"Richard Isay is the doctor who rethought the psychoanalytic development of gay men, rescuing us from the stereotypes and defining our health in terms of self-esteem. . . . A wound-dresser indeed, like a Whitman of the psyche." —PAUL MONETTE

BECOMING GAY

The Journey to Self-Acceptance

Richard A. Isay, M.D

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THE JOURNEY TO SELF-ACCEPTANCE

RICHARD A. ISAY, M.D.

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INTRODUCTION

BEING HOMOSEXUAL AND BECOMING GAY

Throughout most of my thirty-year career as a psychoanalyst and psychotherapist, traditional Freudian psychoanalysis has provided the most widely accepted view of the origin and nature of male homosexuality. The theory holds that a man desires someone of the same sex because a binding, engulfing mother kept him from being close to and thereby identifying with his father, or because a father, emotionally distant or physically absent, caused his child to turn to the mother and identify with her. In both scenarios the male child was "feminized" by identifying with his mother instead of his father, and, at about age five or six, at the time of the oedipal crisis, he deviated from "normal" heterosexuality and was on the perverted path of desiring other men instead of women.

As late as the mid-1980s, there had been only minor changes in the psychoanalytic view of male homosexuality.[1] Although it was no longer true, as it had been only a decade earlier, that analysts were equating the quality of homosexual relationships with those of schizophrenics,[2] or stating that homosexuals are "predatory . . . and do not make good citizens, in any society,"[3] most psychoanalysts and analytically oriented psychotherapists still held tenaciously to the idea that normal development led only to heterosexuality and that the same

early parental failures that had caused homosexuality also produced severe personality disorders in all homosexuals. This theory contributed to the self-loathing of many gay men.

I have had the unique opportunity of spending the first half of my career seeing heterosexual men and the latter half, homosexual men. Starting in 1980 I began to work with gay men as patients who had no interest in changing their sexual orientation. They came with problems in living, working, and relationships that were similar to those of my heterosexual patients in the years before. Their histories, along with studies suggesting that the concordance of homosexuality is higher in monozygotic twins than in dizygotic twins and non-twin siblings, convinced me that homosexuality in men was constitutional and probably genetically determined.[4] This conclusion contradicted the prevailing psychoanalytic view that homosexuality was caused by a disturbed early relationship with parents.

I had found that, like the population of heterosexual men who recalled opposite-sex attraction from an early age, many homosexual men could remember experiencing same-sex attraction when they were as young as four, five, or six years. For gay men, this earliest attraction is to the father or father surrogate. It is often repressed and, like the heterosexual's early attraction to his mother, is recollected with difficulty or in a distorted form, displaced onto another male such as an older brother, relative, or family friend. Just as most clinicians generally assumed that the early appearance of opposite-sex attraction suggested a biological predisposition to heterosexuality, I assumed the same to be true for the same-sex attraction of homosexual men.

The same-sex fantasies and erotic desire of homosexual

men, like the opposite-sex fantasies of the heterosexual men I had worked with, were usually stable and persevered throughout their lives, also suggesting a biological rather than familial basis for their sexual orientation.

Gay men usually remembered that they had felt "different" as children of four, five, or six years, a difference sometimes recalled solely in terms of such early behavior as greater sensitivity, more highly developed aesthetic interests, or a lack of interest in rough-and-tumble activities. But they also eventually recalled their different sexual attraction. The recollection of being atypical boys, while real for most, was often also unconsciously used as a screen memory that kept them from remembering an early attraction to their father.

I observed no difference in the parenting of my heterosexual and homosexual patients that could account for their homosexuality. I had worked with heterosexual men who had distant fathers and engulfing mothers, and was seeing homosexual men who had loving and "average-expectable" parents. However, the father of a homosexual son may withdraw from him because of the discomfort caused by his child's affection and attraction or by the feminine or gender-atypical manner or behavior characteristic of many of these boys.[5] The less masculine the boy appears, the more likely the father is to withdraw or to reject him in favor of another sibling. The result is an early assault on the self-regard and sense of emotional well-being of many homosexual children, reinforced by later peer rejection, prejudice, and hatred, which may cause significant emotional damage and affect the nature and quality of their adult relationships.

Another observation also suggested to me that homosexuality was biological and not environmentally induced: serious

psychological damage may be caused by therapists' attempts to change their patients' homosexual behavior to heterosexual or simply to inhibit their homosexual impulses. Although psychological distress may, of course, be caused by efforts to change any behavior that is fixed, whether it is fixed by very early environmental determinants or by its being constitutional, it was the severity of the depression and anxiety caused by these attempts of former therapists that further suggested the biological basis of my patients' sexual orientation.[6]

On the basis of my clinical observations, including the inhibiting effect of society and psychological conflict on homosexual behavior, I suggested in *Being Homosexual* that homosexuality not be defined by behavior but by the predominant erotic attraction to others of the same sex since childhood. One need not engage in sexual activity to be homosexual, any more than one need engage in sexual activity to be considered heterosexual. In fact, to be homosexual one need not even be aware of sexual fantasies, which may be repressed by conflict and the internalization of social bias. Same-sex fantasies should become available to these individuals during a properly conducted analysis or therapy.

Because my clinical experience and personal observation have, by and large, been with homosexual men, in this book, as in *Being Homosexual,* I am addressing their developmental issues only. In my previous book I used the terms "homosexual" and "gay" synonymously because I was attempting to move my analytic colleagues from the medical model of homosexuality as pathology and deviation to a position that was more humanistic, scientific, and clinically useful. But in *Becoming Gay* I attempt to use "gay" to designate one who is aware of being

homosexual and who then develops a personal identity as a homosexual man. Although clinical observation and empirical studies suggest that we are born homosexual, my work with gay men has made it clear that we learn to be gay. The manner as well as the comfort with which one expresses sexual impulses, or even whether they are expressed at all, seems to be determined by social and cultural mores as well as by our earliest experiences and relationships.

In our culture, for example, in spite of a lack of heterosexual desire, many male adolescents who are homosexual will date girls or attempt to have sex with them because of parental, peer, and social expectations. On the other hand, in ancient Greece it was a matter of social status for a heterosexual man of good birth to have an adolescent male lover, as long as the older man was the pursuer and the active partner in sex. It was also an honor for the youth to be loved and desired by one with status and power, and it was viewed as a gift from the youth to the elder for the former eventually to accept his sexual entreaties.[7]

In a modern but distant and foreign culture, adolescents of Sambia in New Guinea are inseminated by elders as part of their initiation rites into manhood. Probably some of the youthful partners in Sambia, as in ancient Greece, have an innate disposition that is homosexual, as do some of the adults who engage in these homosexual acts, but most of the adult males live with women and, like their youthful partners, are constitutionally heterosexual.[8]

To become gay one must be able to label oneself as "homosexual" or "gay." Homosexual boys who have loving parents who acknowledge and accept their different sexual feelings and their different kind of maleness will usually grow up hav-

ing strong, positive self-regard. They will also be more likely to label themselves "gay" with greater comfort and possibly even at an earlier age than those who feel they must conform to society's expectations in order to be loved. Those whose parents have rejected them because of their homosexuality will generally, as adults, be self-deprecating and angry and, therefore, much less capable than those who have felt accepted and loved by their parents of engaging in mutually loving adult relationships.

Awareness of sexual orientation is enhanced in early adolescence by pleasurable homoerotic fantasies and later homosexual experiences. Satisfying sexual experiences motivate the adolescent or young adult who has a healthy self-image to come out to other gay peers and adults and then to parents and close family members, consolidating his identity as a gay person.[9]

It is healthy for an adult to come out in all areas of his life, including to important straight people, in order to provide continuity between his internal, private life and his external, social life. Coming out alleviates the anxiety and depression caused by the sense of inauthenticity that arises from hiding or disguising oneself. Closeted gay men are usually cautious and circumspect in their social discourse and relationships. After coming out, they inevitably affirm that they are now more self-assured and that all relationships, including those with straight people, are more authentic and, therefore, more gratifying.

In a society that is prejudiced against homosexuals, a gay man's active opposition to discrimination is important for solidifying his social identity and to feeling positively about it. It is usually a manifestation of poor self-regard for a gay man to

participate in institutions, organizations, or professions that discriminate against homosexuals without contesting their bias, no matter how out he is in other areas of his life.[10] The anger that is evoked by prejudice, unless one turns it outward to combat the bias, will inevitably be directed against oneself in masochistic enactments, depression, or further self-esteem injury.

But it is the affirming love of another man that is the most effective antidote to the "battered self-esteem" of most gay men in our society. And it is the love of another over time that provides the greatest certainty and clarity about one's personal identity as a gay man. Only then does being gay become indispensable to one's happiness.

Becoming Gay is about my patients' experiences learning to be gay at different stages in their lives. It is also about my own experience becoming gay and how my early development and the later course of my personal and professional life made this journey painful and, at times, hazardous.

Although this book is not about doing therapy, I hope it will help clinicians identify those aspects of the lives of their homosexual patients that may have kept them from affirming themselves and feeling positively about their gay identity. And I hope that *Becoming Gay* will deepen the understanding gay men have of themselves and their development.

- I -

BECOMING GAY: A PERSONAL ODYSSEY

We seek other conditions because we know not how to enjoy our own; and to go outside of ourselves for want of knowing what it is like inside of us.

—*Montaigne*

In Yale's psychiatry department during the 1960s, most of us studying to become psychiatrists believed that psychoanalysis was the optimal therapy for emotional disorders. The analyst, with his esoteric technique that included a couch, free association, and four or five sessions a week over at least that many years, appeared to have greater access to the hidden recesses of his own mind, as well as to the mind of others, than did the psychiatrist in his face-to-face, once- or twice-weekly therapy. Psychoanalysis also offered an all-encompassing theory of mental functioning and human development, and reading Freud was not only intellectually engaging but great fun. The majority of psychiatric residents at that time wanted to be analyzed; many of us hoped to become analysts.

I had wanted to be a psychoanalyst since my third year at Haverford College. In a course on nineteenth-century philos-

ophy I had read Schopenhauer and Nietzsche, whose views about irrational sources of human behavior and the unconscious mind intrigued me. Jung's speculative thinking about myths, archetypes, and archetypal images provided a bridge between my interest in philosophy and a growing fascination with academic psychology. I had no idea that my burgeoning interest in the mind was due to distress and confusion over a longstanding attraction to other boys.

In my freshman year I had fallen in love with one of my classmates. I first saw Bob on the train returning to college from Thanksgiving vacation. He had a slender, well-proportioned, athletic body, dark hair, which he wore in a neat brush cut, soft but intelligent brown eyes, and a warm, engaging smile. I thought he was incredibly handsome. I admired how comfortable he was with our classmates and how much they, in turn, appeared to want him to like them. Although too shy to speak to him on the train, I noted his every move and developed a crush and the determination to get to know him. We lived near each other in the same dormitory, and with a studied nonchalance that belied my excitement I'd drop over to his room to chat. We gradually became friends and decided to live together the following year. I moved into the suite he was sharing with two roommates.

In my sophomore year a recent graduate of Harvard's clinical psychology program had joined Haverford's faculty to teach psychology. He was a demanding and dynamic teacher, interested in psychoanalytic theory and the contributions psychoanalysis had made to understanding human motivation and behavior. In his course on personality we read Freud's views on homosexuality as a perversion, and I became convinced that I was sick. But from what I learned the next