ATTENDING TO SEXUAL COMPULSIVITY IN A GAY MAN

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Abstract
Themes of hiding abound in the developmental narratives of boys who grow up to be gay. Their need to hide is reinforced by the traumatizing public humiliation that ensues from either open expressions of same-sex desire or gender-nonconforming behavior. The experience of being discovered, punished, and humiliated for showing or acting on such feelings or behaviors can lead to hiding activities that persist long after the actual trauma is forgotten. When open expressions of same-sex intimacy are driven underground, clandestine and forbidden sexual activities, highly tinged with interpersonal anxiety, may become a significant mode of relatedness. This paper offers a clinical psychoanalytic approach for working with gay men that distinguishes the concept of sexual compulsion from that of sexual identity. Harry Stack Sullivan’s conceptualization of dissociative defenses is useful in clinically understanding and therapeutically working with gay men in general, and with sexually compulsive gay men in particular. This approach allows the sexual identities of gay men to be respected while addressing the compulsive behaviors that some of them find so troubling.

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Introduction

Themes of hiding abound in the developmental narratives of boys who grow up to be gay. Their need to hide is reinforced by the traumatizing public humiliation that ensues from either open expressions of same-sex desire or gender-nonconforming behavior. The experience of being discovered, punished, and humiliated for showing or acting on such feelings or behaviors can lead to hiding activities that persist long after the actual trauma is forgotten. The late, gay filmmaker Derek Jarman tells of such a defining moment at his English boarding school:

At [the age of] nine, I was caught in bed with Gavin--thrown onto the floor by the headmaster’s wife, lectured publicly and whipped. Frightened by this unexpected outburst, I was to have no physical contact for thirteen years. I lived my adolescence so demoralized I became reclusive....I was desperate to avoid being the sissy of my father’s criticism, terrified of being the Queer in the dormitory...My work also suffered. I dropped behind. At puberty my reports said “more concentration needed.” You see I was distracted [Jarman, 1992, pp. 36-37].

In a culture that claims to value the linkage of sex with emotional intimacy, it is difficult to foster those connections in gay teenagers in the same ways they are encouraged in heterosexual adolescents. It would be an understatement to say that adult support for adolescent gay dating is a rarity. Even fewer parents would consider sanctioning a gay teenager’s search for physical or emotional intimacy with a member of the same sex. Some boys who grow up to be gay, like Jarman, refrain from sexual activity and avoid emotional intimacy during important
developmental years. Others seek and find outlets for their sexual and emotional needs in furtive encounters. For some adults, such activities can become a way of life. The gay writer, John Rechy, idealizes what he calls the “sexhunt” in his book, *The Sexual Outlaw*:

The promiscuous homosexual is a sexual revolutionary. Each moment of his outlaw existence he confronts repressive laws, repressive “morality.” Parks, alleys, subways, tunnels, garages, streets--these are his battlefields. To the sexhunt he brings a sense of choreography, ritual and mystery--sex cruising, with an electrified instinct that sends and receives messages of orgy at any moment, any place...What creates the sexual outlaw? Rage [Rechy, 1977, p. 28].

Rechy calls cruising areas “battlefields.” However, the battle is being fought as guerrilla warfare, heterosexism being too large a target to take down directly. Consider the unthinkable possibility of gay men demonstrating the degree of physical activity that is routinely displayed by heterosexual couples on a beautiful day in Central Park. Even today, there are many neighborhoods in cosmopolitan and liberal New York City where two men holding hands still raises a few eyebrows. In some parts of town, it would surely lead to the raising of arms. When open expressions of same-sex intimacy are driven underground, clandestine and forbidden sexual activities, highly tinged with interpersonal anxiety, may become a significant mode of relatedness. For gay men like Rechy, this is a triumphant act of will, and not a psychiatric problem. Others, however, experience their sexuality as a compelling “force” and feel troubled by it.

Historically, psychoanalytic practitioners like Socarides (1968) argued that compulsive sexual behavior in gay men was evidence of the neurotic “origins” of homosexuality. This formulation conflated treatment of compulsive sexuality with a so-called cure of homosexuality. However, other clinical experiences have
shown that gay men who experience their sexual activities as compulsive do not necessarily experience their sexual attractions as compulsive (Drescher, 1998b). Nevertheless, because of the unsavory nature of the arenas in which they feel compelled to express their sexuality, these men may feel intense shame about being gay. What follows is a clinical psychoanalytic approach for working with gay men that distinguishes the concept of sexual compulsion from that of sexual identity. It allows the sexual identities of gay men to be respected while addressing the compulsive behaviors that some of them find so troubling.

Dissociation

It is important to emphasize at the outset that a person’s sexual identity is not pathognomonic of any defensive style. Focusing on the way gay men dissociate should not obscure the fact that they are a heterogeneous group. Denial, intellectualization, rationalization, and other defenses are as likely to be found in gay men as they are in other patients.

That being said, however, many gay men have a history of being subjected to events, traumatic or otherwise, that exaggerated the normal tendency to screen anxiety-provoking and shameful memories. From an early age, the social stigma surrounding homosexuality led many gay people to hide knowledge about their sexuality not only from others, but from themselves as well. In other words, antihomosexual, cultural prejudices reinforce dissociative activities. This makes Harry Stack Sullivan’s conceptualization of dissociative defenses useful in clinically understanding and therapeutically working with gay men in general, and with sexually compulsive gay men in particular. Parenthetically, Sullivan was himself a closeted gay man (Chatelaine, 1981; Perry, 1982; Ortmeyer, 1995), although it is not clear how central this sexual identity was to his theory of dissociation.
Sullivan (1938, 1956, 1972) regarded dissociation as an interpersonal process, one accessible to observation. In his two-person psychoanalytic model, a therapist noted “gaps” as a patient avoiding certain subjects and topics. It was Sullivan’s belief that this avoidance, or selective inattention, was deliberate, although the patient’s motive to avoid was out of conscious awareness.

Many gay men had a sense of their same-sex feelings years before openly acknowledging them. They learned to dissociate knowledge about their sexuality and also had to prevent other people from being able to recognize the quality of their sexual feelings or desires. This state of mind is commonly captured in the experience of gay men who report they always “knew” they were gay but didn’t want to admit it to themselves.

In Sullivan’s view, there is no self without an other, so hiding from the self is tantamount to hiding from others. This can sometimes be an interpersonally manageable solution, as in the case of a forty-year-old single gay man who lived with his mother. He did not want to tell her he was gay and she did not want to know. In a dissociative enactment of “don’t act, don’t tell,” together they avoided a subject which would have generated anxiety in both of them. She would give him telephone numbers of friends’ daughters while selectively inattending all of the ways in which she knew he was not interested in dating women. When he accepted the names, he could maintain the illusion that his mother believed he was a heterosexual bachelor, while he ignored all the nonverbal ways in which she communicated her fuller knowledge of him. A kind of homeostasis was achieved in which they mutually avoided the anxiety of seeing each other more fully.

This type of selective inattention surrounding homosexuality is rather commonplace. More severe dissociative operations are illustrated by reports of sexual encounters that take place under the guise of being asleep. Sullivan’s Clinical Studies in Psychiatry (1956) provides a dramatic example of this behavior.
when “During the night Mr. A gets out from under his cotton precaution and goes around and tenderly fondles Mr. X, and then goes back to bed under his bottom sheet” (p. 176). The following morning, Mr. A. “feels fine, and has no trace of any information about what has happened” (p. 176). Another patient described a similar incident:

B: An old friend from college and I had sex several times in our senior year. The first time, on a school trip, we were in a double bed together and I pretended to be asleep. His hand started coming over toward me gradually. I knew exactly what was happening, because I had done it myself to other guys. It was very exciting to be on the receiving end. He gradually worked his hand across to my cock and took a hold of it. I kept pretending I was asleep. Somehow, I took off my shorts, but still didn’t acknowledge what was going on. He put his cock between my thighs and started humping me. He was moaning his wife’s name. In fact, he had recently gotten married. He came between my legs, calling her name.

The last time he came over was when I was leaving town to get married. He sat on my bed. The light was on and we talked. We talked about all sorts of things, but not sex. All the while we talked, he was running his hand up my leg and up to my cock. We kept talking without acknowledging that. I started to stroke him through his pants. He pulled out his cock and started to masturbate, and came on my blanket. As long as I had that blanket, I could always see that spot where he came. The experience left me with the feeling that I had failed in some way. We haven’t seen each other or talked to each other since then.

Jumping Into the Pool

The following patient is a sixty-year old gay man who had been severely traumatized in childhood. As a young adolescent, feeling unloved and unwanted,
he found a measure of solace in movie theaters where older men sexually desired and serviced him. The pleasures he associated with his early experiences of furtive sexual activity led to a lifetime pattern of anonymous sex in cruising areas:

A: I had gone out with friends and I suddenly got that overwhelming sex drive when I got home. Although I knew it was stupid, I got dressed and went to a porno theater. It was the most awful one I’ve ever been to, a stage set for sleaze, with homeless people and people on drugs. I asked myself, “What did you expect?”

The patient described both surprise and annoyance with himself after he arrived at the pornographic movie theater and then “suddenly” remembered what he might find there. Forgetting and remembering is characteristic of selective inattention. Sullivan’s detailed inquiry (Sullivan, 1938; 1954, 1956; Shawver, 1989; Cooper, 1995), attempts to explore the inattended, such as the patient’s foreknowledge of what he would find in the theater when he got there:

Th: Had you been to that theater before?
A: Months ago. Upstairs, there are two bathrooms where people sit in stalls waiting for guys to come by and blow them. Downstairs, they have an awful basement with corridors that felt unsafe. This was a dirty and sleazy set. If a set designer created it, it would be almost too much.

Th: You experienced going there as a piece of theater?
A: Yes.

Th: What role were you playing?
A: Maybe I would meet someone who would blow me or I would blow them. But no one was interesting. I’ve been there several times, and nothing ever happens. I tell myself, “You know more efficient ways to get sex. I saw an ad in the Village Voice that said, “Blond hunk looking to meet successful older man.”
Th: Had you considered calling the blond hunk instead of going to the theater?
A: The movie theater is less committing. But answering the ad, that’s a serious commitment. When I was younger, I loved the idea that these guys wanted to suck me. I felt like I was sort of powerful. It felt like I had a scenario or a scene, that I could fall into. That I didn’t have to be concerned with what I really wanted.

When a patient, regardless of sexual identity, experiences his or her sexuality as a compulsive force outside their conscious control, their sexual activities may take place in a reverie state, a severe dissociative phenomenon. It should be noted that a reverie state can be solely confined to one’s imagination, like a daydream. It can be subjectively experienced as a private, psychological space where the inflexible circumstances of everyday life do not apply. However, in this case, the patient’s reverie took place in a sexual arena where other men were actors in his fantasy while he played a role in theirs:

Th: What you describe feels a little like a daydream.
A: Yeah. There was an understanding that I had some kind of power. That somebody would get on their knees and I would say, “Suck that dick boy.” I think they felt sort of lucky. I think that’s what I should have now.

Th: Are you saying you feel powerless and you need to feel powerful?
A: (The patient laughed anxiously, and then yelled angrily) I would say that! Yes! I’m not even happy talking to you about it now. I feel like I’m pushing myself into making sense of how I live my everyday life. This is a stupid way of living!

Detailed inquiries can be experienced as impingements. The subject of the inquiry can, at times, be made anxious, irritable or angry by its intrusiveness. Yet anxiety, irritability, and anger, among other things, are often exactly what a dissociating patient might not allow himself to feel. The ultimate goal with any
patient, when doing a detailed inquiry, is to take them into places where they do not wish to go--and yet not let the patient’s anxiety reach intolerable proportions. This patient became angry as attention was drawn to something he did not wish to attend: feelings of powerlessness. Nor did he wish to integrate the enacted fantasies of his reverie state into his ongoing experience of himself. He was also angrily judgmental of his own behaviors when he openly acknowledged them:

A: Yes, I feel powerless, no question.

Th: In the past, these sexual experiences made your feelings of powerlessness diminish. That no longer seems to be the case.

A: I still hope I can meet someone who might want to suck my dick. (Angrily) I hate talking about this!

Th: You don’t want to talk about this?

A: (Again, angrily) I’ll talk about it! But it’s hard for me to say why I go back to the porno theater. There’s a possibility that something might happen, like years ago, somebody sucking me.

Th: How do you tell yourself that it might happen?

A: I’ll throw myself in there. Part of it is that you don’t have to think. This is blind habit.

Th: I’m trying to draw your attention to how you are not thinking in those moments. It’s almost as if you went there in a trance.

A: I’ll admit it. There is a trance-like state.

Th: You don’t want to understand your trances?

A: I think the function they serve now is a desperate attempt to recapture the person I used to be. I always had a little trance but it used to be more satisfying. It was somebody sucking my dick. People were interested. They were after me. Definitely trance-like. It was like jumping into a pool and not having to think about how to swim. There would be a certain kind of
something that would feel OK for that time. Then it is over. You get out of the pool and you go home. Now, when I go to the porno theater, it’s like throwing myself in the pool. It’s going to be like a wave.

Then the patient’s tone became more subdued:

A: You know, the porno theater doesn’t work. It doesn’t give me what it gave me before, and yet I go. The trance thing is a good image, like someone in a trance. “Go!,” and I’ll be in this atmosphere. Getting blowjobs anonymously was very much a part of my life. It was really like hiding, going into the pool.

The Therapist’s Authority

Helplessness was one feeling that this patient could not tolerate and which contributed to his feeling sexually compelled. A previous therapist had preached the value of monogamy for many years while the patient continued to engage in compulsive sexual activities without telling the therapist about them. When he invited me to take a similar role, I pointed out to the patient that the previous therapist’s discouragement had not seemed to stop these activities, so what purpose would it serve to do so again? The patient became increasingly annoyed that I would not play the role of disapproving authority figure as obligingly as the previous therapist had done. It should be noted that frustrating the patient’s attempt to get me to play this part allowed him to more fully experience his own anger and annoyance.

In his ongoing frustration with my unwillingness to reprimand him, the patient would angrily lecture me, stating it was my job to stop him from engaging in “meaningless behavior.” I told the patient that all behaviors had meanings, including those he wished to define as meaningless. In labeling his sexual behaviors as “meaningless,” he was judging them to be “bad.” His efforts to dismiss and judge what he was doing kept him from trying to understand what he
was doing. This intervention, which was frequently repeated, usually reduced his anger and aroused his curiosity.

Once he ceased trying to make me stop him from engaging in anonymous sex, he began talking about the anxious and lonely feelings that prompted him to search for human contact in that arena. As he came to understand the sources of his anxiety, and to tolerate those feelings as well, he felt a greater sense of control. This feeling increased his own sense of authority and, over the course of his treatment, he went less frequently to the movie theaters. If he felt like going, he would tell himself why he didn’t want to go and often he did not. On those rare occasions when he did feel compelled to go, he was able to look at his actions, talk about them more openly with himself, and then later with me.

In my declining to projectively identify with the role of moral guardian, the patient gradually came to understand that he had to deal with his own reservations about cruising and anonymous sex. This increased his awareness of his own internal struggle regarding his sexual behaviors. The solution he gradually arrived at, going less often, felt satisfactory to him. However, a different patient might have resolved a similar struggle by giving himself permission to go cruising. And finally, contradicting historical psychoanalytic claims that equate homosexuality with sexual compulsivity, although this patient experienced a reduction in what was previously felt to be a sexual compulsion, he did not change his sexual identity or lose his sexual attraction to men.

Conclusion

In the Interpersonal perspective, anxiety is thought to be triggered when knowledge of the self appears to jeopardize an individual’s relationship to others. Given the stigma attached to homosexuality, effeminacy, and promiscuity, it is not
just gay man who may feel anxious about the impact of homosexuality upon his relationships. Many psychoanalysts are also made anxious by the subject.

Freud, in urging neutrality, said “I cannot advise my colleagues too urgently to model themselves during psycho-analytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible” (Freud, 1912, p. 115). Admirable as this admonition may be, psychoanalytic neutrality is not possible. One has only to study the history of psychoanalysis, a field which expressed its anxiety about homosexuality by integrating cultural prejudices into its theories and praxis and by infantilizing and pathologizing gay and lesbian identities (Drescher, 1998a).

A related expression of psychoanalytic anxiety about the diversity of human sexuality can be found in its countertransferential idealization of monogamy. This anxiety is commonly expressed by pejoratively labeling a patient’s non-monogamous sexual behaviors as “compulsions,” “acting out,” or “resistance” (Drescher, 1997). Many a published case report trumpets the treatment’s success by announcing that the patient got married or settled into a monogamous relationship.

Unfortunately, privileging a patient’s wish for conventional, monogamous relationships over his or her other feelings and activities can interfere with a therapist’s ability to empathize with the nonconforming aspects of the patient. Simply treating a sexual compulsion as a symptom can serve the purpose of psychologically distancing oneself from it. In some cases, pathologizing a behavior may reflect a countertransferential judgment of the behavior. This kind of countertransference can be a significant obstacle to empathically entering into the subjectivity of the patient. Therefore, I would recommend that when patients invite a therapist to play the part of baby-sitter or moral guardian, it is preferable to
avoid being drawn into that enactment. Although it may be no easy task, therapists should make every effort to accept both a patient’s desire for unconventional sexual excitement, as well as the longing for a more conventional relationship. At the same time, therapists should also be skeptical about the patient’s desire for conventional relationships and the patient’s characterizing of their sexuality as compulsive. An idealized but impossible to attain neutrality will not get therapists through those inevitably tough moments when they feel countertransferentially judgmental of their patients. Respect for difference, on the other hand, just might do the trick.
References


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