed that “the adolescent’s decision to become homosexual is an example of a late not very comprehensive but socially unadapted decision” (p. 66).


Hamsher. J. Herbert Hamsher (1973, 1977) used Lionel Overssey’s prejudicial psychoanalytic concepts, drawing a distinction between homosexuality and “pseudohomosexuality” (see Lewes, 1988) and modifying both in a context in which transactional analysis theory was developing its own psychopathology of male homosexuality, turning men engaged in same-sex activities into what Foucault (1978) called “a species”—the homosexual.

Hamsher (1973) proposed helping male patients overcome their “constricting banal scripts.” He suggested that “some instances of homosexuality” can be related to how a boy’s mother describes his father to him (e.g., telling the son not to be like his father). The boy may, then, equate love with sex, concluding that his mother fears a homosexual relationship between him and his father; or the boy may use his sexuality with his father as he has learned to use it with his mother. Hamsher thought this dynamic might account for homosexual males who are “more invested in the ‘chase’ than in relationships or sexual activity.” And fathers who received the same messages from their mothers “may at times communicate to their sons their own desire for a love object of the same sex” (p. 26). Hamsher thought these homosexual males were more interested in “tenderness and affection” than in homosexuality per se—a claim I often heard when supervising psychotherapists in the 1970s.

Hamsher (1977) wanted men to get close to other men, to physically touch and hug them in keeping with what had become the norm on touching in transactional analysis.

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He gave men permission to “replay” their adolescent “homosexual” experience, which was “permission for men to love men and achieve intimacy with other men.” Therefore, “It is only when love, nurturing, intimacy can be experienced in the presence of women and without its being defensively sexualized, that a man is truly liberated.” (Here Hamsher was perpetuating another stereotype about gay men.) He added that “homosexual sex that is chosen rather than compulsory is not based on dislike of or exclusion of the opposite sex” (p. 471). He excluded male-male sexuality to encourage men to experience physical closeness to other men in keeping with Berne’s ideal of bringing sexual desire under Adult social control.

During the 1970s, two papers making in- temperate assertions about gay people appeared in the Transactional Analysis Journal. Zechnich (1973) claimed that the game of “‘Rapo” is so common among homosexuals that most play it. Orlando (1974) used a simplistic grasp of script theory to diagnose a gay male’s psychopathology, implicating in his homosexuality the man’s father and paternal grandmother and her two lesbian sisters.

“Don’t Be You” Injunction. A review of the transactional analysis literature shows the persistence of the idea that homosexuality is a script issue. The theory of the “Don’t Be You (the sex you are)” injunction led to widespread confusion among theorists (and practitioners) in transactional analysis. It seems that many patients turned up who were described as carrying with them the injunction from their childhood. Berne had explained the injunction as originating from the situation in which parents wanted a child of a different sex. From this the conclusion was drawn—based on faulty logic as well as limited clinical study (and in the absence of any controlled studies)—that the injunction was the cause of homosexuality. Of course, not explained were all the people with a female-male or male-female orientation (with no same-sex desires or fantasies and many of them reporting no same-sex experiences) who showed up for transactional analysis treatment with painful stories about their parents not wanting them to be the sex/gender they were. James and Jongeward. Muriel James and Dorothy Jongeward (1971) stated three assumptions about personal and sexual identity: (1) Everyone develops an identity as a person, which is related to a basic feeling of OK or not OK; (2) everyone develops a sexual identity, which is related to a basic feeling of OK or not OK as a person of a particular sex; and (3) identity is related to early-life transactions and to the games children play.

These authors also wrote that “maleness and femaleness are biological facts” and “the acceptance or rejection of oneself as either masculine or feminine is psychologically determined by what the child learns to feel about himself as a sexual person” (James & Jongeward, 1971, pp. 168-169). They claimed that if parents reject a child’s sex, the child is likely also to reject his or her own sex. At this point, transactional analysis theory becomes more apparent in their argument: The child who tries to live up to parental expectations is likely to alienate natural qualities of either masculinity or femininity. “While these influences seldom lead to homosexuality or lesbianism, they can, in some cases, contribute to deviation” (p. 169). James and Jongeward cite two examples of (male) “homosexuals” whose mothers wanted them to be girls. Here transactional analysis theory again portrays homosexuality as arising from parental messages and influences.

While James and Jongeward (1971) acknowledged that “homosexual behavior can occur in people for a variety of reasons,” they explained its cause in terms of ego state theory: The behavior “is probably related to the primal feelings in the Natural Child and to the lack of adequate heterosexual adaptation.” Their explanation is that the neonate is “sexually nondiscriminatory,” not knowing toward whom to direct sexual feelings. Early childhood experiences influence the child’s “heterosexual preference” (pp. 169-170).

Later, the Adapted Child makes adaptations. If adaptations are inappropriate, an individual “can feel compelled to try to be the opposite sex” (James & Jongeward, 1971, p. 176). James and Jongeward made their claim after using three examples of sexual identity, noting that a baby may be of the “wrong sex” for its parents. They cite an example of a male homosexual whose mother
treated him as if he were the girl she thought she would have. This kind of story is ready-made for script theory to explain as the workings of a Don’t Be You injunction. James and Jongeward, however, did not mention an injunction, although they explain how script works (p. 169).

James and Jongeward (1971) still derived psychopathology from the injunctions of the script and from the negation of OKness in the basic life positions (p. 96). They listed three “aspects” that contribute to “heterosexual adjustment”: “lack of fear of members of the opposite sex, opportunities for contact with members of the opposite sex, a personal sexual identity that is a realistic acceptance of one’s own sex” (p. 170). This statement implies that the lack of “heterosexual adjustment” causes homosexuality.

Challenges to Viewing Homosexuality as a Psychopathology

As the 1970s went on, the transactional analysis literature reflected a gradual yet marked change of attitudes with regard to lesbian and gay male sexuality. This change was furthered by related changes within both American psychiatry and American society, before the AIDS epidemic began in the 1980s (Shilts, 1988). There was a shift in attitudes among professionals who were sensitive to social issues—including transactional analysts—that may account, in part, for Perlman’s (2000) comment about the seeming absence of “pejorative references to homosexuality in the transactional analysis literature after Berne” (p. 280). However, this may not account for “the lack of writing in transactional analysis about homosexuality” (p. 282).

*English*. Fanita English (1975) offered the first unqualified endorsement in the *TAJ* of lesbians and gay men. In a pioneering article on shame and social control, English urged lesbians and gay men to give up the shame of the closet: “‘Wear a Gay Liberation button!’ (Come out of the shame closet!’)” (p. 27; see also English, 1994, pp. 111, 112).

*Gay Is OK*. In 1976, Douglas Beattie and Richard Erskine published a *TAJ* article entitled, “Permissions: A Cure for Sexual Problems.” It was the first article in the *Journal* (or in any transactional analysis text that I know about) that took the position that in treating lesbian and gay male patients, transactional analysts should not try to change them. Rather, they themselves—just as other patients—need to decide what they want to change. Beattie and Erskine wrote, “Sex preference is a choice which may be either script bound or free.” Further, they made a claim that reflected one made by James and Jongeward: “Heterosexuality as well as homosexuality may be based on script injunctions and early decisions” and people can “choose heterosexuality, homosexuality or bisexuality” (Beattie & Erskine, 1976, p. 415).

Beattie and Erskine’s direct and open affirmation that “gay is OK” weakened the basis for viewing homosexuality as a psychopathology derived from a not-OK life position. It challenged the homophobia within transactional analysis that came through in the work of Berne and Schiff, for example, and that many other teachers and clinical practitioners of that time showed in their treatment of lesbians and gay men (Barnes, 2002a). Even though most transactional analysts could be expected to say that lesbians and gay men were OK, not all took the position that “gay is OK” because while transactional analysis theory affirms that people are OK, psychopathology is not.

Beattie and Erskine’s (1976) article concluded with yet another challenge to transactional analysis psychotherapists that applies to the absence and avoidance of discussions of homosexuality, to homophobia, and to the closet: The absence of discussion of sexuality should alert the therapist to ask, “What’s being avoided by me as a therapist or by my clients?” (p. 415).

*Erskine’s Call for Change*. A year after the publication of the article he wrote with Beattie, Richard Erskine (1977, p. 373) wrote a letter to the editor of the *Transactional Analysis Journal* that puts in focus widespread attitudes toward homosexuality in transactional analysis during the 1970s. It adds a piece to the puzzle Perlman (2000) began to put together about both the lack of pejorative references to homosexuality and the lack of writing about homosexuality in the transactional analysis literature. The letter was a challenge to look for what may not be
so obvious from a quick scan of the literature, and it is significant that the letter appeared in 1977, about 4 years after the decision by the American Psychiatric Association to delete homosexuality as a psychiatric disorder.

Erskine’s position was that homosexuality is not psychopathology: He implied that homosexuality per se is not script, even though for some it may be “an acting out of script.” Erskine’s letter is about policy, not theory. Already it was ITAA policy that there should be no discrimination on the basis of sexual orientation (or preference) for ITAA membership. In his letter, Erskine asked for an editorial policy to avoid creating the impression that homosexuality is psychopathological. What he did was not inconsequential.

Other Challenges to the Theory. There were other transactional analysts who discussed homosexuality without linking it to script or making it a psychopathology. McCormick (1971) wrote up a verbatim interview with a 16-year-old boy in which he discussed the boy’s homosexuality without making it a script issue. Two years before Beattie and Erskine’s (1976) article was published, Helen Colton (as cited in D’Angelo, 1974, p. 45) suggested at the 1973 ITAA Summer Conference that transactional analysis had to update its message about “perversion” (and align it with then-current research). The updated message was that homosexuality is OK. Allen and Allen (1978) discussed the Don’t Be You injunction without a hint that it causes homosexuality. Writing on sexual dysfunctions and dissatisfactions, they drew from the latest scientific works (pp. 96, 109), and their clear, balanced writing about sexual orientation is in keeping with the American Psychiatric Association’s decision about homosexuality. Their earlier article on permission (Allen & Allen, 1972) also included a succinct statement of their position: “Permission to succeed in sex . . . that is, to be able to validate one’s own sexuality and the sexuality of others” (p. 72).

The Gouldings and Redecision Therapy

The work of Robert and Mary Goulding on the Don’t Be You injunction was highly influential during the 1970s. They (Goulding & Goulding, 1978) noted positive ways that people deal with this injunction in their life script so as to avoid its psychopathology (p. 218). If parents who give this injunction value heterosexuality, their “child may decide to accept other, better messages” (p. 217) and not become homosexual. They also listed a variety of possible decisions in response to this injunction, including transsexual surgery. They added, “Some simply continue lifetime private wars against the other sex” (p. 218). Nevertheless, in the 1970s the Gouldings still conceptualized this injunction as the basis for the psychopathology of homosexuality. They suggested that children receive this injunction when they are the “wrong” sex, that is, not the boy or girl the parents wanted (Goulding & Goulding, 1979, p. 37).

The Gouldings, did, however, solve some of the perplexing problems posed by Berne’s theory of life as a predetermined drama. For example, they shifted the locus of power from the potency of the psychotherapist to the patient (the “power in the patient”). In contrast to Berne’s (1972, p. 294) position that a person’s life plan is determined, the Gouldings (Goulding & Goulding, 1978, pp. 11, 180) conceptualized childhood decisions as based on the information available to a child and on his or her interpretation of that information. Their approach was to do in psychotherapy what seems to happen in everyday life: Children make decisions that they may, and often do, change later.

For the Gouldings, the child’s decisions in response to perceived parental injunctions verify that the nature of being human is to be volitional or decisional. It follows that decisions are not determined (as Berne believed) by parental injunctions and scripts; rather, volitions or decisions determine the script. (For Berne, the injunctions are numerous and the decisions and life positions are limited; for the Gouldings, the injunctions are limited and the decisions are unlimited. Thus, for the Gouldings, the only “real” life position is the one affirming OKness of both the I and the Thou.)

The Gouldings (1978) selected from their patients’ statements what they took to be “the decisions made by patients when children” (p. 222), surmising “that if the child made a decision, he could, and often did, change it later, and not necessarily in therapy” (p. 222).
“We recognized that we were listening either to what really happened or what [the patient] thought happened, and it didn’t make any difference” (p. 222). The Gouldings did not, however, go to the next level of abstraction and recognize that what they were hearing was selected by the theory that they constructed and were using to interpret their patients’ utterances.

They wanted their patients to get “in touch with the power they had as little kids” (Goulding & Goulding, 1978, p. 222) to make survival decisions. They encouraged their patients to change from within the stance of the patients’ “position of power.” Their patients perceived “that they were the ones to decide to be distant, or sick, or childlike, or always working [and that therefore] they were the ones who could change all that” (p. 222).

The Case of the Transsexual. I wish now to discuss in more detail the case of a transsexual presented in Robert Goulding’s (1972) initial paper on redecision transactional analysis and later reprinted in a different form in Goulding and Goulding (1978). I consider this to be the archetypal case of redecision transactional analysis. In it the male patient is identified as homosexual. When he entered psychotherapy, he was “depressed, suicidal, alcoholic, and blind” and “a homosexual whose behavior might best be described as frenzied” (Goulding, 1972, p. 109). Goulding says the patient’s mother gave the patient the injunction Don’t Be a Boy and dressed him in girl’s clothes. She hated men so her counterinjunction (from her Parent to his Parent) was “Be a girl.” (Here I have cited the text from 1978 [p. 22]; the 1972 counterinjunction text reads, “Don’t be a boy” [p. 109]. “Don’t be a boy” is neither logically nor psychologically the same statement as “Be a girl.” I take this change in the content of the message as I might take a slip of the tongue, assuming that what I am hearing may be different from what the speaker might have intended. The Gouldings’ change of the content of the counterinjunction gives away that the whole exercise is hypothetical, that the theorists, not the patient or the mother, are making up the message.)

The patient—if understood according to the Gouldings’ theory—complied with his mother’s directives. It seems that several psychotherapists had worked with the patient to try to help him change his decision about his maleness as a result of the hypothetical (Don’t Be Male) injunction received from his mother. Goulding (1972) reported:

At the end of . . . two years, the patient was no longer suicidal, but he was certainly not well, and he was still blind. At this point, the patient decided to undergo surgery to change his sex. . . . After considerable effort [he] persuaded both the surgical team and the psychiatric team that such an operation was justified. . . . While he was receiving hormonal treatment, his blindness . . . disappeared, and he/she no longer felt depressed. Subsequently, both stages of surgery were completed, and for over two years the patient has been doing well, living and loving as a woman. She is now married and has two step-children. (p. 109)

What conclusions did Goulding (1972) draw from this case? First, he concluded that the case “illustrates the power of the Injunction.” (This case suggests that in 1972, Goulding, like Berne, considered the injunction to be able to operate independently to determine behavior.) Second, when making contracts with patients, psychotherapists should not let their “own convictions” influence them. Third, even if patients’ goals are to change their early script decisions, they may decide otherwise. If the patient, says Goulding, “persists in his determination to stick with the early Injunction he was given, after considerable work has been done, the therapist would do well to re-examine and, possibly, revise his own commitment to implement that contract” (p. 110).

This case contains theoretical assumptions that are relevant to my argument here, and the presentation of the case suggests how the theory performs when psychotherapists apply it. In Goulding’s report of the patient’s failure to do what the theory suggested he would do, Goulding tells us how the theory is supposed to work when its concepts are properly applied, what the concepts do when they are enacted, and what relationships they create between psychotherapist and patient.

Interestingly, Goulding surmounted his own theory, but after, not before, his patient
had done so. Goulding did not fall into a typical clinical trap and allow himself to come up with another explanation to show that, according to his theory, the patient would have been cured if he had overcome his parental injunction. He did not believe he knew better than the patient, but, rather, that “the power is in the patient.” (Later, however, the Gouldings devised three degrees of impasses and postulated the transsexual as a victim of a third-degree impasse, which they described as an impasse between the Free Child and the Adapted Child [see R. Goulding, 1978, p. 625]).

As Robert and Mary Goulding traveled around the United States lecturing in the early 1970s, they presented this case in vivid detail. I heard Bob use an entire lecture to present it to a professional audience in Virginia in 1972. It was a courageous presentation, especially for that time and place, one full of nuance and layered with many meanings. As I recall the presentation, he reported that his work with this patient, which followed after other transactional analysts had worked with the same person, was focused on helping the patient accept and feel good about himself/herself. Even if he did not do that, other cases suggested that both he and Mary did that sort of thing in their work with patients.

Here is an example of a theory becoming a “counterfactual.” A counterfactual is a contrary-to-fact condition, an example of which is the following statement: “If the patient’s parents had not given him the Don’t Be You message, he would not have become a homosexual.” For the observer-psychotherapists who might think of attempting to predict a patient’s behavior on the basis of theory, or on the basis of a redecision, I recommend reading Goodman (1954/1983, pp. 36, 59), who wrote, “To say that valid predictions are based on past regularities without being able to say which regularities, is thus quite pointless. Regularities are where you find them, and you can find them anywhere... The theory works where it works” (p. 82).

Kuhn (1970) showed that scientists do not abandon a theory even when anomalies show up. They treat anomalies as counterinstances. Comparing theory with the world does not lead scientists to reject a previously accept theory. “They will devise numerous articulations and ad hoc modifications of their theory in order to eliminate any apparent conflict” (p. 78).

The beauty of the Gouldings’ theory is that it acknowledges creating a context—an environment—in which individuals can change how they tell their stories about the past and then, perhaps, to make up new stories about how they want the future to be. But, the theory is not predictive; it need not be nor should it claim to be.

The argument could be made that this case shows the irrelevance of the theory that an injunction (Don’t Be You) is related to homosexuality, as Collinson (1975) suggested and as the Gouldings (1989) later explained. The theory is applied to homosexuality to explain it as a psychopathology rather than to foster acceptance of the gay individual whose “homosexuality” should not be questioned or challenged. The case as I read it shows that if you accept individuals as they are and as they wish to become, you can help them with their troubling life issues.

R. Goulding (1972) noted that Berne and those close to him in San Francisco failed to grasp that if a parental injunction is to have any effect, the child must agree with it. The same may be said for the theory of injunctions and decisions. The patient must agree with the transactional analyst that the theory is correct. By agreeing, the patient accepts the injunction as the therapist interprets and presents it and as the patient understands it. If the patient feels committed to the idea of injunctions, this conceptualization will engender the emotions and attitudes of such a message, as if the individual’s parents had given it. This is an explanation for how I think psychopathology may be engendered in the discourse of the psychotherapy.

Goulding’s transsexual patient agreed with the psychotherapists about the injunction. Yet Goulding found that even agreement had no power, so he as the psychotherapist had to change his convictions. Here he made an important positive statement about accepting an individual patient: “We provide our patients with an opportunity to change their early decisions. At times, they may even make the same decision they did as children (except for
the decision not to be), for although the decision may have had an adverse effect on their early development, that decision would now be considered relatively ‘safe’” (Goulding, 1972, p. 111).

There is another movement that calls for comment. We have Robert Goulding’s report of how he heard and interpreted the patient’s story. He then categorized the patient’s story according to theoretical concepts, using the concept of injunctions. Note, however, what happened. The patient’s story, which Goulding now conceptualized according to the theory, gets a new interpretation, according to the psychotherapist’s theory. He goes on to describe the patient as having received the Don’t Be You injunction. Did he forget that the patient did not receive such an injunction until he heard it from his psychotherapists? Yet this injunction, which is an abstraction, has now become concrete. It is a message that the patient received, attributed to him (or to his mother) by the psychotherapists. It follows that whatever a parent says to a child will not have the meaning for the parent that it will have for the child. And what the patient tells about what the parent said when the patient was a child is likely to have a different meaning for the patient in the psychotherapy context than it had when the patient was a child. Further, the psychotherapist will interpret all these statements differently from the ways the patient interprets them. A theory permits us to use the same concepts, but the objects we talk about will not be the same objects. Each of us will have our individual interpretation of each concept and our unique image of each object (Barnes, 2001).

Goulding’s case is about the failure of the psychotherapy to help a homosexual patient change by changing his/her script. The psychotherapist believed that the patient could change by “redeciding” a decision that he/she thought was a result of the injunction Don’t Be You. This presentation is a clear instance—and maybe the first in a transactional analysis publication—of the acceptance of the individual over the theory (and one in which the patient was not made to fit into an alternative theory). Goulding began with a theory that made a psychopathology, coming later to reject some of the theory’s premises and shifting his attention away from the theory to the patient, still applying the theory but disagreeing with Freud and Berne that the theory is the psychotherapy.

The Gouldings (1989) later followed the logic of their clinical work and defended what they call “being different” (pp. 105-107). Some people go through life thinking “there’s something wrong with me.” This belief may be the result of parental thinking or it may come from society, as 30-40% of little boys and 30-40% of little girls do not test like the majority on psychological tests of gender identity showing that little boys are different from little girls. “Instead of using percentages to prove that boys and girls are different . . . it would be kinder to acknowledge that millions of perfectly healthy children do not fit stereotypes. . . . At least 10 percent of all boys . . . grow up to be men who love men. At least 10 percent of all girls . . . grow up to be women who love women. Society tells them, ‘Don’t be what you are’” (p. 106). The Gouldings therefore advised lesbians and gay men, “If your lover is of your own sex, there are also millions of other gays and lesbians who are out of the closet, plus a growing number of heterosexuals who are supporting your choice [to be what you are]” (p. 107).

Gay Contributions to the Literature

None of the major transactional analysis theorists of the 1970s admitted in print to being gay—if, in fact, any were. Without gay contributions, the theory ended up conveying a tone and attitude external to lesbians and gay men and their experiences. By making homosexuality a psychopathology, transactional analysis effect located lesbians and gay men in the vicinity of the closet, setting terms for the transactional analysis “epistemology of the closet” (Sedgwick, 1991).

Nevertheless, during the 1970s there were three gay transactional analysts (out of more than 10,000 ITAA members!) who wrote openly about homosexuality: Laurence Collinson, B. A. Aiken, and Stephen Karakashian.

1970 and was active in the Institute of Transactional Analysis in Britain from its beginning (Collinson, 1984). He seemed never to accept the closet; his pioneering gay psychotherapy groups ran for many years, and his contribution to correcting script theory served to undermine the basis for the psychopathology of homosexuality. However, even today his significant contribution (Collinson, 1975) is still seldom acknowledged. He challenged the conventional or standard explanation of the injunction Don’t Be You (the sex you are) by writing: “It seems to this observer that the ‘usual’ negative injunctions that affect the scripts of most people are, in the case of homosexuals, reinforced by a cultural message that is transmitted from every possible direction: ‘Don’t be what you are!’ ” (p. 8). He suggested that this leads to the notion that “the prevalence of homosexual feelings . . . may be as ‘instinctual’ in some people as are heterosexual feelings in others.” Further, there is no place in psychotherapy for the prevailing assumption that homosexuality is a sickness to be treated. He insisted that demonstrable evidence does not exist “of any homosexual having been ‘cured’ of his ‘condition’ ” (p. 8). Collinson observed that conventional treatment groups often take for granted the attribution “Accept your gender,” thus perpetuating the social and cultural “don’t-be-gay message.” In experimenting with transactional analysis treatment groups exclusively for gay men, he found that the parental-cultural injunction Don’t Be What You Are did not have the effect it seemed to have in groups with a heterosexual orientation (p. 9).

As the pioneer in running gay transactional analysis treatment groups, Collinson may serve as the exemplar of the place and role of lesbians and gay men in transactional analysis in the 1970s. It is indeed ironic that not one major theorist acknowledged or took note of Collinson’s insightful modification of the injunction, and when others came to the same position (Goulding & Goulding, 1989), his work had already been forgotten. It did not, however, escape the notice of Aiken (1976), who referred to Collinson’s “unusually informed article,” in which he “states the [Don’t Be You] injunction quite pointedly from a gay perspective, ‘Don’t be what you are!’ ” (p. 21).

B. A. Aiken. The first article about lesbians and gay men to appear in the Transactional Analysis Journal was by B. A. Aiken (1976) of San Francisco, an ITAA staff member and founder of Gay Fathers Unlimited. He was the first openly gay author to have an article published in the TAJ and one of the few younger gay transactional analysts who openly challenged the transactional analysis theory of the psychopathology of homosexuality. Aiken’s (1976) article was primarily designed to make straight psychotherapists aware of gay issues and what life was like for lesbians and gay men. It proposed a framework for understanding and respecting such individuals by comparing and contrasting two epistemologies with different premises about what it is to be human, to be a sexual being, and to live with a gay self-description in a society whose basic institutions do not acknowledge the rights of lesbians and gay men. “A transaction between a Gay and a Straight is in fact a transaction between one person who knows and lives in two worlds and a second person who knows and lives in only one world” (p. 23). Aiken’s article confronted the practice of using either game analysis or script theory to interpret the activities of lesbians and gay men as psychopathological. For example, he suggested that transactional analysts who tell lesbians and gay men who are coming out of the closet—and thus putting their employment security at risk and possibly subjecting themselves to police harassment—that they are playing “Kick Me” make “as much sense as saying that Jews were playing ‘Kick Me’ with Hitler” (p. 24). Such psychotherapists fail to understand that the victimization of lesbians and gay men is real, that it is perpetrated by real persecutors operating with the consent of an oppressive society (p. 24). Aiken argued for the importance of strokes, utilizing Steiner’s (1974) theory, and urged psychotherapists to become sensitive to changes occurring in the self-understanding of lesbians and gay men: “Some gay people still present themselves for therapy in hopes of becoming heterosexual. Even if the therapeutic contract does not call for the Gay to become heterosexual the therapist is often non-gay
and knows very little of the gay world and gay lifestyles” (p. 21).

The difficulty for straight theorists in trying to grasp Aiken’s argument may be seen in the way Brown and Kahler (1978) abstracted his article. The dust jacket of their book claimed to provide “a brief summary of virtually every important book and article published in the field of Transactional Analysis.” They included the abstract of Aiken’s article under their section on game analysis. Here is what it says: “This article concentrates on how gays cope with stroke deprivation in a straight society. Reference is made to organized crime and law enforcement agencies who have an investment in ‘Cops and Robbers’ with the ‘gay establishment’” (p. 49).

The subtext of the Brown and Kahler abstract is that homosexuality is a psychopathology. The accent is on how lesbians and gay men cope, and the phrase “gay establishment” has a pejorative ring, presaging terms such as “confirmed homosexual” and “gay agenda.” How can an oppressed minority be an “establishment”? To respect the content of Aiken’s article, all the abstractors needed to do was cite its theses: first, that the emotional suffering of “gay people is due to stroke-deprivation not homosexuality,” and second, “that attempts by the gay minority to overthrow the injunctions that keep them stroke-deprived are prohibited and punished by police harassment, employment insecurity and social censure” (p. 21). Conveyed in the Brown and Kahler abstract is nothing about how Aiken’s article might be of help to “straight establishment” transactional analysts, including themselves. Aiken was placing on straight psychotherapists the responsibility for stopping their inclination to look on lesbians and gay men as disturbed—and in the process he was implying a need to change the theory of injunctions and script theory in general. There is no reason to accuse Brown and Kahler of untoward feelings or hostile attitudes about lesbians and gay men. Their abstract seems to have been written on the assumption that homosexuality is deviant or a psychopathology, thus further illustrating Aiken’s observation that lesbians and gay men live in two worlds, including one in which they must understand and cope with an epistemology that denies their right to exist.

Stephen Karakashian. A biologist, transactional analysis psychotherapist, and teacher in the health science program of the State University of New York, Stephen Karakashian first told the story of his coming out of the closet in Issues in Radical Therapy (Karakashian, 1973; also cited in Wyckoff, 1976), which was published by a collective in Oakland, California. (There is also a noteworthy contribution by Wyckoff [1973] on bisexuality in that same issue.) Karakashian’s story made him an exemplar for closeted gay men in transactional analysis during the 1970s. Married for 13 years and the father of two boys, he allowed himself “no gay relationships” and “lived in dread that my friends and colleagues would discover who I really was.” Yet his wife and a few straight male friends “knew and understood” (p. 20). His story and his various presentations at conferences in the 1970s called attention to gay social and political issues, to gay people as an oppressed minority, and to their liberation. His story also emboldened lesbians and gay men who were making their way out of the closet.

The Disappearance of Homosexuality and the Homosexual

While the psychopathology of homosexuality did not disappear from transactional analysis, the concept of the homosexual did. This is because if homosexuality is the product of a life script, and if transactional analysts can change the “homosexual script,” cured individuals are no longer homosexuals: Remedial script work changes their script and them.

It was Perlman’s (2000) mention of the “invisibility” of homosexuality in the post-Bernean transactional analysis of the 1970s that provoked me to connect it with the notion of the closet. Aided by the language of Sedgwick (1991), I connected the invisibility of homosexuality with the “vicinity of the closet.” From the beginning and continuing through the 1970s, the literature of transactional analysis made homosexuality invisible, keeping lesbians and gay men—especially gay men—in the vicinity of the closet. The literature also shows something else with profound implications for the theory as a
whole and for gay clients and transactional psychotherapists: It shows how the concept of homosexuality as a viable sexual and life orientation and with it the concept of the homosexual were extinguished. (I traced this development step-by-step in part two of this essay.)

Why did gay transactional psychotherapists in the late 1970s feel concern about coming out of the closet of transactional analysis? Answers to that question began taking shape as I worked through the literature. Even many years later, Perlman (2000), speaking for himself as a client and a psychotherapist, wrote that he was afraid to apply the theory of transactional analysis to himself: “The description of homosexuality becomes the etiology of illness and therefore something to be cured.” He continued, “As a gay client I have not explored why I am gay, originally for fear of being pathologized, later for fear of pathologizing myself” (p. 280). How is it, three decades after Berne’s death, a gay transactional analyst had to feel such fear?

These questions returned me to the notion of invisibility and to another comment by Perlman that “it may be that homosexuality was too difficult a subject to deal with from an ‘I’m OK, You’re OK’ perspective as transactional analysis gathered mainstream acceptance” (p. 280). By the late 1960s, Berne had equated OKness with winning and becoming winners. There was the prevailing sentiment in transactional analysis—as in the popular culture—that there was no way to be an out-of-the-closet lesbian or gay male and also be a “winner.” I pursued that line of thinking, but it did not go anywhere. I thank Perlman for indirectly helping me by suggesting the notion of the invisibility of homosexuality in post-Bernean transactional analysis. That was the thread that I needed to identify. For example, Perlman noted that Berne’s “‘discreetness’ comment, although implying that homosexuals should not be seen to exist, removes homosexuality as an issue per se” (p. 277).

I think the invisibility of lesbians and gay men goes back to the beginning of transactional analysis and reached its zenith in the 1970s. Clearly, gay transactional analysts of the 1970s were not likely to come out of the closet in view of the stigma of homosexuality as a psychopathology, except for a few who surmounted the closet’s onus and liberated themselves from it by rejecting its epistemology. There certainly were gay transactional analysts in leadership positions in the ITAA, and there were some gay contributors to the transactional analysis literature who maintained public silence about homosexuality and remained in the transactional analysis “closet.” One reason is clear: The theory had created a psychopathology that some of them accepted as part of their self-description, leading to a public effort to appear “normal” or “straight.” The atmosphere was such that any individual who was recognized as a homosexual was likely to be seen as gamey or scripitty or both, thus keeping the closet door tightly shut. How could gay transactional analysts come out of the closet unless they could offer clinical or empirical evidence to challenge the theory?

In addition, except for the literature I have cited here and elsewhere (Barnes, 2002a) and perhaps a few additional references, there are clearly very few references to homosexuality in transactional analysis writings. In some works, the concept of sex disappears altogether; in most, the homosexual (or gay individual) has become invisible. For example, there was a special women’s issue of the TAJ (January 1977 and part of the April 1977 issue) with not a mention of lesbian issues. The question to be asked about the literature is the same one Beattie and Erskine (1976) asked when their groups were silent or avoided discussing sexual issues: What was being avoided? Why the silence about gay issues, same-sex activities, homophobia, and the closet?

The Gouldings restored the gay individual by giving power to the patient: the patient decides. They rejected Berne’s determinism, asserting that the patient may construct the script injunctions instead of receiving them. Their approach called into question Berne’s representational epistemology with its assumption that an individual can make accurate representations of reality. The Gouldings’ patient could decide to change his sex (and gender). What, according to the theory, may have begun as a deeply embedded script was turned from a self-destructive direction to an affirmation of what the patient felt him-
self/herself to be.

A theory that set out to show how the discourse of parents both constitutes their children’s experience and shapes their destiny came to be not only the way to interpret and understand experience, but also to be the script for transactional analysis psychotherapy. Transactional analysis had to account for same-sex desire and behavior, but it took as given the psychopathology of homosexuality, and it did so by conceptualizing it as a psychopathology caused by a life script. Conceptualizing homosexuality as a script meant psychotherapy could change homosexuality by changing an individual’s script. In that move, homosexuality disappeared in transactional analysis. But it was not replaced by any notion of the legitimacy of same-sex desire and activities. It was as if the fiction of the theory became fact, as if the forecast of theory had already been verified empirically: “You were homosexual but you’ve changed (redecided) your script, and now you are normal (OK).” The edifice of the theory is built on assumptions about human nature, normality, or OKness; about how people move to abnormalities or not-OKness; and about what to do to restore them to their original condition of OKness.

Berne constructed the concept of the Child ego state. There was not one until he made it up. The evidence for how he went about his constructive work is in his writings. One of the ways he went about making up the concept of the Child ego state was by turning his images of the seductive homosexual into images of a “writhing child standing naked before adults.” I asserted in part two that, ironically, it was his patient’s homosexuality that led Berne to develop the concept of the Child ego state and thereby eventually to eliminate the concept of the homosexual as a legitimate individual. I argued that without lesbians and gay men on whom Berne directed his intuitive gaze—transforming their theory-constructed psychopathology of homosexuality into a primal image, then converting primal image into a primal judgment, then converting that judgment into an ego image of a “writhing child,” and finally constructing from that image the Child ego state—the Child ego state would not exist. As a result of the constructions of that transforming process, Berne’s “homosexual” was transformed into the Child ego state. Thus, the Child ego state appears as a result of the disappearance of the homosexual in Berne’s theory and transactional analysis.

The Return of the Other

The return of the disappeared is the return of the other, which thus closes a loop. But the other returns in a new guise and does not show up in the uniform of a theory. Rather, the other becomes a presence in moments of intimacy. And there is no unitary experience of intimacy, just as there is no unitary experience of sex or a unitary theory to account for human diversity in terms of sex and gender.

With the return of the disappeared gay person (the theory’s homosexual), transactional analysis theory comes full circle and mirrors itself. If we neither apply the theory nor see through it—if we only read it—it references and thus reveals itself. It does not reveal gay individuals, nor does it represent their experiences, their worlds, or their reality. And reading transactional analysis theory (with at least a modicum of the diligence that Berne put into composing and writing it) may make visible the gay individual who disappeared in the theory, exposing the closet’s epistemology and increasing visibility in the vicinity of the closet. It may also make visible that the transactional analysis theory that proposed psychotherapy for homosexuals to cure them of the psychopathology of homosexuality is, itself, what is pathogenic.

Opening the door of perception to see that the disappeared other has returned is to see lesbians and gay men as children grown tall who are constituting themselves in relation to the self-constituting other. It is to see them through their eyes, hearing their self-descriptions and self-redescriptions. They are saying, “Talk to us rather than about us,” talk to each individual rather than talk about an amorphous “them.” Do not write theories making up different kinds of people and go-
ing on from there to create categories into which to fit human individuals.

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REFERENCES


HOMOSEXUALITY IN THE FIRST THREE DECADES OF TRANSACTIONAL ANALYSIS