The Psychotherapeutic Treatment of Male Homosexuality

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In recent years very few psychodynamic contributions to the aetiology or treatment of male homosexual behavior have been made. This paper based on material from patients, and noting the contributions of others, indicates that such patients can be understood and treated successfully.

A possible aetiological factor that has not been mentioned before in the literature, the abortion of a pregnancy conceived by the male patient that may have led to the patient "coming out" or declaring his homosexuality, is discussed.

Three main conclusions are reached. First, that human sexuality is not rigidly compartmentalized into either hetero- or homosexuality but varies on a continuous spectrum, and is affected in any individual by psychodynamic influences. Second, that before “coming out,” young people should have the opportunity to explore their sexual identity with a psychodynamically oriented psychotherapist. Third, that some patients whose fantasies and behavior have been homosexual at some time, can become comfortably and fulfilling heterosexually with psychotherapeutic treatment.

In recent years there have been very few psychodynamic contributions to the aetiology or treatment of homosexual behavior. This stands in sharp contrast to the 1960s, when the contributions of Bieber, Socarides, Ovesey, Stoller, and others significantly increased our knowledge and understanding.

One possible explanation for this change may be the success of the homosexual activism generally known as the “gay liberation” movement. In psychiatry, this activism has mainly been directed toward emphasizing the
“normality” of homosexual identification and practice, and strongly discouraging any attempts to change homosexual orientation or behavior through psychotherapy.\(^5,6\)

In 1974 the American Psychiatric Association voted to drop the term “Homosexuality” from its list of “Mental Disorders,” and recent years have seen renewed attempts to establish an organic, genetic, nonpsychodynamic basis for homosexual choice and behavior.

However, these changes have not been helpful to psychotherapists whose psychodynamic training and clinical experience has given them a very different view from that considered “politically correct” today. Nor has it been helpful to those patients unhappy with their homosexual drives and activities, nor to those suffering from symptoms that appear to be classic examples of symptom substitution.

In presenting the case histories of two male patients who had thought of themselves as being homosexual and whose behavior had been homosexual, but who became comfortably and consistently heterosexual during successful, long-term psychodynamic psychotherapy treatment, I suggest to therapists that the psychodynamic understanding and treatment of such patients is still valid and helpful.

**CASE HISTORIES**

**Case 1**

Mr. R. was referred to me by another physician because troubling thoughts and feelings that he had about people he worked with were pushing him toward taking a prolonged leave of absence from his work.

Mr. R. was a tall, handsome, well-dressed man in his mid-forties who kept himself fit with regular, early-morning jogging and evening swimming. Having entered his field of work quite young, he had reached a senior position with considerable responsibility for a large number of people. He had almost reached the peak of his career but was contemplating stopping because he was convinced that the people that he worked with were whistling at him. This supposed whistling upset him, and he was convinced that the whistlers intended to make him uncomfortable. He believed that knowledge of this discomfort was being disseminated among a wide range of people that he had professional contact with, and that some of the more senior people who had influence over his career progress were aware of his homosexuality and were talking about it.

There was absolutely no confirmatory evidence for these beliefs, but they were troubling him so much that he was strongly tempted to take a leave of absence that would probably have finished his career.
At an early stage in our meeting he told me that he was homosexual, that he had been so for many years, that he felt quite comfortable with that, and that it was not a problem. His problem was the attitude of the people he worked with, and did I agree that a leave of absence was the solution?

As his story emerged more fully it became clear that while most of his close friends were homosexual, that the restaurants and bars that he frequented were predominantly homosexual meeting places, and that the people that he appeared to be most physically attracted to were “beautiful” young males, nevertheless his sex life was furtive, limited, quite unsatisfying, and unfulfilling.

Furthermore, he revealed that in the past he had had relationships with women. While there had been one experience of sexual inadequacy with a woman who had ridiculed him, he had had a very successful and enjoyable sex life with another woman.

That relationship had occurred in his mid-twenties. It had lasted for some months, and was a very good relationship from both emotional and physical aspects.

Unfortunately, the young woman became pregnant. Mr. R. being in his own way a highly ethical and moral man, offered to marry her but she did not then feel ready for marriage or for becoming a mother, and she terminated the pregnancy.

From that time on, Mr. R. turned to homosexuality. He was not consciously aware of making any such decision. His own belief was that he had just gradually discovered his greater attraction to men and taken what in his mind had been the “courageous” decision to acknowledge his homosexuality and become integrated into the “gay” life.

For him, that also meant leaving his smaller town of origin and moving to the big city, cutting off a number of his previous family and social contacts, and keeping that aspect of his life quite private as far as his working world was concerned.

Until coming into therapy he had no further sexual contact and very little social contact, with women.

When the discordance between his initial belief that he was quite comfortable with his homosexuality and the very obvious indications of his discomfort and unhappiness with it became evident to him (as manifested by his continual fear of discovery and his lack of real sexual enjoyment and fulfillment), his symptoms rapidly disappeared. There was no further talk of a leave of absence and he now looks back at that with a somewhat amused amazement, finding it hard to believe that he could ever have thought of making such a potentially disastrous move.
Psychodynamic psychotherapy continued on a regular basis for a number of years. He developed a more balanced life style with a number of professional and personal relationships with women. He was able to complete the remaining years of his original career successfully and enjoyably, took the early retirement with large pension that he was entitled to, and successfully started a second career.

His sexual life in practice has been successfully and pleasurably fully heterosexual for some years though occasional homosexual fantasies remain, and he has kept the nonsexual long-term friendship of a few close male homosexual friends.

Case 2

Mr. D. was 32 when his family doctor referred him to me because he had been running into serious difficulties at work.

Mr. D. was a man of medium height, strongly built who also exercised regularly. He was a highly intelligent and articulate man who had spent most of his working life in one form or another of public service. At the time of referral he had been having personality clashes with his superior and turning up late for important appointments. His own belief was that he was not "thinking clearly," and, therefore, he had taken a leave of absence.

A quite narcissistic man, he believed that he deserved to be in a higher position than he was and that it was only the lack of paper qualifications that had held him back so far.

He declared his homosexuality at the first consultation, and insisted that he was comfortable with it and that it had nothing whatsoever to do with his symptoms.

In discussing his relationships, it emerged that when younger he had been quite heterosexual and had had a number of successful sexual relationships with women. He then mentioned a young woman becoming pregnant by him. Neither of them were ready to marry or become parents, and the woman made the decision to have an abortion.

From that time to the present he had become exclusively homosexual in his sexuality, though he still maintained some social contacts with women.

Unfortunately he had a high resistance to self-understanding, and, as I had predicted in my consultation letter to the referring doctor, his temptation to leave therapy early proved to be too great to overcome.

Case 3

Mr. C. was in his mid-thirties when he entered psychotherapy in a state of near panic following a failed sexual encounter with a woman.

From adolescence, he had been driven by his numerous homosexual fantasies, and sought frequent homosexual encounters in such places as
bathhouses. The encounters were almost invariably brief and impersonal, no long-term relationships were formed. At least one such encounter had landed him in legal trouble.

He was a university graduate and had a good, secure position in his profession, and his level of expertise and reputation would eventually lead to a number of consulting commissions.

However, his fantasies and encounters had dominated his life, and feeling under some family-cultural pressure to attempt to develop relationships with women and marry, he made some very occasional, rather pathetic and unsuccessful attempts, one of which propelled him (almost literally) into my office.

He was an only child of old-fashioned, rigid European parents who like so many, had had to leave their country of origin in the Nazi era and build a new life in a new country with a totally different language and culture. Many of his sexual fantasies and conflicts centered around the confusing and contradictory messages he received from his parents and from the society that he lived in, but had great difficulty adjusting to. He grew up feeling pressured and guilt-ridden, very dependent on, and yet resentful toward, his "foreign" parents. He seemed preoccupied with the need to be "on top," with feeling powerful and in control, and these themes became predominant in his sexual fantasies and behavior from his late teens to his mid-thirties.

I was at first reluctant to take him on as a patient in psychotherapy because I had had some minor prior social contact with him, and initially referred him to an analyst colleague who rejected him as being "too passive."

But after that, I commenced a long therapy that in spite of being mildly contaminated by the occasional social crossing of paths, has resulted in this patient marrying and fathering three children and living a heterosexually fulfilling and enjoyable life.

When stressed, he continues to have fears that he might yield to the temptations of acting on his occasional fleeting homosexual fantasies, but in the nearly twenty years that I have known him this has not occurred.

**DISCUSSION**

The first patient, Mr. R., came to consultation for reasons apparently unrelated to his homosexuality and he claimed himself to be comfortable with his homosexuality. Further exploration revealed that this was far from the truth. A successful long-term psychodynamic psychotherapy treatment helped relieve this patient of his original presenting symptoms, and enabled him to become comfortably and consistently heterosexual.
Both this patient, and another male patient, Mr. D., gave histories of having made a rather sudden change from heterosexuality to exclusive homosexuality. They both "came out" following the abortion of the developing child that they had helped conceive.

There are no previous reports in the literature of such an event as a woman lover having an abortion precipitating the emergence of a homosexual practice or identification. However, Socarides (personal communication) has described a patient who came into psychoanalytic treatment as a homosexual. After nine months of treatment the patient had begun to have a heterosexual relationship but the woman became pregnant and had an abortion. The patient was devastated and returned to a "full-scale homosexuality," which was explored and resolved as treatment continued, and the patient again engaged in heterosexual experiences.

I have recently seen in consultation a woman whose story mirrors that of Mr. R. In her early twenties she became pregnant, had an abortion under less than pleasant circumstances, and then in her own words "swore off men." She involved herself exclusively in homosexual relationships for the next twenty-five years, until she experienced an upsurge of heterosexual fantasies, and sought my help to explore the possibilities of redeveloping heterosexual relationships.

Regarding Mr. C. there was no history of a woman becoming pregnant by him and having an abortion, prior to his homosexual behavior.

"Coming Out"

"Coming out" is the announcement or acknowledgment in some way by an individual that he or she is homosexual. In the homosexual activist literature it is described as developing the "awareness and acknowledgment of homosexual thoughts and feelings," as "developing and expressing a gay identity," or "an integrated and positive identity," and in that literature the predominant approach is to encourage, integrate, and accept it. Rarely is it suggested that before encouraging the acceptance of a patient's "homosexuality" there should be an exploration and search for possible psychodynamic aetiologic factors. There is an absolute assumption that is implicit in most such reports that "coming out" represents the patient's acknowledgment of his or her "true" sexual orientation.

Those sources repeatedly emphasize that the goal of any therapy or counseling with such patients is to "facilitate the growth of the new social and sexual identity." Isay assures us that "the effort to change the sexual orientation of gay patients is not clinically helpful," there is no "clinical justification for attempting to change . . . basic homosexual behaviour," and
"core sexual orientation remains unchanged,"5 "nor would I expect to be able to change . . . sexual orientation."6

More recently Isay has asserted that "efforts to change homosexuals to heterosexuals . . . represent one of the most flagrant and frequent abuses of psychiatry in America today."10 As Chairman of the Committee on Gay, Lesbian, and Bisexual Issues of the American Psychiatric Association, Isay has also suggested "organizing some action" against the work of a therapist who published a book about treating male homosexuals, and "finding a way to isolate" a group of therapists who have formed an organization devoted to "Research and Treatment of Homosexuality" and who offer psychotherapy to homosexuals who request it.11

The obvious question is, what is the "core sexual orientation" of any individual? If a person has had heterosexual relationships and experiences for some years and then changes toward homosexual relationships and experiences, which is the "true" orientation? Furthermore, is it really a case of either/or?

Why is the assumption made by homosexual activists that the homosexual behavior now represents the "true" orientation, and everything up to that point has been a facade or a falsehood? That the person has now discovered his or her "true" identity and should be encouraged to accept and integrate this, while a patient who has had homosexual fantasies and experiences should not have the opportunity of receiving psychotherapeutic treatment that might help them become comfortably heterosexual?

The clinical experiences with patients reported in this paper would not support the positions of Isay and others. Neither does the scientific evidence support such a polarized either/or position, and would appear to be against the view that "coming out" represents the discovery of a person's "true" identity. It would seem that a more realistic appraisal of the situation would help separate evidence from polemic.

HUMAN SEXUALITY AS A CONTINUOUS SPECTRUM

Coleman claims that "sexual object choice" is determined early in life, that the average ages at which homosexual men and women had become aware of "their homosexual feelings" (my emphasis) was approximately 13–14 years, and that "commitment to a positive homosexual identity is related to healthy psychological adjustment."9 Isay insists that there is a "core sexual orientation" and that attempts to change it "are, in all likelihood, futile."5 For Isay, "it is the erotic fantasy that defines the homosexual and not his behaviour," and those erotic fantasies "are either almost entirely or exclusively directed towards others of the same sex."5
But against those personal opinions must be placed a number of findings. McConaghy\textsuperscript{12} has summarized the literature that has evolved since the Kinsey reports of 1948 and 1953. Kinsey\textsuperscript{13} et al. had found that a large percentage of their subjects reported awareness of erotic responses to members of their own sex though only a small percentage described their behavior as being exclusively homosexual.

They came to the conclusion that sexuality is on a continuum. That finding, even though it has often been challenged, has repeatedly achieved confirmation and acceptance.\textsuperscript{12,14}

McConaghy reported on a study of the awareness of homosexual feelings among medical students and demonstrated that the distribution of such feelings could best be explained as lying on a curve rather than as two either/or, polar extremes.\textsuperscript{12}

Ellis et al.\textsuperscript{14} found that about one-third of a group of men and women reported at least occasionally fantasizing about sexual interaction with someone of the same sex. Their results also led them to conclude that sexual orientation was best seen as being on a continuum.

If human sexuality is a continuous spectrum, then heterosexual or homosexual behavior are best understood as being manifestations of people moving along that spectrum toward or away from the opposite, or the same sex.

Psychodynamic research and treatment in this area arise out of an assumption. That assumption is: that all the biologic and evolutionary evidence points towards heterosexual expression as being the “desired” outcome of “normal” psycho-sexual development, while homosexual expression represents a compromise resulting from interferences with heterosexual expression at either the developmental level or later.

That assumption is of course most challenged by those gay activists who wish to see homosexuality understood and accepted as being a fully normal, healthy, alternative, minority sexual orientation, preferably genetic or inborn in origin in much the same way as lefthandedness or color-blindness.

But in the absence of any definitive agreement as to which position is the correct one, the psychodynamic assumption obliges those who accept it to try to find explanations for the interferences that have shifted individual patients away from the opposite sex and toward their own sex.

This paper adds a psychosocial factor that has not previously been reported in the literature, the termination of an abortion, that may affect or “shift” sexual behavior in a few people.

Both Mr. R. and Mr. D. appeared to be men who were frightened of their own violence, and who saw themselves as having been responsible for
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contributing to a life being destroyed. It is possible that in their unconscious a “vow” was made to “never” let that happen again, i.e., by turning away from women and the possibility of creating life—toward men, who were “safe.”

A commoner explanation for the “shift” of adolescent or adult males toward homosexual relationships or behavior is that noted by Socarides, among others, who suggested that his patient feared “the destructiveness of women” that led the patient to “run away to homosexuality.”

In Mr. C.’s case, his fear of “the destructiveness of women” came directly from his experiences with his dominating, punitive, capricious mother. He was another example of those patients that many psychotherapists are familiar with, patients who initially presented as being involved in the “gay scene” with numerous homosexual experiences, but who with good, long-term therapy have become fully and comfortably heterosexual.

In these days of AIDS it must be noted that these patients who have been treated successfully have openly expressed their gratitude for more than just the opportunity to develop the loving and supportive relationships with the women they have found.

A number of other authors have also reported successful results in treating male homosexuals.15–21

However, as Bieber and Bieber21 so insightfully commented nearly fifteen years ago, “[We] have seen well over 1000 male homosexuals. . . . We have followed some patients for as long as 20 years who have remained exclusively heterosexual. Reversal estimates now range from 30% to an optimistic 50%. . . . [But] others claim that a true homosexual cannot change. . . . Despite the treatment results we reported and the published findings of other respected colleagues, these cynics steadfastly refuse to place any credence in these reports,” a position that does not seem to have changed during the past fifteen years.

From the clinical material it is clear that in the cases of Mr. R. and Mr. D., the solution of turning away from women was not ultimately successful, but led to the eventual development of symptoms, even though both patients consciously maintained at the outset that they were comfortable with their homosexuality and that it had nothing to do with their symptoms. To just accept such opinions from patients, and refuse to acknowledge the crystal-clear implications of the clinical evidence, would, for all intents and purposes, be jettisoning the whole of psychodynamic psychiatry.22

It is strongly recommended that therapists take a more skeptical approach toward the so-called “coming out” process, and not accept as scientifically established the homosexual activist position that any therapy
with such an adolescent or adult must inevitably and only be directed toward supporting the identification of that person as being positively homosexual. Being skeptical should in no way be mistaken for entertaining any notions of discrimination, of seeing those whose behavior is homosexual as being mentally ill, or less worthy as human beings. There should be no doubt that people can have satisfying *homosexual* relationships, while distressing and unsatisfying *heterosexual* relationships constitute much of the daily work of most psychotherapists. But it is suggested that the strong evidence indicating that sexuality is on a continuous spectrum should lead therapists toward taking a position that those who are contemplating “coming out,” or who are unhappy with their homosexual drives, or who have symptoms that seem to have arisen from displacement and substitution, should be seen as being in a state of flux, and should not be denied treatment. It is totally in keeping with the understandings of psychodynamic theory that the psychodynamics of that state of flux be explored more deeply, so that the areas of conflict can be resolved in ways that might bring such patients greater maturity, health, and long-term fulfillment.

**SUMMARY**

This paper discusses aspects of the aetiology and treatment of male homosexuality, a topic that has become quite controversial in recent years. The paper is based on material from the author's patients, and also notes the contributions of others. In spite of many reports of successful treatment outcomes, some people continue to deny such results. This paper confirms that such patients can indeed be understood and treated successfully. A possible aetiological factor that has not been mentioned before in the literature is discussed, namely, the abortion of a pregnancy caused by the male patient that may have led to his “coming out” or declaring his homosexuality. Three main conclusions are reached. First, that some people who have had homosexual fantasies, behaviors, or identified themselves as homosexual, can become comfortably and fulfillingly heterosexual with psychotherapeutic treatment. Second, that human sexuality is not rigidly compartmentalized into either hetero- or homosexuality but varies on a continuous spectrum, and is affected in any individual by psychodynamic influences. Third, that before “coming out,” young people, especially teenagers, should have the opportunity to explore their sexual identity with a psychodynamically oriented psychotherapist.
REFERENCES
