A Retreat From Hypersexuality: The De-Emphasis of Overt Sexuality in Homosexual Change Therapy

Richard H. Anderson

Follow this and additional works at: https://scholarsarchive.byu.edu/irp

Recommended Citation

This Article or Essay is brought to you for free and open access by the Journals at BYU ScholarsArchive. It has been accepted for inclusion in Issues in Religion and Psychotherapy by an authorized editor of BYU ScholarsArchive. For more information, please contact scholarsarchive@byu.edu, ellen_amatangelo@byu.edu.
Despite the removal of homosexuality from the list of sexual disorders in DSM-III (APA, 1980), Goode and Troiden (1980), Brown (1981), and others report that there are still a significant number of therapists working with homosexuals who wish to change their sexual orientation.

Of critical interest to such clinicians is determining what commonalities successful change therapies share. Despite the wide variety of reorientation therapies available--most therapeutic modes have supplied one--almost all current therapies share a common focus: the overtly sexual aspects of homophilic behavior. The sex act itself seems to be the starting point and the ending point of most of today's therapy procedures, with the tacit assumption that if a client can be induced to once stop having sex with his own gender and start having sex with the other gender, he must be "improved" if not "cured." The work of Feldman and MacCulloch (1971), Bancroft (1970), Fookes (1968), Freeman and Meyer (1975), McConaghy (1969), and Thorpe, Schmidt and Castell (1963), naming only a few, document this focus on explicit sexual behavior. Current therapy seems to be literally inundated with attempts to "seduce the patient back to heterosexuality." Even the services of prostitutes have been secured in this attempt (Moan and Heath, 1972).

While some attention to the sexual behavior of the client is obviously necessary, recent reviews of the change literature have commented on what seems to be an unwarrantedly narrow focus of many therapies: "The behavioral treatments have oversimplified the matter--they have assumed that simply discouraging homosexual arousal and encouraging heterosexual arousal would be sufficient treatment--to assume that the only behavior of a homosexual relevant to treatment is his sex behavior is a mistake" (Sturgis, 1977). James, in an unpublished dissertation, answers, "It is questionable whether heterosexual intercourse should be considered the ultimate evidence for successful reorientation, as it seems to be implied by so many therapists" (1978). Says Tanner, "The addition of social skills training past the purely physical would be useful" (1974). Sturgis reports that only 14% of the studies he reviewed endeavored to alter the social skills of the individual seeking treatment. And Wilson and Davis, in the same vein, suggest a need for multi-component treatment for complex sexual behaviors (1974).

My thesis follows as a logical extension of the above: those therapies which de-emphasize overt sexual activity during therapy, both homosexual and heterosexual, are more likely to produce lasting change than those therapies which use overtly sexual procedures. The de-emphasis of sexual activity in a therapy process where success is ultimately measured in terms of sexual activity may at first seem puzzling. A review of the change literature supports this position, however, and a number of therapeutic experiences demonstrate a sound practical reasoning for a focus away from overt sex during therapy (Brown, 1981).

Such, then, is the justification of topic. Two points, however, need to be raised briefly before the bulk of the argument can begin. First, I have referred to, and will continue to refer to, homo-heterosexual shifts as "change" and not "treatment." This has been deliberate. Terminology in the helping professions has often been a burden, both to the theorist in his attempts to conceptualize the problems of sexual orientation, and to the therapist in his relationship with his homosexual client. The removal of homosexuality from DSM-III was at least in part an attempt to remove some of the stigma derived from a traditional disease model, where such value-laden words as "illness," "deviance," "treatment," and "pathological" were used to describe the homosexual. It does no good to burden clients with such terms. As long as there are individuals who wish, for any reason, to change their sexual orientation, the question of "treating" a homosexual for his "pathology" is irrelevant. Voluntary change is what we are concerned with, not socially imposed treatment. Secondly, implicit in the modes of treatment discussed in this article is the personal responsibility of the client for this decision to change. Kierkegaard said that no matter what forces helped shape a man into what he was, that man was responsible for what he could become (Fear and Trembling). Without a personal acceptance of responsibility and a belief that personal decisions can lead to meaningful progress, change is unlikely.

SEX AS AN APPETITE

It is currently popular to assume that the sex urge is a biological need, a drive reduced only by sexual release or by suitable sublimation of the sexual impulses. This assumption is rarely seen in writing per se, and it is therefore almost never challenged. Nevertheless, it is present. It is consistent with the instinct theories of Freud and his contemporaries; it fits today's emphasis of finding physiological determinants for behavior; and it is echoed in the literature of pop psychology. The necessity of regular sexual release is now virtually assumed in the bulk of the literature on sexual problems and treatment—researchers today simply assume that frequent sexual activity is a psychological, even physiological

*Brother Anderson is a graduate student in Psychology at Brigham Young University.
concomitant to good health, and place its importance as a drive not far below the needs of food, air, and elimination (Masters and Johnson, 1970, 1974; Kaplan, 1974; Socarides, 1968).

Sexual behavior in humans is a multi-faceted phenomenon, and it is not my purpose to underestimate the role of physiological factors in sexuality. However, such a de facto assumption—that sex is a physical drive—however well hidden, is unwarranted:

No genuine tissue or biological needs are generated by sexual abstinence. It used to be believed that prolonged sexual inactivity in adulthood resulted in the progressive accumulate of secretions within the sex glands and gave rise to sexual urges. Modern evidence negates this hypothesis. (Beach, 1977)

"The present generation would seem to be 'victims' of the misconception that periodic sexual outlet is biologically required" (Hardy, 1964).

I question the mentality of assuming, a priori, that sexual activity is necessary for physical as well as mental health. It is possible that psychologists, as high priests of a "me-generation," are echoing more the self-indulgent wishes of our society for continual gratification than they are indicating actual research results. (Lasch, 1978).

Hardy has suggested an alternative (1964). Based on a review of the hormonal evidence, hermaphroditic studies, phyletic comparison, and other psychosexual research, Hardy suggests that sexual motivation can be adequately conceptualized not as a drive, but as an experientially developed appetite. Developed through social learning processes, the strength of the sexual appetite is largely contingent upon affective experience: the more you have, the more you want.

While Hardy by no means dismisses biological considerations in human sexuality, he favors the psychological construct of an "appetite" over purely physiological explanations. Psycho-biological paradigms obviously cannot be ignored in sexual research. Sex differences of the CNS; the deprivation of prenatal sex hormones; fetal androgenization; congenital adrenal hyperplasia, adrenogenital; and other syndromes all play a undeniable role in psychosexual orientation. But research is incomplete, and the exact nature of those roles is still unclear (Money and Ehrhardt, 1968, 1972; Ehrhardt, 1974, 1979; Dorner, 1978). As such, the explanatory power of purely physiological paradigms in human sexual regulation remains weak, at least for the present.

But in therapy—whose realm is almost entirely limited to cognition and affect—the construct of a sexual appetite may be very useful in illuminating to the client the possibilities of consciously regulating his sexual behavior. For the purposes of therapy, sexual appetite is a viable model.

The implications of an appetitional model in the treatment of problems of sexual control contrast sharply with treatments derived from theories that place sex as a drive. According to drive theories, sexual tension is released by a) the direct gratification of sexual impulses, and b) the sublimation of the sexual drive into non-sexual, more appropriate channels. Freud, of course, first elaborated the concepts of sublimation and substitution. Psychoanalytic interpretations of literature, art, music, etc. as sublimated sexual urges form an impressive literature all their own.

Appetitional theory, however, interprets the control of sexual impulse in quite the opposite way: "If the substitute activity is sexually stimulating, then the appetite will tend to increase and the problem is increased. If the activity is non-sexual in character, sexual impulses will neither be relieved nor aroused" (Hardy 1964).

Appetitional theory implies that the way to control inappropriate sexual desire is not to gratify the sexual urge, nor to sublimate it, but to reduce the sex urge by abstinence. Masturbation or sexually explicit reading material, as obvious examples, would not be considered acceptable substitutes for inappropriate sexual behavior, because rather than relieve sexual appetite, they tend to increase it. It is a common expression in the armed forces and other one-sex groups that no sex is better than a little sex—a taste titillates the appetite, while total abstinence reduces it.

I am not encouraging celibacy, however. I am simply attempting to demonstrate that, viewed as an appetite, the problems of sexual control are quite different than sex viewed as a drive, a biological imperative. Where greater sexual control is deemed desirable—as in homosexual reorientation—an appetitional conceptualization implies that reduced sexual activity and reduced exposure to sexual stimulation will lead to a reduction of sexual impulse; while the continued gratification of sexual urges will tend to maintain or increase sexual appetite.

To the agentive therapist, this view is very promising. Appetitional theory holds more hope for those clients who desire impulse control than a drive theory can traditionally offer. It suggests that the client be taught responsibility for his sexual appetite: "The idea that sex is not a drive—i.e., uncontrolled— but an appetite is important because it implies that sex desire can be controlled...we don't have to change our values to fit a 'biological sex drive'; sex is appetitional and subject to conscious control" (Hardy, 1964).

In summary, sexual motivation can be conceptualized not as the physiological tissue need assumed by so many professionals, but as an appetite. As with any appetite, increases of sexual indulgence lead to increased sexual appetite, and appetite is reduced during periods of abstinence. This conclusion has implications for homosexual reorientation.

INTIMACY VS. HYPERSEXUALITY

As a group, homosexuals appear to be more sexually active than heterosexuals. While some studies have recently challenged the universality of homophilic promiscuity (Bell and Weinberg, 1978; Tripp, 1975), it is evident from these same studies that homosexuals, taken in the aggregate, are much more promiscuous, in terms of number of partners and frequency of sexual contact, than their heterosexual counterparts. Bell and Weinberg report that a male homosexual, established in a gay subculture, may have literally hundreds of sexual contacts within a one-year period (1978). "While the
-range of sexual contact among homosexuals varies greatly, it is true that homosexual men are far more likely to have sex with many partners than either heterosexual men or women" (Saghir and Robins, 1973). Rechy, well-known homosexual writer, states, "Among some homosexual men, having sex with many partners on an impersonal, casual basis is almost a mark of pride" (1977). And Goode and Troiden report: "Clearly, homosexual men are more promiscuous than other heterosexuals" (1980). While there are undoubtedly those who lead a monogamous existence, a majority of male homosexuals tend toward a relatively promiscuous lifestyle.

The outstanding features of most homosexual encounters, both in and out of gay subcultures, are transience, and a lack of interpersonal involvement, typically much less involvement than in heterosexual relations. Goode and Troiden write:

The charge that promiscuous sex is related to the emotional superficiality of one's sexual encounters is difficult to refute; our evidence clearly supports the charge. This is indicated by a variety of measures and manifestations...clearly, it is difficult to have anything but a superficial relationship with a very large number of partners...emotional superficiality appears to be a fixture in promiscuous homosexual sex. (1980)

In the ferment of sexual activity frequently surrounding a gay lifestyle, homosexuals learn to replace human intimacy with a hypersexuality. This comment demands careful explanation.

It is a normative goal of individuals of our society to develop a number of relationships which fulfill different kinds of needs. Thus we see familial attachments, romantic relationships, best friends, etc. It is within these attachment bonds that the human need for intimacy--long term, permanent attachments of emotional closeness--are met (Schofield, 1965).

A number of investigators have noted that homosexual males, as a result of inadequate childhood experience, develop a limited repertoire of interpersonal behavior, which may supply a limited amount of interpersonal involvement (Brown, 1980). Indeed, a lack of social repertoire development and subsequent limited interpersonal involvements seem to be, in an otherwise storm of contradictions, a commonality. Writes Apperson and McAdoo: "Early in life, he [the homosexual] resorts to methods of interaction which reduce risk of failure, and reduce potential for further confusion and pain. Because deep and emotional intimate relationships are not within his ability to develop, he learns to meet his needs, often impulsively, by emotional and physical collaboration with others" (1968). Thompson echoes this idea: "It might be said that he [the homosexual] develops skills not of relationship, but of alienation" (1949).

The result of these inadequacies is to compensate by withdrawing into a lifestyle which does not require heavy interpersonal involvement. Unilateral means of self-expression and a narcissistic self-focus often characterize a homosexual lifestyle (Brown, 1980, Tripp, 1975). Lacking the necessary social skills, many homosexuals develop interests and modes of living which preclude intimate relationships with other people. "Without a comfortable role identity and a good repertoire of interpersonal behavior, a homosexual simply may not feel secure enough with his identity or his abilities to enter into very many close, satisfying relationships" (Tripp, 1975). Often above average in intelligence and confronted with a society that places high values on achievement, the homosexual tends to invest his energies in activities which require minimum collaboration and provide maximum self-expression (Schofield, 1965, Brown, 1980). Thus, interior design, drama, music, dance, and literature legitimately attract many homosexuals, not because of sexual preference per se, but because those fields allow individual achievement, without great interpersonal involvement.

In football I was a running back. I liked to do things myself. I didn't like team sports because someone else could lose for you. But on the wrestling mat, it was me and the other guy...I think you have to understand clearly that I was one of the most antisocial and consequently asexual people that I've ever met. I couldn't relate to people on a friendship level...I couldn't touch. I was too wrapped up in myself. (Adair, 1978).

I am not intimating that homosexuals are social outcasts, without friends or someone to spend an evening with. Not at all. They are not necessarily even more lonely than heterosexuals. But it is possible to be socially facile, to have friends, to be an excellent conversationalist, and yet still be deprived of intimate relationships. Intimacy is most easily developed in a familial or marital setting, both of which homosexuals miss, almost by definition. Intimate relations require permanence, which is often at a premium in gay subcultures. Intimacy requires a certain minimum of role security and interpersonal skill, neither of which the homosexual may have, given the etiology of homosexual development. In such a climate of obstacles, the homosexual may find long term, intimate relationships almost impossible.

Limited in their intimate relationships by the very nature of their sexual preference, it is not difficult to understand how (or why) homosexuals substitute promiscuity for unachievable permanent intimacy. Caught desiring the universal human need for intimate social contact but unable to achieve it, the homosexual, in or out of a gay subculture, may float from relationship to relationship, seeking what satisfaction he can find. And in a milieu of transience and emotional superficiality, with both partners seeking self-gratification, that satisfaction is likely to be sexual. Bathroom contacts, pick-ups in gay bars, bath houses, short affairs, where most of the involvement is from the waist down, become not only the replacement of intimate relationship, but its anathema, because often the people with whom the homosexual becomes sexually involved are not those he would want to associate with socially anyway. Concludes Goode and Troiden:

Emotional superficiality--or rather, the absence of emotional involvement--appears to be a fixture in promiscuous homosexual sex. The larger the number of men a homosexual has had sex with, the higher the likelihood that he will generally
have sex with a partner only once, and the lower the likelihood that he and his partner will be involved interpersonally. At the same time, it is clear that promiscuous sex among male homosexuals is accompanied by a number of experiences that are almost universally regarded as undesirable—even dangerous. (1980).

The Impracticality of a Direct Shift

Earlier I questioned the assumption that sexual activity is a physiological necessity, and proposed that sex, for the purposes of change therapy, be viewed not as a drive, but as an appetite, subject to voluntary control. I then suggested that lacking an interpersonal repertoire and social opportunity, homosexuals learn to replace intimate relationships with a promiscuous, hypersexual lifestyle. My third argument derives from these earlier points: it is impractical to sustain a direct shift from overtly homosexual behavior to overtly heterosexual behavior. The use of the word “direct” is deliberate.

While the homosexual replacement of relationship with sex is not an adequate substitute, his sexual encounters are powerfully rewarding and tend to perpetuate themselves. The homosexual is drawn, often against his conscious inclinations, into an increasingly heavy schedule of transient, my-turn, your-turn sexual contacts. As the homosexual’s behavior becomes more sexual in tone, especially sex outside meaningful relationships, his sexual appetite naturally increases. It is important to see the experienced homosexual as an individual with a stimulated and increased appetite for sexual gratification (Reid, 1976; Cory, 1960).

Bearing in mind this increased homophilic sexual appetite, we can now begin to take a critical look at change therapy. As mentioned at the beginning of this paper, the overt sexual behavior of the client has been a major focus for most of the change procedures I reviewed. Reading change literature, one senses the assumption of many therapists that if a client can be induced to have a successful heterosexual orgasm(s) and simultaneously reports a drop in homophilic arousal, he must be at least improved if not cured (Acosta, 1975). Aversive conditioning, covert sensitization, aversion relief, masturbatory conditioning, desensitization, positive conditioning, behavioral rehearsals, modeling, surrogate sexual training; all of these techniques, well represented in the literature, are aimed, almost without exception, at the explicit sexual responses of the client (Bieber, 1962; Cautela, 1971; Hatterer, 1970).

Multi-component approaches, which attempt to work with more than one dimension of the problem, have become increasingly popular (James, 1978). But even multi-component therapies tend to focus their barrage of techniques at the sexual behaviors of their clients (James, 1978; Haddon, 1967). James writes, “Homosexual retraining is often an integral part of the therapeutic procedure in both behavioral approaches and more traditional verbal therapies...but even when social retraining is utilized as part of a multi-component therapy, the training has usually concentrated on handling sexual, and potentially sexual encounters” (1978).

A particularly blatant example which illustrates this singular sexual focus is found in the 1972 work of Moan and Heath. “The investigation began with an implantation of electrodes into the septal region of the brain--the so-called pleasure center (Olds, 1956). When a pleasure response to electrical stimulation was established, the investigators proceeded, over a period of several weeks, to condition the homosexual subject to respond pleasurably to heterosexual stimuli. After the subject regularly reported a conditioned pleasure response to presented heterosexual stimuli, the subject was left alone with a female prostitute, hired for the occasion, whose instructions were to seduce the client. She succeeded, and the subject was pronounced “cured.” During the entire experiment, no attention was reportedly given to other factors which may have influenced the emotional well-being of the client(?). One wonders at the ethics of such “treatment.”

It is questionable whether heterosexual intercourse should be considered the ultimate evidence for successful reorientation, as seems to be implied by so many therapists” (James, 1978). Change therapies which focus on overt sexuality, either homosexual or heterosexual, are likely to have limited success, because they do nothing to reduce the sexual appetite of the client. Therapeutic techniques which emphasize overt sexuality in any form (e.g. aversive relief, masturbatory conditioning, etc.) do not relieve sexual appetite; on the contrary, they stimulate it, leaving the client with an increased desire for sexual release. And is he going to release heterosexually? Probably not. Unless the client is already far into a heterosexual relationship (unlikely at early stages of treatment) or has immediate access to temporary heterosexual partners, he is not likely to find a way to release pent-up sexual appetite, appetite which may actually have increased during sexually oriented therapy.

I have to confess to you that what you’d said about how I spend more than two-thirds of the session talking about one form or another of sex is affecting my lifestyle. I just don’t get it out of my mind. (Bell and Weinberg, 1978)

Unable to release heterosexually, the client quite naturally turns to the form of gratification at which he is already skilled—homosexuality.

It may help to visualize the homo-heterosexual shift as two large mountains (homo and hetero-erotic) with a deep valley of neutral ground in between. In the attempt to change homosexual arousal directly into heterosexual arousal, the therapist attempts the difficult task of moving the client from peak to peak without first taking him down into the neutral valley. It seems pointless to keep a client on a sexual high when he is not emotionally or socially prepared to act as a complete heterosexual.

Most important, from the outset he [the therapist] must avoid a hypersexual approach, informing the patient that his problem is not solely a sexual one...the patient must be given a sense of his total humaness and of his life in other than sexual terms...a therapist’s show of excessive interest in homoerotic detail can too rapidly set a sexual tone, and direction of treatment. (Hatterer, 1970)

It is an oversimplification to even tacitly assume, by a focus of treatment, that sexual considerations are all
that are involved in a homophilic orientation. Insecurity of role, lack of identity, limited social repertoire, fear of opposite sex, may all play a part in the maintenance of homosexuality (Acosta, 1975; Brown 1980; Masters and Johnson, 1979). Overtly sexual techniques, which try to transfer homoerotic arousal directly into heteroerotic behavior encourage a continuance of sexual gratification. For the committed homosexual that gratification is most easily found within the homosexual milieu (Saghir and Robins, 1973). Masters and Johnson reported that homosexuals reached sexual fulfillment more easily and with greater frequency than their heterosexual counterparts (1979). They achieved orgasm more often and with greater ease than married couples. Other researchers have pointed out the availability of sex within the gay subcultures (Bell and Weinberg, 1978, Goode and Troiden, 1980). The reality is that homoerotic sex is probably more accessible and just as fulfilling as the heteroerotic variety. Having better sex is not a compelling reason for switching to heterosexuality.

Therapy, then, which emphasizes overt sexuality, homosexual or heterosexual, can have the following negative consequences: 1) it maintains sexual appetite, most easily gratified in the already established homosexual mode; 2) it may focus attention away from the development of interpersonal skills, necessary if the client is to develop lasting intimate relations, sexual or otherwise; 3) it promotes the feeling that once heterosexual intercourse has been achieved, the problems of homosexuality are over. This last, of course, is far from true. Writes Hatterer:

Once having negotiated successful intercourse, many patients feel that their problems are over. However, at this point the therapist must caution the homosexual patient that intercourse per se is not the answer, particularly intercourse that has taken place in a superficial manner. (1970)

An Asexual Approach to Therapy
For the reader who has followed the reasoning thus far it will come as no surprise that I advocate a therapeutic milieu of asexuality, at least in the beginning stages of change therapy. No matter what therapeutic techniques are employed, simply teaching the homosexual to respond hetero-orgasmically is not a sufficient answer, perhaps not even a partial answer. The homosexual does not need new--albeit heterosexual--means of sexual gratification; he is already expert and can find sexual release more easily on his own. At least in initial stages of therapy it is important to de-emphasize any form of sexual gratification, homosexual or heterosexual. This de-emphasis should be reflected in all communication between therapist and client, and in all therapeutic procedures employed.

This is a departure from therapeutic procedures currently in vogue. But too many change therapies operate on a "quick-slip" principle, hoping a shift into a hetero-orgasmic mode will balance the loss of the client's homosexual identity (James, 1978; Wilson and Davison, 1974). Homosexuality is far too complex for such a trade-off. As previous sections have pointed out, an increased sexual appetite and the lack of an adequate behavioral repertoire make such a direct shift of sexual targets impractical.

It is not my purpose to elucidate a new change therapy. Rather, I have suggested an approach of asexual orientation--a principle which should prove useful in developing more successful future therapies. While I wish in this writing to avoid alliance to any particular therapeutic mode, our discussion does imply several general suggestions which may have application within a broad range of therapies:

1) Successful change therapy should begin by urging the client to limit, as much as possible, all sexual activity: including homosexual behavior, heterosexual behavior, masturbation, the viewing of explicitly sexual material, and other fantasy activities. Commensurate with our discussion, such a period of abstinence may be considerably facilitated by the de-emphasis of overt sexuality during therapy sessions. This idea is not new: a number of current therapies, particularly multi-component types, advocate beginning therapy with a period of sexual abstinence (Hatterer, 1970). The primary purpose of such a time-out period is appetite reduction; figuratively, to starve the sexual appetite into submission. A secondary advantage will be to simplify the life of the client. Most homosexuals enter therapy terribly confused. It is much more practical to help a client limit all sexual behavior--for a time--than to ask him to try and sort out one sexual impulse from another.

Complete sexual time-out will not happen overnight; after all, the cessation of homosexual behavior is itself a major goal of therapy. Nevertheless, urging a client toward even a modest attempt at self-restraint will itself be beneficial (Sturgis, 1977). Thought-stopping, and other cognitive and behavioral techniques may prove useful in beginning and maintaining a time-out period (Brown, 1980; Hatterer, 1970; Haddon, 1967). It is important to remember that such procedures assume the client is highly motivated to change: without such motivation, success rates drop precipitously (James, 1978).

2) In this period of sexual neutrality, a second appropriate therapeutic goal may be to teach the client to accept responsibility for his sexual behavior. It is here that an appetitional model can be a useful conceptual tool. If a client regards sex as a drive, a biologic necessity, he is likely to perceive his homosexual lifestyle as inescapable (Acosta, 1975; Haddon, 1976). Indeed, it is symptomatic of the confirmed homosexual to regard his sexual behavior as something he was born with, and the prevalence of this mental set has been a serious obstacle to many therapies (Brown, 1979; Sturgis, 1977). Without attempting to judge the presently-unclear role of hormones in human sexual orientation, it is safe to assert that a client seeking sexual reorientation has a much greater chance of success if he proceeds with the strong belief that he can consciously control his sexual activity. It is this mental set of appetitional control that a therapist can impart to a client most easily in a period of sexual time-out.

3) As the client reduces his sexual activity and hence
his sexual appetite, he will begin to notice the vacuum surrounding him; a vacuum created by his inability to develop lasting intimate relationships. He may to some extent be aware of this vacuum already, but his homosexual lifestyle prevented him from acting on this perceived lack.

At this juncture, a third goal of therapy may be to help the client understand his homosexuality as a substitute for interpersonal intimacy. The etiology of a particular client's homosexual orientation needs to be thoroughly explored, evaluated, and finally accepted by the client. While the means for making this exploration will vary depending on the therapy employed, all clients may benefit by case-study presentations of other homosexual clients whose etiologies—and subsequently successful therapies—are similar to their own (Hatterer, 1970; Brown, 1979). Such case-studies are often reviewed by the client with a strong sense of relief (“Other people feel the way I do!”); they reinforce the cognitive set that sexual appetite is controllable; and they provide a strong role-model that sexual orientation can be successfully, i.e. permanently, changed (Brown, 1979).

As the client continues to develop control over his sexual appetite, a fourth goal of therapy may appropriately be the acquisition of an increased social repertoire of male behavior. This also is nothing new; multi-component therapies have been teaching social skills to homosexuals for years (James, 1978). However, the emphasis advocated here is hetero-social skills, rather than heterosexual.

When the client understands the etiology of his homosexual orientation, he will realize that his physical relations with men were really an expression of his inability to become emotionally close to men. This emotional inability finds its roots in early childhood, where as a pre-homosexual, he did not develop behavior skills necessary for closeness to his male peers (Bieber, 1962; Acosta, 1974). The irony of homosexuality is that the male homosexual is really only eroticizing his desire to be “one of the gang” (Reid, 1976).

The changing homosexual therefore needs to be taught heterosocial skill. Role playing, modeling, and other hands-on practice techniques are probably most effective in the acquisition of such a behavioral repertoire. A couple of points are worth noting, however. First, a homosexual does not need to be taught how to be “macho.” In fact, this sort of hypersexual image is frequently identified with the homosexual milieu from which the client is trying to escape. Homosexual clients typically have no trouble perceiving themselves as male (Acosta, 1974; Bieber, 1962); what they need are communication skills. Ancillary to this, while most homosexuals (not bisexuals) have negative feelings toward women, before such feelings can be adequately addressed in therapy, the client needs to learn to relate with men non-sexually.

The last point has touched upon a fifth goal of therapy: teaching the client the possibility of non-erotic intimacy. As the social repertoire of the client expands, his social behavior outside therapy sessions will begin to move past the sexual and the superficial. With appropriate encouragement from the therapist, the client will begin to move into deeper relationships with both men and women. At this point in therapy, the continued de-emphasis of overt sexuality will prove beneficial. The client should not be encouraged to move immediately into liaisons of an overtly heterosexual nature. The homosexual needs to be taught that intimacy does not need to be sexual. Hatterer states it perfectly:

The patient needs to learn that it is possible to relate on a non-erotic, yet affectionate, man-to-man basis...attempts at intimate relationships of a non-erotic nature with heterosexual male friends should be supported. (1970)

In an environment of sexual neutrality, where the client feels no pressure to respond sexually—because it is against the rules—he is in an excellent position to develop real intimacy with both genders. By keeping the focus away from sexuality, the client can practice, in low-pressure situations, new-found interpersonal skills. By moving away from the purely sensual, he can begin to experiment, perhaps for the first time, with much more subtle more gentle pleasures—holding hands, discussing the football game, inviting a woman to a concert, embracing a man non-erotically, etc. He can begin to experience a retreat from hypersexuality.

REFERENCES


completed on page 28

Hadden, S. B. “Male homosexuality.”


Fookes, S.H. “Some experiences in the use of aversion therapy in male homosexuality.”


