The Psychological Treatment of Homosexual Orientation Distress

By Joseph Nicolosi, Ph.D.

In the most recent issue of *The California Psychologist*, Dr. Richard Feltman states that some therapists continue to offer homosexual reorientation therapy from the perspective of the disorder myth. He believes that such therapy may be unethical, even harmful. He says: "The APA Office of Social and Ethical Responsibilities acknowledges 'rumors' of such treatment, but cannot explain why complaints are not presented formally to their office."

I would like to introduce myself as the author of one of those rumored treatments.

Joseph Nicolosi

There is an assumption among many members of our profession that the "disorder myth" has been settled, and to propose otherwise is archaic. I propose that the controversy is far from over and that the APA decision to delete homosexuality from the DSM III-R did not resolve the issue--it simply silenced eighty years of psychoanalytic observation.

Many members of our profession still privately express the opinion that homosexual development is not normal.

In his scholarly analysis of the APA's reversal of the diagnostic classification of homosexuality, Ronald Bayer concluded: "the result was not a conclusion based upon an approximation of the scientific truth as dictated by reason, but was instead an action demanded by the ideological temper of the times."

Most members of the psychiatric profession are well-intended people invested in their commitment to alleviating emotional distress. The profession made a leap of assumption that diagnosis of homosexuality would perpetuate social prejudice. I believe this is not necessarily the case.

Another reason for removing homosexuality from the DSM is that historically, the cure rate has been relatively low. We are resorting to the logic "if we can't fix it, it ain't broke."

The logic of this latter assumption eludes me. For the fact remains that there is a significant population of men whose homosexual behavior is in conflict with their aesthetic, social or moral values, as well as their deepest sense of self. These men I call "non-gay homosexuals."

The term "gay" has become synonymous with "homosexual." In fact these terms have quite different implications. Gay is a socio-political identity, while homosexual is simply a psychological state. Not all homosexuals choose a gay identity.

Many of my clients were relieved to discover that there are reorientation therapists. They were frustrated--sometimes devastated--by their former therapists' advice to "accept who you really are" when they believe that "who they really are" ultimately requires claiming their deepest heterosexual selves. Such a client is not necessarily a guilt-ridden, intimidated, fearful person but one who out of the larger perspective of his own identity, chooses not to embrace the gay lifestyle.

Growth out of homosexuality is not an easy process. It requires a particular vision, ego-strength, and patience with the cyclical nature of human development. It is not the shortest path to feeling good--but for some clients it is the right direction.

I believe that homosexuality can never be ego-syntonic on the deepest level of self, and that symptoms will always emerge to indicate incompatibility with self. In fact, the claim that there is no relationship between sexual orientation and psychological functioning must address the issue of gay promiscuity. In the pre-AIDS era, Bell and Weinberg (1978) found that 28 percent of gay men had had 1000 or more partners. Nearly 80 percent of all respondents said the majority of their sexual partners were strangers. In *The Male Couple*, gay authors Mattison and McWhirter could not find a single gay male couple that had been sexually faithful for more than five years.

How can such a lifestyle be equated with psychological health?

For those clients who insist on treatment, Dr. Feltman's solution is to increase bisexual response. He attempts to reconcile the "punishers" (therapists who attempt to diminish homosexuality) and the "reinforcers" (gay affirmative therapists) by proposing the orthogonal rather than bipolar view of sexuality.

This is an unfortunate consequence of the politicization of mental health: so as not to offend any one political group by extinguishing one behavior, he attempts to promote both. The goal of treatment for SOD is therefore, bisexuality, and he concludes that "...once the individual experiences the orthogonal nature of sexuality, then his SOD is resolved." Yet bisexuality has always been a confusing concept and is not a goal to strive toward. The gay man is only bisexual to the extent that he has not resolved his incomplete masculine identification.

Furthermore, clients are not distressed so much by their inability to perform heterosexually, as by their unwanted homosexuality. What service do we provide for a man who--as a result of such treatment--can function sexually with a woman but still is homosexual? What woman will share him with his male lover?

In fact the problem is not simply behavioral--i.e., the need to "perform" heterosexually--but is more deeply rooted in an internal sense of being adequately masculine, and a deep ambivalence in relation to other men. In fact, a number of my clients are married and can perform heterosexually: that is not the problem. The problem is the homosexual behavior which interferes with their marriage.

Why does the DSM call this problem Sexual Orientation Distress (SOD) rather than Homosexual Orientation Distress (HOD)? Never in the history of psychotherapy has there been a documented case of a patient seeking the services of a psychotherapist because he was distressed by his heterosexuality and wanted to change it.

I would like to briefly outline my own treatment for clients whose homosexual behavior is at odds with their values and their deeper sense of self. Much of this treatment is based upon the psychoanalytic writings of Dr. Elizabeth Moberly.

Very simply, we believe the male homosexual is not fully gender-identified. At a critical time in the formation of gender identity (approximately the second half of the second year), the boy emerges out of his relationship with the mother and becomes emotionally invested in the father or father-figure. He experiences an intense interest and emotional investment and if during this critical period the father is hostile, rejecting, hurtful or non-responsive to the boy's interest, the boy develops an incomplete masculine identification. In protection against further hurt he develops what Moberly calls "defensive detachment"--he rejects father and what he represents, namely his masculinity. All my clients have reported poor relationships with their fathers.

In later years, this defensive detachment is extended from the father figure to his male peers. An overview of the literature supports our hypothesis in that homosexual men frequently exhibit gender nonconformity in childhood and have had difficulty with boyhood friends.

Men remain mysterious, and the young man is sexually attracted to yet fearful of men--bound into a same-sex ambivalence. This same-sex ambivalence has much to do with the characteristic unfaithfulness in male homosexual relationships.

Treatment--first individual, then group--attempts to foster intimacy, mutuality and trust with males, without sexualization. We do not wish to repeat the historical error of psychoanalysis, which focused on the development of a heterosexual response. As we see it, the problem is not fear of women: it is an incomplete identification with men.

For all our talk about sensitivity to the needs of the client, the truth is that the therapist places himself in the role of making a judgment call. The client who expresses SOD (HOD) is often torn between his sexual inclinations and his value system. Our profession decides to change the values to accommodate the sexual orientation. Somehow values are considered more flexible, transitory, and adaptable. Sexual orientation is deemed more a part of "who one really is."

The treatment outlined here is not a simple process, and may take many years, perhaps a lifetime of inner struggle. Yet neither is the alternative a simple solution: coming out and gay reacculturation are also seen as lifelong processes.

There may be other causes for homosexuality--but we are providing an effective treatment for those men for whom our theory rings true. Men in our therapy report a diminishing of homosexual thoughts, feelings and behaviors and a growing ability to develop male friendships characterized by mutuality and trust.

Is it possible to address the needs of the "non-gay homosexual" and propose a model of psychological disorder which will not offend those who do not wish to change?

The only answer seems to "agree to disagree," by allowing the debate to continue. Too often, intimidation and threat have forced an end to the discussion.

We owe everything we have to offer to the men who choose this other struggle.

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