



SHAME  
AND  
ATTACHMENT  
LOSS

The Practical Work of  
Reparative Therapy

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and Robert Perloff, Ph.D.

  
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# Introduction

My first act of free will, shall be to believe in free will.

—William James

**T**HIS BOOK IS FOR PSYCHOTHERAPISTS who seek techniques to assist a systematically ignored group, the non-gay homosexual—a population thought by most of my colleagues not to exist.

Non-gay homosexuals are same-sex attracted men whose deeply held values and sense of self prevent them from embracing a gay identity. In the past twenty years I have worked with more than one thousand such clients, all of whom seek to diminish their unwanted homosexuality and develop their heterosexual potential. These men now compose about 95 percent of the case-load at our clinic.

As a result of “politically correct” graduate school training and of relentless promotion by the media, the vast majority of my colleagues now erroneously believe that their clients’ sexual destiny is biologically sealed. Approximately 50 percent of the clients we have seen were previously told by another psychotherapist that they could not change—that they were “born gay.” They were advised that their sole choice was to “resolve your internalized homophobia,” and to “embrace these feelings—because whether you like it or not, this is who you really are.”

Describing his previous therapy, one teenager said: “My first shrink told me that I had gay DNA, and to basically have a coming-out party!”

But we do not accept the fatalism of the “born that way” concept. Instead, we propose an alternative model—addressing and resolving the underlying conflicts that have, in our view, laid the foundation for the symptom of same-sex attraction.

In a detailed informed-consent form at our clinic, we explain to our clients

that our theoretical position differs from that of the American Psychological Association. We clarify that we do not offer gay-affirmative therapy, yet we respect our clients' viewpoints, which sometimes change radically during the course of therapy. Some clients decide to make a complete about-face and self-identify as gay, leaving reparative therapy. Others may go back and forth for months—into and out of a gay lifestyle during the course of our sessions together. Respecting these changes of heart and mind, I always tell my clients, “Don’t accept anything I say unless it rings true for you.”

### **Born That Way?**

Our profession has been swept away by the media blitz promoting the “born that way” theory. However, there is no evidence to support the idea that homosexuality is simply and solely inborn. On the other hand, biological factors indeed probably *influence* some people toward homosexuality—either genetic (inherited) factors that cause gender nonconformity, or prenatal-hormonal influences, especially in men, that may result in a low-masculinized brain.

In all likelihood, any factor—biological or social-environmental—that leads a male to feel less secure in his maleness has the potential to affect his gender identity and thus his sexual orientation.

*But none of these factors mean that homosexuality is normal and a part of human design.* Further, none of them prove that homosexuality is inevitable in any particular person—or that it is unchangeable.

This work is dedicated to those men who seek to live out the sexual orientation that corresponds to their biological design. Our theories pose a radical challenge to the gay-identified man’s narrative that at his deepest level of self, homosexuality is “who he really is.”

### **Our Bodies Tell Us Who We Are**

Philosophically, I am an essentialist—not a social constructionist: I believe that gender identity and sexual orientation are grounded in biological reality. The body tells us who we are, and we cannot “construct”—assemble or disassemble—a different reality in which gender and sexual identity are out of synchrony with biology.

The belief that humanity is designed for heterosexuality has been shaped by age-old religious and cultural forces, which must be respected as a wel-

come aspect of intellectual diversity. This viewpoint is not a phobia or pathological fear.

Natural-law philosophy says this view derives from humankind's *collective, intuitive* knowledge—a sort of natural, instinctive conscience. This would explain why so many people, even the nonreligious, sense that a gay identity is a false construct.

The very man who was instrumental in removing homosexuality from the list of mental disorders—psychiatrist Robert Spitzer, a self-proclaimed atheist—said that in homosexuality, “something’s not working.” If his own son were dealing with same-sex attraction, Dr. Spitzer added, he hoped he would explore change therapy.

Putting this same intuitive knowledge into blunt terminology, one of my clients asked, “How could I have been designed by the Creator for anal sex?” He scoffed at the American Psychological Association’s idea that homosexuality is equivalent to heterosexuality. “Anal sex is damaging to the body,” he said. “It’s demeaning to a man’s dignity; it’s unhealthy. I couldn’t have been created for a same-sex relationship whose *very design* makes biological parenthood impossible.”

He laughed ironically. “So I was designed this way? Then I have been created by an absurd god.”

Many other men have told us, “I tried homosexuality, but I found out that it didn’t work.”

The fact is, the vast majority of clients who come to us have found same-sex attraction to be maladaptive in their lives. Their impetus for change comes from their deep conviction that underneath it all they really are heterosexual men, and they seek a therapist who sees their inner potential. But, as George Orwell said, “In a time of universal deceit, telling the truth is a revolutionary act.”

### **Not an Easy Road**

Like all authentic commitments to self-improvement, efforts to change will make for a very challenging task. Change cannot be motivated primarily by social or religious guilt. Rather, the man must find his strength from a profound and abiding commitment from within. Success in treatment can only come from an *intrinsic* motivation, expressed in terms of a strong personal

aspiration or a deep commitment to a worldview or a particular faith tradition. This is distinct from an extrinsic motivation, such as pressure by outside influences—“My wife wants me to come to therapy,” “My church said I need help,” “My parents said I should change,” and so forth.

For these men the journey begins with the internal conviction that homosexuality is not merely wrong but that—on yet a broader dimension—homosexuality simply isn’t “true.” Most men cannot explain it any better than that, but in their own ways they express the conviction that gay sex doesn’t “work”—it never satisfies their inner longings, and it doesn’t reflect who they are as gendered beings.

Calling gay life “a bait-and-switch game,” one client described his disillusionment. “It is not the sex that I want, but it always ends up that way—as just sex. What I’m really looking for is to be close to someone, to hold and to be held, to love and to feel loved, to whisper and to be heard, to reveal myself to another person. But in the end gay sex always feels empty. It doesn’t feel honest. It doesn’t feel true.”

Another man said, “In gay sex the parts don’t fit. Most psychologists think homosexuality is normal, but I *know* it’s not normal.”

### Honoring Client Self-Determination

The only remaining debate within psychology, at the time of this writing, is this: “Should treatment for unwanted homosexuality be considered *permissible*?”<sup>1</sup> In response to this question, various authors have argued persuasively that it must *not* be banned.

The push within my profession to *outlaw* treatment for unwanted same-sex attractions (SSA) is in striking violation of contemporary liberalism’s own professed commitment to diversity. Only a few members of our profession have had the courage to speak up for a true diversity of worldviews. The men I am about to quote represent those striking exceptions. Both are champions of gay rights, self-professed liberals and former presidents of the American Psychological Association—and both were keynote speakers at annual conferences of the National Association of Research and Therapy of Homosexuality (NARTH), of which I am the former president.

At the 2004 NARTH Conference Robert Perloff, Ph.D., past-president of the American Psychological Association, said:

The individual has the right to choose whether he or she will accept a gay identity. It is his or her choice, not that of an ideologically driven interest group. To discourage a psychotherapist from undertaking a client wishing to convert is anti-research, anti-scholarship, and antithetical to the quest for truth.

Nicholas Cummings, Ph.D., past-president of the American Psychological Association, who has personally helped homosexual clients reorient to heterosexuality, observed at the 2005 NARTH Conference:

I remain fiercely dedicated to freedom of choice for all people, and especially in their right to choose the goals for their own individual psychotherapy.

Patients should have the right to explore their heterosexual potential.

Robert Spitzer, M.D., who led the team that deleted homosexuality from the diagnostic manual, said in 2001:

Contrary to conventional wisdom, some highly motivated individuals, using a variety of change efforts, can make substantial change in multiple indicators of sexual orientation, and achieve good heterosexual functioning.

And Sigmund Freud, M.D., wrote in 1918:

We refuse most emphatically to turn a patient . . . into our private property, to decide his fate for him, to force our own ideals upon him . . . in the service of a particular philosophy. In my opinion, this is . . . to use violence [upon the patient].

### **The Mainstream Mental Health Groups**

At the 2006 Annual Conference of the American Psychological Association there were fifty picketers greeting conference attendees. All were ex-gay men and women carrying signs that said, "APA, Please Help Us!" "Keep My Choice Ethical!" and "Diversity Includes Us!" Most of the psychologists who spoke to the picketers expressed surprise that their profession would wish to restrict reparative or reorientation therapies. If a person isn't satisfied being gay, why shouldn't he have help to reduce his unwanted homosexuality and develop his heterosexual potential?

Why not, indeed? Asked this very question during an open meeting at the same conference, APA's then-president, Gerald Koocher, agreed. Highlighting the importance of client autonomy and self-determination, Dr. Koocher stated to the audience, "APA has no conflict with psychologists who help those distressed by unwanted homosexual attraction." As long as there was no coercion, and proper informed consent was obtained, he said, reorientation therapy could indeed be ethical.

As he left the meeting, however, Koocher was surrounded by angry gay-activist psychologists, and he quickly issued written clarifications, including the insistence that homosexuality must not be presented to the client as a mental illness.

In an e-mail to psychologist David Blakeslee on August 15, 2006, Koocher offered this reasoning: "In fact the data show that gay and lesbian people do not differ from heterosexuals in their psychological health. By that I mean that they have no greater instance of mental disorders than do heterosexuals."

### Remarkable Misinformation

Regarding this crucial subject President Koocher was actually remarkably uninformed. In recent years all the available data has converged on the incontrovertible conclusion that gays and lesbians have a markedly higher level of mental health problems than do heterosexuals.

The *Archives of General Psychiatry*, an established and well-respected peer-reviewed journal, offered three such papers (Fergusson et al., 1999; Herrell et al., 1999; Sandfort et al., 2001; and a commentary by Bailey, 1999). J. Michael Bailey concluded with a commentary on the article, which had summarized all the available research on the subject. (Bailey, it should be noted, conducted the much publicized gay-twin studies, which were used by gay advocates as support for the "born that way" theory.) Bailey said,

These studies contain arguably the best published data on the association between homosexuality and psychopathology, and both converge on the same unhappy conclusion: *homosexual people are at substantially higher risk for some forms of emotional problems*, including suicidality, major depression, and anxiety disorder, [and] conduct disorder. . . . The strength of the new studies is their degree of control. (Emphasis added)

Yet here we were seven years later, and the APA president—who has evidently “turned the henhouse over to the foxes” when it comes to gay issues—continues to believe that homosexually oriented people *do not differ from heterosexuals in their psychological health*.

### **But What If the Client Doesn't Change?**

Of course, reorientation therapy is a long and difficult process, with no guarantee of success. We do know that change is possible.<sup>2</sup> But, what if the man doesn't change? Will he have gained anything of value?

There is far more to reparative therapy than change of sexual behavior. In fact, people are often surprised to hear that there is very little discussion about sex. Good therapy addresses the whole person and aims to change him on many levels.

Reparative theory holds that the origin of SSA is in unmet emotional and identification needs with the same sex. I typically tell clients in the very first session, “Rule number one is: Never accept anything I say unless it resonates as true for you.” His experience, whatever that may be, must always trump any preconceived theory. If that theory doesn't feel true to him, he will usually decide to leave therapy after one or two sessions. He may then decide to see a gay-affirmative therapist, who will affirm his homosexuality as an intrinsic part of his identity.

But if he continues, the therapeutic setting will provide an opportunity in which he can explore, reexperience and assimilate past trauma. Here, he begins to liberate himself from old patterns of shame and self-sabotage. He grows beyond the emotional isolation and chronic loneliness that have so long limited him, and develops a renewed emotional investment in authentic relatedness.

Most especially, through a relationship with an attuned therapist, the client discovers how it feels to emotionally disclose to another man and to reveal those long-buried feelings of gender shame. He receives a deep acceptance of wherever he is in his life at that point in time, whether he changes or not. Such an experience is always therapeutic.

Besides an enhanced ability to develop genuine male friendships, the client will discover healthier relationships with females—where he learns to prohibit the boundary violations with women that may have been causing

him to compromise his separate, masculine selfhood.

He will also learn how to examine himself with appropriate criticism. As one client put it, "In the past I simply assumed the worst about myself. But now there is a clarity of wants and needs—strength in my voice—and a deeper way of communicating."

Rather than focusing on sexual-orientation change, the primary work of therapy is to teach the client to relate from a place of authenticity, openness and honesty. This is what we call the "assertive stance," where the person matches up his inner feelings with his outer dealings—to paraphrase psychologist Diana Fosha, who defines the healthy individual as the person who is actively "feeling and dealing."

We believe that "feeling and dealing" is the essential ingredient to the healing of SSA: teaching the person to live and love from his authentic self. When he truly does so, we believe, his unwanted SSA will greatly diminish, thus releasing him to develop his heterosexual potential.

As one struggler expressed it, "My homosexuality is like a snake, always trying to wrap itself around my identity." Treatment is carried out not by focusing on the "snake" but on the whole person around whom it has wrapped itself.

And another young man told me, "The sinister nature of homosexuality is that it gets me to focus on *it* rather than on *me*." Therapeutic success requires not a mere elimination of the same-sex symptom but the growth and maturation of the whole man.

But what about the client who fails to change; will he be left in a sort of "intimacy limbo"—not heterosexual, yet unable to be intimate with men? The truth is, our client was never intimate with men. That is why he came to therapy. He also came to us because he believes that true sexual intimacy with a person of the same gender is, in fact, not possible: same-sex eroticism simply fails to match his biological and emotional design and does not reflect who he is as a man.

Some clients, of course, alter their worldview. Jason left reparative therapy to live in a gay relationship. He had come to believe that homosexuality was indeed (contrary to his earlier beliefs) truly compatible with his religion. His worldview had changed so much that he and I were no longer in fundamental agreement about the meaning of homosexuality, and we agreed to end our working relationship. He told me, "I didn't change sexual orientation, but I can truly say that I no longer fear straight men—and I've learned to be my own person."

A few men enter reparative therapy as gay-identified from the start, and

not desirous of change. With those clients we agree on a precondition to our working together—that is, we will not address the issue of sexual-identity change, but we will work on all of their other problems in living. And so we work on issues like capacity for intimacy, problems with self-esteem, internalized shame, childhood trauma and the search for identity.

The good therapist always conveys his complete acceptance of the client, even if that client eventually decides to gay-identify. Like Jason, some of our clients decide to change course and embrace homosexuality as “who they are.” Others remain ambivalent about change, while going in and out of gay life over a period of months. We accept their choices even if we don’t agree with them, because we accept the person.

The overall focus of this book is on isolating “what works.” I have attempted to minimize the theoretical discussion and instead concentrate on practical techniques for the reparative therapist.

And yet this book is not an explicit “how to,” but a suggestive “how might.” At first glance some of the specific techniques will appear reductionistic, rigid and neglectful of the complexity, nuance and individuality of each client. Since each client presents a unique history and personality, we can only offer here guiding principles, not absolute formulas and dictums.

In particular, the diagrams throughout this book can be criticized as crude, simplistic, even naive. And in a sense they are. Still, having conceded that, I offer the practitioner these diagrams as a rudimentary tool to describe the clinical art of reparative therapy.

Of course, there is still something artificial in the attempt to reduce what is essentially a creative process into a schematized set of clinical interventions. But if psychotherapy is more art than science, then—like all art—it must be guided by certain procedures and rules within which the artist executes his creative work. These interventions should be applied without compromising the primacy of the client’s experience. The danger is to squeeze the client into a predetermined framework. The good psychotherapist is challenged to honor each person’s unique narrative, while loosely applying methodologies and techniques that are dictated by his careful empathic attunement.

The fact remains that people do not change through the application of techniques. *People change through relationships*—relationships with caring people who apply those effective techniques.

### Staying Politically “Safe” in Dangerous Territory

A Christian psychologist contacted me to discuss reorientation therapy for same-sex attracted (SSA) men. Hoping to find a political compromise with the APA, he was anxious to avoid value judgments, preserve his standing in his profession and remain safely noncommittal about the homosexual condition. The solution, he thought, would be to develop a simple behavior-modification program that helped clients change their unwanted behavior but did not value heterosexuality as preferable to homosexuality.

Speaking from my twenty-five years of experience in this field, I told him I found his approach naive and ultimately unworkable. Our men do not come to us to change their unwanted behavior. They come to us to change their sense of self—to *be* more heterosexual, not just to “act” heterosexual; to feel comfortable in relationships with straight men, to learn to hold on to their masculine autonomy with women—in short, to fulfill their heterosexual potential. A behavior-modification program might be politically safe, but because of its shallowness it would inevitably fail.

“Why should I refuse to reveal my philosophical position,” I told him, “when gay-affirmative therapists are working very hard as boosters of their own philosophy? They tell clients that same-sex feelings are ‘sacred.’ They push them to revolutionize society’s and the church’s attitudes. Any client’s conviction that heterosexuality is the norm will be redefined by the therapist as a ‘psychological illness—homophobia.’ ”

“The fact is, neutrality fails for clinicians on both sides of this issue,” I told this psychologist. “Clinicians like you and me, who believe that humanity was designed for heterosexuality, must speak up to defend our worldview. These men with unwanted SSA want boosters, allies, advocates, as they claim their masculine identity—someone who believes in them and stands strongly at their side.”

### A Clinical Picture Is Essential

Furthermore, what will happen when the uncommitted (“neutral”) therapist hears his client revealing self-destructive behaviors that are statistically proven to be associated with SSA? How will he interpret these behaviors? Staying out of philosophical territory with the client would require a “Rog-erian neutrality” that even Carl Rogers himself couldn’t live up to. And once

seen, how can these factors—including their meaning and likely origins—be ignored?

The men that stay with us in therapy do in fact believe that “something happened to them.” We offer them an understanding of the traumas they tell us about—and one that deeply resonates with them. We also offer a way out, albeit a difficult one, that has been proven to work with other men.

### Client and Therapist Together

Indeed, the most powerful dimension of the working alliance can only come into play when therapist and client together view SSA the same way. When the therapist takes a neutral position (“I see gay and straight as equally OK outcomes”), this dilutes the power of the transference and leaves the client feeling incompletely understood and incompletely supported.

What sustains the client during difficult periods of therapy is the therapist’s unwavering conviction that he does possess a latent heterosexual nature. For these men, to know that a salient man sees this potential, however hidden—even when they themselves are undergoing doubts—is a powerful inspiration.

### Reconnecting the Man to His Gendered Self

In discussing their family backgrounds, over and over our clients tell us that they never felt known and loved for *who they really are*. This is not to say their families didn’t love them—most of their parents loved and wanted the best for the children. But with this particular son, there was a disconnect . . . a malattunement. The majority of my clients say they never felt truly “seen” by their parents. And so it is the work of therapy to undo the shame, repair the attachment loss and reconnect the man back to the gendered being he was designed to be.

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*Postscript:* In the clients’ stories and transcripts I have used in this book, all identifying names and details have been changed to protect confidentiality. The client stories and quotes are composites; therefore any resemblance to a person known to the reader is coincidental.