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A. Dean Byrd, PhD

Editor: Do you have any preliminary comments?

Dr. Byrd: Yes. Before I begin responses to the interview questions, I would like to clarify my position regarding the treatment of those with homosexual struggles. I am convinced from both a spiritual and clinical perspective that homosexuality is not an immutable condition. While I acknowledge the right of individuals with same-sex attraction to choose a gay lifestyle, I also support the right of those individuals who are unhappy with their same-sex attraction to diminish/eliminate those attractions and to make changes in their lives.

Editor: What is your view of human nature and of homosexuality?

Dr. Byrd: Human nature involves developmental processes that are influenced by biological, environmental, and spiritual contributions. Similarly, human sexuality follows a developmental sequence. Although the familiar continuum, homosexual-heterosexual is touted in the popular literature, another continuum, asexual-heterosexual is probably a better description. Using this continuum, homosexuality (more appropriately defined as homosociality to separate out sexual activity) broadly conceptualized, would represent a part of the developmental process en route to becoming heterosexual. For example, same-sex attraction is often noted in the preadolescent boy’s desires to be like and to be with other boys as a means of having his masculinity affirmed. This is characteristic
of the homosocial phase of normal sexual development. For a variety of reasons which may include early emotional detachment of boys from their fathers and/or trauma from sexual abuse, this same-sex attraction becomes sexualized, preventing a normal transition. In essence, homosexuality is a pathological adaptation resulting from being “stuck” in this process and unable to make the normal transition into the next developmental stage. Perhaps, here is a good time to make an important distinction. There is a difference between “homosexual” and “gay.” Homosexual refers to same-sex attractions which, in many cases, has become eroticized. Gay refers to a social, political identity. While some individuals may choose to respond to their same-sex attraction by adopting a gay lifestyle, others do not. Rather, because of social, religious, or personal reasons, they choose to diminish their same-sex attractions. In many ways, those with homosexual struggles are “latent” heterosexuals. Finally, in this area, it might be good to note that the biological theory of homosexual behavior holds little validity. The excellent paper by Byne and Parsons (1993) quite accurately addresses the flawed research and conclusions of the recent twin study as well as the study focusing on the hypothalamus. I certainly do not doubt that there may be biological predispositions such as those associated with alcoholism. However, as John Money (1987) would agree, biology, independent of postnatal history, is simply not sufficient to predetermine a homosexual orientation. Byne and Parsons (1993) concluded, homosexuality is a “complex mosaic of biologic, psychological, and social/cultural factors” (p. 237).

Editor: What types of changes do you believe are possible for homosexual men to make as a result of psychotherapy?

Dr. Byrd: “Change” is an interesting term. It’s better than “cure,” but still the word “change” conjures up all sorts of expectations. I have found it useful to view change as a process about becoming who you are instead of a process to make you into someone who you are not. Men with whom I have worked have been able to diminish/eliminate their homosexual attractions and many have developed heterosexual attractions. It is often the case that these men find that they can meet their same-sex needs (emotional needs) in non-sexual ways. Many have come to see that
the seemingly incompatible aspects of their identity can be integrated, that the seemingly shameful parts of themselves are normal and may be accepted by others in their lives and that strong needs can be met in unexpected, nonsexual ways rather than denied. A clear majority of these men who seek help come to view their homosexual attraction as a need to be affirmed in their own masculinity by other significant men. Once they become solid in their own masculinity, their challenges are easier to handle and transitions in their lives are easier to make.

**Editor:** What do you believe are the conditions necessary in order for homosexual men to experience these type of changes?

**Dr. Byrd:** As is the case with any emotional struggle, motivation is important. Accurate information, which is often lacking, can provide a valuable source of motivation. Individuals who struggle with homosexual attractions need to understand the origin of these attractions. They need to understand that homosexual needs are legitimate emotional needs that have become sexualized. Individuals need to understand that treatment is a process. It takes time, depending upon the needs of the individual. A question is often asked, do the attractions continue after treatment. The answer is there may be an occasional intrusive memory but how the individual responds to that memory makes all the difference. It's not so unlike treatment outcomes for other emotional struggles. Do we expect the individual to never struggle again? No, we simply expect that they will have the resources to respond to their struggles appropriately. It might be well to note that the attitude of the therapist seems to have a tremendous influence on treatment progress. Many of these men have struggles with authority figures and assertiveness issues. Consequently, they may be reluctant to express concerns. Authority figures may involuntarily trigger feelings of anxiety and resulting response of avoidance and detachment. Therapists who de-emphasize authority, power and the hierarchical nature of relationships and emphasize positive regard, equality, and reciprocity, are more likely to be effective with these individuals.
Therapy Process and Technique

**Editor:** What do you believe are appropriate goals for therapy when working with homosexual men?

**Dr. Byrd:** Goals need to be set jointly with the client and expectations clarified. Significant time is spent diminishing or eliminating homosexual attractions, gaining control over their lives, developing appropriate relationships with men and women (especially developing nonsexual relationships with heterosexual men), understanding the sources of their homosexual attractions, and making choices about how they will respond to such unwanted attractions. For many men, we spend significant time separating the sexual from the emotional and responding to their expressed needs for acceptance from other men which is a way of validating their masculinity. It is interesting to note that many of these men related experiencing a defensive detachment from their fathers or other significant men. This detachment surfaces early in treatment. It is important to resolve the defensive detachment issues. Frequently, this defensive detachment is accompanied by a reparative drive or a drive to become affirmed or validated by other men and is reflected in sexual activity. Many clients have reported therapeutic gains from resolving issues associated with this defensive detachment and in finding appropriate ways to develop intimate, nonsexual, fulfilling relationships with men.

Relationship Establishment and Assessment Stages

**Editor:** What do you do in the initial session?

**Dr. Byrd:** Much of what happens in the initial session is data collection and providing accurate information. Acceptance and empathy are important to convey. In fact, there seems to be a greater need for a demonstration of sensitivity than with many other clients. It is crucial to help these men understand that they are not innately bad and that they were not born homosexual. It is equally important to help them understand that they did not consciously choose their same sex attraction any more than others choose an emotional condition such as depression. However, how they respond to their same-sex attraction is a matter of choice. I
will often share with them the appetitional theory of sexuality: sexual activity is an appetite not a need. The need is intimacy. Helping them reframe their homosexual attractions as indications of legitimate emotional needs is a primary task in early sessions.

**Editor:** How do you structure your sessions?

**Dr. Byrd:** Sessions are based around the needs of the client. Because many of these men have spent significant time in the gay lifestyle, there appears to be issues related to that lifestyle that need attention such as addictive behaviors, disillusionment and tremendous fears. The following tripartite therapeutic approach seems to be characteristic of the treatment of these men: early sessions focus on behavioral control as a prerequisite to behavioral change; intermediate sessions focus on a cognitive interruption of the obsessive/compulsive process; later sessions focus on affective relating via group process: that is, development of a non-erotic support system with heterosexual men, assertiveness with self and others, defensive detachment and masculinity issues, frustration with change, forgiveness, realistic expectations from self and others, feeling discrimination, and intimacy issues.

**Editor:** What structured or unstructured assessment techniques do you use? What information/issues do you view as essential to do an assessment on?

**Dr. Byrd:** Completion of an extensive social history is routine. I obtain a sexual history as a part of this social history. I have found that many of these men were either sexually abused as a preadolescent or adolescent boys and/or had early, confusing introductions to sexuality. Often this early eroticization of same-sex relationships seems typical for this population. It is interesting to note that many of these men who were abused have difficulty viewing abuse as abuse because of the physical stimulation. Instead of asking whether or not they were abused, I ask them how old they were when they had their first sexual experience. More often than not they talk about having sexual experiences at ages 11, 12, or 13, frequently with an older male. Because homosexual struggles do not occur in isolation, there are often other emotional problems reflected on Axis I and/or Axis II. Such emotional problems need
to be diagnosed and addressed in the treatment context. The MMPI and MCMI are useful instruments in this process.

**Editor:** Other comments about this stage?

**Dr. Byrd:** There is a focus on many of the issues noted in my earlier responses. In addition, I am interested in family relationships, particularly father-son relationships. Many of these men do not seem to feel solid in their masculinity. Consequently, there seems to be a tendency to develop relationships with men who possess characteristics that they lack or view as lacking in themselves. (Van den Aardwig [1986] talks about the psychology of envy when describing homosexual men.) These men view homosexual relationships as an attempt to have masculinity affirmed by taking or sharing in the masculinity of other men. (It is interesting to note that masculinity is highly valued in the gay community.) Issues of what it means to be a man as well as how to develop appropriate nonsexual relationships with heterosexual men are important therapy issues.

### Intervention Stage

**Editor:** What are some key issues or areas in which you attempt to promote client insight or change?

**Dr. Byrd:** Many of the intervention issues were noted or alluded to in the previous questions and responses. These men need to understand that their homosexual attractions are symptomatic of legitimate, emotional needs that can be met appropriately. They need to develop nonsexual, fulfilling relationships with heterosexual men, to become more solid in their own masculinity, feeling secure in who they are. A very difficult task is assisting them in integrating the seemingly incongruous parts of themselves.

**Editor:** What “in session” strategies and techniques do you use to promote client insight and change?

**Dr. Byrd:** I employ many behavioral, cognitive and affective strategies. These strategies include reframing, role playing, re-experiencing and many behavioral techniques. However, the characteristics of the therapist seem to be more important. Often the therapeutic relationship represents the first genuine relationship
these men have had. A trusting, honest relationship seems to provide a needed safe setting where intimate issues and sensitive feelings can be expressed and explored. There are two very useful techniques that I have found to be of tremendous value. One is called emotional tracing. In this technique, a strong emotion is identified and the therapist asks the client to try to remember another feeling that was present before the identified feeling. More often than not, primary emotional feelings are identified prior to intense sexual feelings. Another technique that has been particularly useful I call "defragmentation." Many of these men have had a significant number of sexual experiences with men whom they do not know. These sexual partners seem to have particular characteristics (usually envied masculine traits). These sexual partners are dealt with in a fragmented way, as if they were fantasy people. In this defragmentation process, I have them make these images whole with real people. Later, I direct them to desexualize these fantasies and attractions using the process that we have practiced in an office setting.

**Editor:** What “homework assignments” do you use to promote client insight or change?

**Dr. Byrd:** Journal keeping seems to be a must with these men. It is a valuable source of information for both the client and the therapist. They submit journal entries and I provide feedback in a clarifying or questioning way. Many of these men monitor their thoughts through this journal process. They practice skills such as assertiveness in appropriate settings. Most rebuild relationships with significant men in their lives such as with their fathers. Many find (through sports programs) ways to feel more solid in their masculinity, which was often lacking in their early years.

**Termination**

**Editor:** How do you decide it is time to terminate therapy with your homosexual clients?

**Dr. Byrd:** The termination phase is an intriguing process. There are several indicators: the client discontinues using labels like homosexual (even after therapy, many of these men refuse labels
such as ex-homosexual or ex-gay); there are clearly defined emo-
tional struggles; they come to understand the origin of their homosexu-
al attractions; there is less intensity and they respond to their homo-
sexual attractions as emotional needs and meet them appro-
priately. These clients feel better and function better. Termination
is gradual. Many will send a note or make a call later to let me
know that they are doing well or will schedule a follow-up
appointment to explore other issues. A couple of classic statements
might be appropriate. One client had a revealing experience in
therapy where he identified his struggle. He exclaimed, "I was
thirsty and simply drank from the wrong cup." Another who had
strong homosexual attractions reported understanding that "pain
comes but misery is optional."

Editor: When do you make referrals to other professionals
when working with homosexual clients?

Dr. Byrd: I should note here that I have never worked
successfully with an LDS man who has homosexual struggles
without a close collaborative relationship with a bishop or stake
president. For LDS men there are many spiritual issues and these
priesthood leaders have had a significant impact on the healing
process. I refer to other professionals when there is a presentation
of symptomatology with which I do not have the expertise to
address. It is typically a need for a medication evaluation, a
collaborative opinion, or when there are other disorders in addition
to the homosexual struggles. Some Axis II disorders cause me
discomfort. I try to identify these problems and make referrals
early in the process so that I do not have to address abandonment
issues.

Editor: Are there any issues which often seem to come up
as you prepare for termination with homosexual clients?

Dr. Byrd: The anxiety surrounding termination does not seem
to be significantly different from other clients. Fears arise about
facing the world. Group therapy seems to address many of these
termination issues because in many ways, group therapy represents
a "real world experience."
Perhaps, I could make a few concluding comments. We have not addressed the role of mothers. Often, homosexual men have an overly close, protective relationship with their mothers. Mothers of these men often seem to notice that these men, as boys, do not become close to their fathers and they try to compensate. All of the men I have treated indicate that they are closer to their mothers than their fathers and often report that they become their mother’s confidant. Eli Siegal in the 1940’s characterized the relationship between homosexual men and their mothers as “adoring contempt.” This translates into very mixed feelings of love and anger. It is important to note that I often will have a few family sessions to help with these issues. Finally, it is important to understand that parents should not be “blamed” for their son’s homosexuality. There are a multiplicity of factors involved. In fact, the parents of homosexual men often report not being able to get close to their son, viewing him as “different” and simply not knowing how to help. It is important to deal with the issues of blame with parents and to help lift that burden from them. Finally, I want to emphasize that there is a strong spiritual part of the healing process. These men have some very powerful spiritual experiences as they become affirmed in who they are. They seem to develop a greater ability to empathize and a greater ability to love.

Editor: Could you relate a case example to illustrate how you tend to work with homosexual clients and to illustrate the types of change that you tend to observe with such clients when therapy is successful?

Dr. Byrd: I have kept meticulous case notes over the years and have had many graduate students interview clients to gather information about the change process. In addition, for the last ten years or so, I have had clients write their own story towards the end of therapy. Perhaps it might be more useful to have you review the story of a very difficult case: a homosexual man who had AIDS. His story was used at a conference a few years ago. This autobiographical sketch contains a great deal of information about the change process. R. was a 39-year-old, married, Caucasian man. It was my first attempt to treat homosexual struggles in the context of AIDS.
My Story
by R.

I am not exactly sure of what I am being asked to do. I understand that you are having a conference and that sharing my story might be helpful to you in your work. I did prepare an audio tape, but because of my illness my voice is very raspy and I did not want to detract from what I want you to hear. I do have a short tape that I prepared about 6 months ago and it can be used at the end of my story.

It's hard to know where to begin, so maybe I'll start where I am now. I have the Acquired Immune Deficiency which was diagnosed in 1985. My physical condition is poor and I sense that my time is very short on this earth, but that's not what I want to talk to you about.

I came from a good family, that is, outwardly everything looked good. We were active in the Church. I served a mission, got married in the Temple, and did all the "right" things. Early in my life, I recall not being particularly close to my dad. He was a good man, but I wasn't close to him and sometimes felt that he did not approve of my interests. I wasn't particularly athletic and his lack of attendance at some of my school activities bothered me a little. Mom was always there so that helped. In fact, mom and I were more like "buddies" than mother and son. When I was a teenager, an older man became my friend—and I am sure that you know the rest. I always knew that something wasn't quite right and the sexual part of the relationship was not particularly enjoyable but the closeness was special. It is interesting to note that I never viewed this as sexual abuse because I willingly participated. Therapy helped me to see this differently. From this point, my homosexual activity began. There was already a great deal of masturbation but this increased as did fantasies of sexual relationships with different men. Even though there were periods of inactivity, mostly white-knuckling, I participated in every imaginable activity. It seemed that the more activities I participated in the easier the arousal process and the greater the urge. My life seemed consumed with homosexual concerns. It seemed that I was always looking for the ideal man to fulfill me. I completed a good mission, but shortly upon my return home, I began again. I did go to my bishop who simply told me that I should get married and that everything would be okay. Shortly after the marriage, I began my activities again. I led dual lives—actually served in a bishopric while engaging in a variety of homosexual activities. The more I engaged in homosexual activities, the more I felt driven and interestingly enough, the less satisfying the homosexual activities were.
I had heard about AIDS but maintained the adolescent-like attitude, “it will never happen to me.” It began with a canker in my mouth and then the diagnosis. It was the shock of AIDS that forced me to be honest. I had to face the reality of my life. I had just been given a death sentence. I began seeing LDS counselors and saw several in a period of two to three years. Each tried to help, but frankly most of them either reminded me of my former bishop with the simplistic answer “to be good and fast and pray” or had their own agenda about what I was feeling. Sure, I was concerned about death and dying, but I knew that I would have time to work those things out. This homosexual thing, for the first time, frightened me. I wanted to talk to the Prophet to have him tell me it was okay—that I was born that way. Maybe there would be a revelation like the Blacks and the priesthood. Someone suggested that I may want to go to my bishop and see someone in LDS Social Services. First of all, I did not want to go to the bishop. I just couldn’t, well my family could not withstand a Church court. It would be like an insult on top of injury. I was depressed. I thought of suicide. One of my gay friends said that he had heard about the Church developing a program for treating homosexuals. I almost laughed to myself. My parents, especially my sister, suggested that I give it a try. I called LDS Social Services and a man answered the phone. My first thought was that they even have male secretaries. Anyway, the person on the phone did not act like a bishop nor a social worker. I began with this story about a good friend of mine who was struggling. The counselor simply listened. After what I am sure must have been an hour, I asked what he thought my friend should do. His response was, “When would you like to schedule an appointment to come in?” I didn’t know what to do so I scheduled an appointment. I said what about the bishop’s order and his response was, “We’ll take care of that later.” I felt relieved and scared. I showed up an hour ahead of time and just walked outside the office complex. The first appointment was key for me. The counselor was sensitive enough to allow more than 50 minutes and for the first time, I felt hope. I don’t know for what, but I just did. A lot happened in the next year-and-a-half. Let me kind of review what transpired.

The counselor provided a lot of information about homosexuality and there were times when he said “I really don’t know” which was okay, too. He explained some things about the counseling process and how we would work together. I agreed to give it a year or so. He was very straightforward in his expectations. I would need to give up the homosexual activities. This was very difficult because there were so many addictions. The first part of counseling, the first few weeks simply
focused on learning behavioral techniques to deal with my thoughts and fantasies. Once I started doing the monitoring, I was astonished to see how much of my time was spent with sexual thoughts and fantasies. I also had to structure my time and manage other areas of my life better. I did not understand this until later but these assignments helped me get control of my life. Actually, I felt pretty good about being able to manage better. I began to understand the toll that participation in the gay lifestyle had taken on my life. The first part of counseling seemed to focus on these management areas. I avoided old places, learned to distract myself, and to change thought patterns. Then we began doing something differently which I learned later helped to break the addictive process. I began practicing breathing exercises, relaxation exercises and a lot of exercises had to do with what was happening inside my body and inside my brain. It’s hard to explain. Let me give you an example of how I applied this information. I could walk into a shopping center and see an attractive man. Previously, I would turn away and avoid the situation. But now, I would take a deep breath, re-experience the relaxation response, acknowledge the physical attraction and look toward the person. But, I would complete the picture. I would ask questions in my mind like what was he really like, did he have a family and other nonsexual questions. I would never approach these people, but as I followed this procedure, the intensity of the urge decreased. It was almost like I was not responding to what I was seeing in the same way. Something began to happen on the inside of me. Sometimes it scared me and I became afraid that the sex drive was being taken away and I was becoming sexless. I felt confused, empty. The feelings were much like I felt years ago before my first homosexual experience. There was a vacuum on the inside of me. Now this did not happen over night but this was about the 7th or 8th month of counseling. As we talked about this in counseling, I came to learn that maybe this homosexual thing wasn’t really sexual—maybe it was more emotional. I just wanted a close, intimate relationship with another man. This intimacy thing was tied into my feelings of masculinity. This intimacy thing, I think, turned out to be the cause of the whole problem. I had sexualized my need for intimacy and masculine affirmation. I did not fully understand it until the counselor suggested that I was perhaps thirsty and simply drank from the wrong glass. It made sense. I began to repair relationships, especially with my father and slowly the vacuum began to fill. The group was the most important part of counseling. I did not feel alone. I learned a lot about detachment, assertiveness, and roots of my homosexual attractions. There was comfort in knowing that there were
others with similar problems. And the group helped me practice some of the things that I had learned. And there was tremendous support.

There is a spiritual part of all of this. I finally did get a bishop’s order after a year and the interview was bad. However, the stake president was a wonderful man who gave me a blessing of health and peace. In fact, he taught me about the atonement and as I was about to leave the interview, he recalled me to the room and embraced me saying, “this is how the Savior will greet you on the other side and He will understand.” For the first time in many years, I not only knew that the Savior loved me but actually felt the Savior’s love.

The last part of counseling was like a healing process. We had a few family counseling sessions which were very helpful. As a side light, my health has actually been pretty good up until recently. One interesting thing is that, contrary to my expectations, there was never a focus in counseling to make me heterosexual but rather a focus on wholeness and healing. I was helped to more fully be myself. This may sound strange but as I developed appropriate relationships with men and women, I actually had some heterosexual, sexual feelings. Almost like I was an adolescent again. I had a few “wet” dreams, except this time there were heterosexual images.

What do I want you to know. First of all my experience tells me that homosexuals are treatable. It is not easy but as I face the inevitable state of death, I have a sense of peace. With death, I will no longer suffer the physical distress of AIDS and what is wonderful is that I will not have to struggle with homosexuality in the next life. In fact, I recently had a dream where I had died. I was doing missionary work on the other side. I was teaching the Gospel to those who had homosexual problems and I was speaking from my own conversion. My heart is full and I am grateful for the many blessings that I have received. This tape will tell you where I am now. Thank you. (The tape provided by R. was a personal a capella rendition of “I Know that My Redeemer Lives.”)

The information contained in this interview is reflective of my work for twenty plus years with more than 200 men with homosexual struggles. Although some of the information may apply to lesbians, some will not. I have had limited experience in working with lesbians.

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References

