A Typology Of Male Adolescents And Young Adults Seeking Therapy For Same-Sex Attraction

By Edward "Ned" Stringham, Ph.D.

I have worked as a mental health professional for twenty-five years, assisting men with concerns about same-sex attraction (SSA) during my entire career. I have witnessed several attitudinal shifts about sexual orientation that have affected the field of psychology during that period, but over the past ten years or so I have observed marked changes in the thinking of young male counselees seeking professional help for SSA. These changes have exerted major, direct influences on my methods and expectations in evaluation and treatment.

First, there has been a significant increase in the number of males requesting therapy. However, there is also a second and more fundamental change. That is, I have found that young males now present with a wide variety of motivations and goals for coming to treatment--as well as a potpourri of assumptions about homosexuality--and that these motivations, goals and assumptions do not necessarily fit easily within the basic principles that undergird reparative therapy. I can no longer assume that teens and young adults asking for therapy for SSA either recognize that homosexual orientation is necessarily problematic or understand that developing heterosexual potential is possible. Even when clients grasp these ideas, young males seeking help from a reparative therapist are not always interested in orientation change.

There are many explanations for this shift. Through a wide array of cultural media, males in the 14-25 age range have been repeatedly exposed to and even inundated with dogma promoting the acceptance of homosexuality. More importantly, most of them have been instructed in many of these ideas by influential adults such as teachers and sometimes even parents. Many have adopted a worldview defined by these concepts, while others experience confusion and doubt about beliefs that earlier generations of men relied upon to guide them in making decisions about morality and identity. Therefore, there no longer exists a set of generally accepted values that provide an essential framework for understanding and communicating with young male clients about SSA.

Other psychological factors also help explain the challenges associated with conducting clinical work with this age group. For example, extrinsic motivations, particularly parental pressures, often play a major part in the decision to enter therapy. Furthermore, psychosocial developmental factors and family dynamics influence clients' responses and abilities to benefit from counseling. However, in my view the values confusion, abetted by the messages sent by many of our dominant social institutions, has played a decisive role in the changing psychology of young men. In order to provide effective therapy under these cultural conditions, it is necessary to respond sensitively to the set of values held by each client. Therefore, I suggest that a typology of young males requesting SSA therapy exists that includes the following six groups: the naive, the deceived, the hypocritical, the traumatized, the family-centered and the reparative. The characteristics of each group with corresponding recommendations for treatment will be described here.

The *naive* is the client who is most confused and intimidated by SSA. He comes to therapy after repeated failures to annihilate his attractions, but continues to hope that if he avoids unwanted feelings they will eventually disappear on their own. He is likely to be self-conscious and anxious, his ambivalence being expressed by trying to please his therapist while simultaneously protecting his family, especially his father, by giving vague responses to probing questions. Denial is the main defense of the naive.

The naive most needs to acquire a willingness to face and accept reality and the courage to take action accordingly. His therapist should be a confident, assuring man who progressively guides the client to face truth in small increments. If possible, especially with adolescents, a therapeutic alliance should be formed with the parents so the client can view his participation in counseling as a contribution to the family's well being rather than as an act of betrayal.

The *deceived* presents himself as confident and, at least at the outset, as agitated and antagonistic to participation in counseling. If he is a young adult, he seeks help after he acts out homosexually and "comes out" to family members, usually at a holiday gathering. If he is an adolescent, he attends counseling after being caught concealing activities such as surfing Internet porn sites, communicating in chat rooms, attending a gay club at school, or in some cases acting out sexually with a male peer. He is seeing a reparative therapist at the urging or insistence of family members but has no interest in cooperating.

He views his parents, and perhaps his therapist, as foolish oppressors who are attempting to manipulate him to deny his immutable gay identity. He epitomizes the Fundamental

Attribution Error, that is, he views others as the cause of his problems and believes they alone have the responsibility to solve them. Deceived clients demonstrate limited insight and do poorly in Emotionally-Focused Therapy, maintaining a one-dimensional focus upon anger and frustration, which they claim is caused exclusively by the refusal of family members to accept that they are gay. In the more extreme cases, deceived clients present with symptoms of Delusional Disorder.

The therapist working with the deceived must be very careful to avoid becoming one of his oppressors (or in the case of paranoia of becoming part of the delusional system). I have found that it is often necessary to establish a relationship by discussing topics, such as music, movies or hobbies, that have no obvious relevance to the goals of counseling. The client will only explore subjects that expose his emotional vulnerability after he has experienced the counseling relationship as enjoyable, supportive and non-threatening. I never argue with the deceived about Gay Agenda issues, and I also provide informed consent to family members explaining that I will honor the client's right of self-determination in treatment and will also guard client confidentiality. If the client sees me as an ally protecting him from family intrusiveness, there is a good prospect for establishing a therapeutic relationship. Over time, the client may develop insights that permit an examination of psychodynamic themes and empower him to challenge his assumptions about his development, identity and relationships.

The *hypocritical* are essentially deceived clients who pretend to be naive. These males willfully and consistently misrepresent both their actions and their motives to their therapists (as opposed to other clients' occasional lapses in truth-telling) and do not benefit from confrontation or support. Because they either believe they would face unacceptable punishment for claiming a gay identity, have weak ego strength, rigid denial or arrogant narcissism, they prefer to lie about their behavior and intentions rather than acknowledge them candidly. In my experience, it is usually a waste of time to work with the hypocritical, and I recommend that they be terminated quickly with the exception of those cases where there is a significant risk of suicide.

The *traumatized* comprise a group of clients who have suffered sexual molestation, severe rejection or abuse from peers or a parent figure. Traumatized SSA teens and adults are motivated by the same factors that bring other survivors of abuse to counseling – the needs to heal psychic pain, resolve tortuous memories and overcome demoralization and shame. SSA may be either a primary, a secondary or a non-issue for these individuals, but they may choose a reparative therapist simply because they have confidence that in doing so they will benefit from a compassionate approach provided by a professional who is at ease talking about homosexuality. Because gay writers (e.g. Cassese, 2000) increasingly urge gay men to obtain help for childhood sexual abuse, it is expected that reparative therapists will also receive more requests for this treatment.

Provided they have the training and expertise to perform the work, I recommend that reparative therapists make themselves available to traumatized clients. Many of these men likely carry an unspoken hope that working on trauma will help them address the pain of SSA although citing reorientation as a goal may be too overwhelming for them to contemplate early in counseling. Nevertheless, it is important to provide a full informed consent that clarifies that therapy will honor the client's right of self-determination, but that, should the client choose to embrace a gay identity, the counselor will not help him work toward the goal of increasing his comfort with that decision.

Family-centered men enter therapy with the hope of changing their role in the family or altering the relational dynamics that affect them. Family-centered clients demonstrate insight into relational problems and are motivated to work on changing them. They differ significantly from the deceived in that the latter cling to a rigid view that demonizes family members and blames them for refusing to endorse the belief that a gay identity is unchangeable. In contrast, family-centered clients demonstrate an ability to empathize with others and recognize systemic problems such as weak communication with their fathers or over-involvement with their mothers. Family-centered men may either be gay-identified, interested in change or unsure about sexual orientation issues.

Family-centered men are intriguing because, in effect, they do reparative work without labeling it as such. The key to counseling with them is to focus on the issues they present without imposing any expectation of reorientation as a therapeutic goal. As resolution of troubled dynamics progresses, these clients individuate from their families-of-origin, grow toward maturity, and in some cases even report a subsequent decline in SSA. Therapists who work with them provide a valuable service.

The *reparatives*, clients seeking sexual orientation change, still comprise over half of the total SSA population that I see. Citing reorientation as a therapeutic goal, these young males demonstrate resilience by enduring both the shame of SSA and the ridicule and derision of peers who belittle their belief that change is possible. Typically, they have a positive relationship with at least one older adult and adhere to a belief system, such as a religion, that challenges the prevailing cultural assumption that homosexuality is normal. As the media and the schools increasingly promote the ideology of the Gay Agenda, I expect that more adolescents and young adults will become reparative clients.

The confusion in values that has afflicted our culture is exacting a cost on families and frequently creates dilemmas that complicate counseling relationships. The increased vulnerability of young men to the ill effects of this philosophical turmoil is motivating more of them to enter therapy for SSA at earlier ages. Whether facing ambiguity, affirmation or antagonism, it is the role of the reparative therapist to demonstrate compassion and flexibility, skillfully responding to the needs and developmental readiness of each client. Understanding the typology of young male clients will assist the therapist in making the strategic decisions that will maximize counseling's effectiveness.

Reference:

Cassese, J., Ed. (2000). *Gay Men and Childhood Sexual Trauma: Integrating the Shattered Self.* New York: Harrington Park.