Lust Triggers: A Culturally-Sensitive Conceptualization for Unwanted Same-Sex Compulsions in Orthodox Jewish Men.

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What are some helpful ways to conceptualize unwanted same-sex compulsions in Orthodox Jewish men? What are some culturally compatible terms and theories that therapists can use to help these clients make sense of their urges and gain more control? This article presents a new conceptualization based on my 15 years of experience working with this population in a private practice setting. The model is specifically geared to helping men who report this compulsive quality of sexual experience, as opposed to a more voluntary and freely chosen sexual interest.

This article rests on the premise that in the Jewish Orthodox populations, same-sex compulsions will be a more consistent source of sexual-religious conflict and distress than in the general population. I hypothesize that this distress is common among men who adopt the gay identify and lifestyle and among men who don't. As such, this population may be at a particularly high risk for the development of psychological symptoms. Given the gaps in ethical and culturally-sensitive conceptualizations in the current literature, this population can also be considered clinically underserved.

Clinical Population: The conceptualization presented here is based on my work with 80 Orthodox clients whose sexual compulsions were unwanted and felt as a source of clinical distress.[1] Where urges were unwanted, the person experienced strong and frequent temptations to fantasize, look at and sexually engage with their preferred type of man, but was ultimately distressed about the presence and intensity of these urges. They came to therapy believing and hoping that these urges could be understood and reduced. These clients wished to develop and maintain fulfilling heterosexual relationships and traditional families.

The clients included in this cohort were between the ages of 18-73 years. They came from a wide variety of occupations and from diverse Orthodox subcultures, including Chareidi, Modern Orthodox, Chasidic, Yeshivish and Sephardic communities across the globe. 60 men were single. 20 men were married to women. No one in this particular cohort identified themselves as gay. These clients were seen anywhere from 1 to 300 sessions over the course of 15 years. 30 clients attended 5 or less sessions.

Though these clients all presented with compulsive same-sex urges, they varied widely in the frequency and intensity of their compulsions. They also presented with three different types

[1] Though I also worked with several gay identified clients, these clients did not report distress around their sexual compulsions. They believed that strong same-sex compulsions were a normal part of their natural gay sexual orientation.

of explicit therapeutic goals: (a) to understand where their urges came from, and find an accurate diagnostic term and psychological theory (b) to feel hope and clarity about having satisfying heterosexual relationships, and (c) to reduce their compulsive urges and get more control. All of these clients, however, were generally motivated to date women, get married or stay happily married. None wished to identify as gay or come out.

Identifying the Need:

The need for such a conceptualization is especially important now for three main reasons. First, it is well documented how much religious men can struggle emotionally, socially, religiously and spiritually, on account of having same-sex urges, even today where a gay identity and lifestyle is more accepted in the world and in many religious Jewish communities (Sorotzkin, Novic, DSM history article). This distress is known to be common in both men who come out, as well as with those hoping to build heterosexual relationships. (source)

From my own clinical observations, this distress can include:

a) high levels of conflictual anxiety, because homosexual behaviors and relationships are prohibited in Jewish law, which they generally adhere to
b) despair and grief about the possibility of not being able to live a heterosexual life, and not participating in the foundational parts of Orthodox Jewish life and community
c) recurring bouts of depression for succumbing to urges and not feeling in control of one's actions.
d) a sense of living a "sham" or being a fraud, if they keep their same-sex desires a secret, whether or not they act out on them.
e) a desire to live a gay-lifestyle, not because they want to, but because they hope that it will help reduce the shame they feel about their compulsions
f) despair and hopelessness about their religious and family future, when considering how they may never be able to have the life they want or have the same social connections
g) self-loathing if they see themselves as an inherently different man, a victim of their biology or early childhood distress who is unfit for heterosexual Jewish marriage.

In this author's experience, much of this distress can be significantly reduced through psychoeducation and using the right terms and theories to help clients conceptualize their struggles.

A second rationale for a new conceptualization relates to the difficulty that both therapists and clients have in accessing theories, which see same-sex compulsions as independent psychological symptoms, but not as manifestations of something more ingrained or natural. For example, both the gay affirming and change-oriented approaches like reparative therapy, put

more clinical focus on the gender involved in their urges than on compulsions themselves. While maintaining polar-opposite views about the pathology of same-sex attractions and whether these urges can change, both methods share the view of these sexual feelings as essential and ingrained in the overall personality.

The problems with this conceptualization are threefold. First, when clients are known to experience significant shame and distress about the male object of their compulsions, a therapist who then confirms their worst fears - that indeed, there is something deeply essential about their same-sex desires - can significantly exacerbate their distress.

A second flaw relates to the "goodness of fit" of these conceptualizations for religious Orthodox men. In the case of gay-affirming approaches, religious clients who do not have a desire to label themselves as homosexual and live a gay lifestyle, will not find it useful to meet with a therapist who advises them to do this. These clients may even be skeptical about the very construct of "gay" and "straight" because these terms are not part of their own cultural tradition.

Equally so, clients may also not fit neatly into the conceptualization of change-oriented approaches, which sees same-sex attractions as symptoms of family dysfunction and an expression of an ingrained psychological illness, such as "gender insecurity" (Nicolosi) or "psychosexual immaturity" (Berger). Many clients who I worked with, for example, did not feel that these conceptualizations fit with their own experiences. And those who worked with conversion or reparative therapists in the past, felt misled to believe that if they just improved their self-esteem and "male confidence", their involuntary arousal reactions would magically switch from men to women.

A third flaw of both gay-affirming and change-oriented approaches is that they each suffer with a controversial reputation in one of the two environments that Orthodox Jewish men tend to associate with. In the religious world, the gay-affirming approach is often seen as culturally incompatible and out of synch with Jewish traditional family values. And in the secular world, reparative therapy is often painted as unethical and harmful.

Hence religious men may be led to conclude that there is no safe "in-between" therapeutic approach, which doesn't, on the one hand, "diagnose" them as gay and then pressure them to come out and, which also, on the other hand, doesn't pathologize them and pressure them to take on intensive psychotherapy. So even if one of these approaches could be helpful in theory, the sense of taboo that each is imbued with, can lead men to avoid seeking therapy for this issue altogether.

In fact, years of clinical and supervisory experience leads me to believe that many therapists themselves can feel torn between these two polar-opposite but well-known approaches. This leads some therapists to refuse these clients altogether. Other therapists will reluctantly accept them, but with concern that their interventions might cause harm or might veer into "conversion therapy territory". Several consultees that I've worked with, for example, disclosed

their fears of even seeking private consultation with colleagues and mentors because of the topic's political charge. This compromised therapeutic atmosphere especially highlights the need for a new, and less controversial, conceptualization.

The lack of in-depth sexuality education for therapists across degrees, disciplines and orientations, points to a third special need for a different conceptualization. The literature clearly documents, for example, how poorly clinicians are educated around basic theories of desire, even though sexuality is a common topic of distress in so many populations. (Shalev, other sources) Even when their sexuality background is more comprehensive, therapists may still not have access to a wider range of terms and theories that can be used to help diverse cultural populations who might reject a sexual orientation lens to describe them. Without more access to diverse conceptualizations, therapists may be forced to rely on their own incomplete assumptions and biases when guiding religious clients.

For example, one common unchallenged perception that I have heard repeatedly from my own clients and supervisees is the belief that "all healthy heterosexual men are preoccupied with women on a romantic and/or sexual level". By implicitly adopting this belief, therapists may then easily pathologize those who do not have this pattern as either asexual or gay.

In this particular example, what therapists often miss is that: (a) this may be more of a media stereotype than a fact, and many healthy men do not have sexual and romantic preoccupations with women even if such a pattern is common nowadays, (b) men's romantic and sexual preoccupations with women are not necessarily a sign of being "a healthy straight guy" because many men learn from a young age to get their emotional needs met by sexually fantasizing about and pursuing women, but this is not intrinsic to their heterosexuality, (Hastings) (c) from puberty and onward many males are socialized to sexually objectify women as a way of asserting their masculinity and bonding with their peers. But not all men participate in these "rituals" and these attitudes do not necessarily reflect their natural drives.

This example shows how much misinformation can cloud a therapist's judgment when it comes to their client's distress and confusion around their sexuality.

In working with Orthodox Jewish populations, the ability to separate myth from fact, or black and white from nuance, may be especially necessary since this population's sex education and sexual experience is often more limited than in the general population. **(Frances)** These gaps make young people particularly vulnerable to absorbing misinformation whether from the media, porn, the playground, or even from an uneducated parent or teacher. It is therefore especially vital for therapists who work with this population to consider the identification and correction of misinformation as a potentially central component of treatment. This means that some therapists, themselves, may need to reflect on their own gaps and internalized assumptions to make sure that they are not inadvertently transmitting these to clients.

<u>Lust Triggers: A Psychodynamic and Sensorimotor Conceptualization</u>

From the 80 religious men who reported with same-sex compulsions, each consistently revealed that they were not just attracted, but rather, "immediately and powerfully aroused by very specific types of male types, body parts or situations from a young age." This pattern was also evident in the gay-identified men whom I worked with but who I did not include in the cohort used for this article.

All clients reported compulsive urges to look, fantasize or engage with specific types of male physiques, body-parts and personalities and to sometimes have specific kinds of interactions with them. They reported these specific compulsions as exciting since childhood, which always had a direct connection to actual events from their early life. [2] Clients also reported involuntary arousal reactions when seeing or thinking about these specific stimuli, even if they were not actively seeking them out.

These observations led me to start thinking about these patterns more along the lines of fetishes, paraphilias, and perversions (Stoller). This concept is also dealt with at length by Anne Stirling Hastings (1998, Treating Sexual Shame) who describes how various stimuli - both erotically normative and idiosyncratic - can become "cross-wired" with sexual energy from an early age based on childhood circumstances, making these stimuli a source of powerful arousal when fantasized about or seen. Similarly, Gagnon and Simon (1974) uses "sexual scripts" to refer to those situations that can bring on immediate and powerful arousal for a person unlike any other erotic situation or relationship.

Building on these models, I developed the term "lust-trigger" to describe similar reactions, a term I find more value-neutral than the pathologizing language of fetish, paraphilia and perversion, which implies that there are some specific types of people, objects or interactions that are normal to have an immediate and powerful arousal reaction to, while others are "kinky" and abnormal. Lust-triggers "even out the playing field" so that clients are not misled to think that there are inherent differences in people with different types of lust "objects", whether male, female, object or interaction. As opposed to Hastings' idea of "cross-wired sexual energy" or Gagnon and Simon's (1974) idea of "sexual script", I find the term lust-trigger to be more intuitive and aligned with people's lived experience of being immediately and powerfully aroused at the mere thought or site of a specific trigger.

In my experience, clients are often misled to determine whether their sexuality is normal based on the "cultural normality" of their lust-trigger object and not based on the unusually potent quality of their sexual arousal reactions and how emotionally dependent or addicted they are to "using them" as stress-coping strategies. The risk of using cultural norms as a measure of sexual health, however, is that "normal" shifts over time and is dependent on the values of a specific region, community or religion.

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[2] In my clients who did not report same-sex attractions, about 30% reported lust-triggers for other very specific types of female personalities, body types, body parts, garments and interactions or for other inanimate objects, including specific smells.

This “yardstick” of pathology can especially be a source of confusion for clients whose lives intersect with more than one value system, such as Orthodox clients who are religious but who also interact with the modern world. Are their arousal reactions to stimulus “x” normal and moral as their modern world dictates? Or are they abnormal and immoral as their religion might state? Lust-triggers, therefore, provides a more timeless and universal way to define these reactions, regardless of the object that arouses them.

Since people’s specific lust triggers are never actively chosen and develop from an early age, this value-neutral term of “lust-trigger” can also help clients feel less ashamed about their particular trigger. The term brings clinical focus to the quality of sexual energy and how clients might be channeling this energy outside of intimate relationships, whether to engage specific types of men, women, objects or situations.

I will now provide a theoretical understanding of lust-triggers, including how they develop in childhood, different meanings of common trigger types, and the psychological function of sexual compulsions.

Developmental Origins: From the developmental histories of my Orthodox male clients, I was able to identify a consistent pathway toward the creation and ongoing struggles with their same-sex urges or lust-trigger compulsions. I will discuss this pathway here as a general theory, that requires more research to see if it is generalizable to the larger cohort of Orthodox men with same-sex attractions, and even more broadly, to any person, from any cultural background with any kind of compulsive lust trigger urge.

From what I’ve learned, lust triggers start out as coping reactions to childhood distress. Usually, the child experiences chronic abuse, neglect, criticism, fear or chaos. Sometimes the child experiences a specific acute trauma. In either case, the adult caregiver is unable to respond adequately to the child’s distress for any number of reasons. The child then compensates for this missing nurturing experience by fixating on a specific type of person, body, interaction or object that stands out in some way within their immediate vicinity, to attach to either in fantasy or reality. The child uses this image to cope with their difficult reality, whether it is a momentary event or an ongoing situation. In their young imagination, the “object” is idealized - and split off from the qualities of the actual person. Fixating on it helps to restore their sense of safety, specialness and control.

If their environment is still lacking, the child may more actively seek out fantasies or interactions with this stimulus as their “go-to” for self-soothing. Around puberty it can easily become sexualized since it is already “on their radar” as something that stands out as special. The more they engage this lust-trigger object in fantasy or reality, the more it becomes part of their habitual stress-coping response cycle, so that ongoing feelings of frustration start to immediately bring on this exciting image, and the desire to see it and engage with it.

The following case vignette shows how a lust-trigger for high heels can develop in early childhood through this process.

As a child, Dan grew up with a cold and critical mother who was always at her busy finance job. Despite this, Dan had distinctly pleasant memories of his mother trying on new clothes in her room asking him how she looked. In those moments Dan had that rare feeling of being "the apple of her eye". Particularly striking, were her shiny high heels that she would put on in front of him. He could not remember if she put them on in any kind of seductive way, but he remembered always being mesmerized by these high heels both on his mother and later on other women. In puberty he started to feel involuntary arousal reactions when he saw them and began to masturbate to pictures of high heels on the internet during times when he felt tense or upset. The pattern continued and escalated through his adulthood as he regularly sought out casual sex with women wearing high heels

Specific same-sex tropes: In my experience, there are some common same-sex tropes involved in men's lust-trigger. In the world of gay-culture these tropes are well-known and have specific nicknames. (Stein) Here I will discuss them as specific fixations that point to different stages and types of developmental distress. Similar to any other lust-trigger – including those involving the opposite sex - the eroticization of these objects involve childhood defense mechanisms of idealization, introjection, sexualization and, sometimes, turning passive into active. Sexual fantasies and experiences with the lust object allow the person to psychologically "take them in" as a way of temporarily filling in an emotional need.[3]

Idiosyncratic lust triggers for very specific inanimate objects or body part-objects tend to be indicative of earlier childhood distress, prior to age 8. The child fails to get the basic protection, admiration and connection with the parent early on, so displaces this need onto a part-object that stands out as special in some way. Some examples of part-object involuntary arousal reactions from my practice have included: getting a wedgy from a young man, the smell of car exhaust, mother's underwear, breasts, a person getting larger, high heels, an erect penis, hairy man's chest, images of dead people, pecs on men, diapers, seducing a "straight" man, large biceps, large hands (female), large hands (male).

A second common trope is the large, cuddly-looking and hairy "bear", or "lumberjack" type of man, which among Jewish religious men, often includes tall, large looking Rabbis with long beards. The trigger fantasy tends to involve being hugged and protected by this person. The desire is to perform sexual favors – rather than receive them - for these men in return for the fantasied protection they offer. This specific lust trigger is indicative of early distress around basic safety. The type of person becomes a protective parent substitute in their fantasy life. When

[3] This psychological process is written about extensively when it comes to infant's introjection of their mother's breasts, where the gazing and fantasizing acts as a way to "take in" the object and provide self-soothing. (Klein or other psychoanalytic source). But even beyond infancy, children can use this more "magical" fantasy based type of coping mechanism when reality is too overwhelming.

the client connects to a “bear” through gazing and touching, they describe feeling taken care of and almost magically soothed of their constant anxiety and feelings of danger.

A different trope is the teen-age looking, chiseled, hairless man, who is often athletic, “cool” and confident. In gay subcultures this type is commonly called a “twink”. This trope is indicative of adolescent-teenage social distress and their struggles with core needs such as belonging, acceptance, competence, self-worth and confidence. Often there is a notable history of being bullied, isolated or excluded either by peers or family members. Clients describe an adolescent history of staring intensely at these types almost like they are trying to “drink them in”. Imagining a close friendship or physical connection to this person– or actually having this connection – starts as a way to soothe their distress. In puberty and onward it becomes a source of sexual excitement and arousal. Often, just under the idealization, is a potent feeling of self-loathing, hopelessness and envy.

The fourth common trope that I have seen in my practice is the fantasy of being physically forced into a sexual position by an older, larger person and sometimes abused and anally penetrated by them. These fantasies often relate to early experiences of being verbally or physically abused and humiliated over a long period of time, often by a father, brother or close relative. The fantasies are not necessarily a direct reenactment of something that occurred but are often an exaggerated depiction of a toxic relational dynamic. The operative defense mechanism here is called “turning passive into active”. I have also worked with clients where the roles were reversed and the fantasy was to be the active seducer or aggressor, which may come from the same exact type of trauma but, which operates through a different defense mechanism called “identification with the aggressor”.

<u>Function of Compulsive Behaviors: A Sensorimotor Approach:</u> A trauma-informed sensorimotor psychotherapy approach to compulsive sexual urges views sexual acting out- or any impulsive tension-relieving behavior- as the nervous system’s way of regulating a traumatized person’s attention and normal functioning, and of helping them to temporarily manage overwhelming stress in their present lives.

For example, a present frustration in the client’s life automatically activates bodily sensations, feelings, memories as well as “young” painful, exaggerated, *but implicit*, beliefs about Self or the world. “I’m not good enough” “I don’t matter.” “I’m not safe” are some common examples of these beliefs, unconsciously chosen by the person in childhood as a way to make sense of painful events and interactions. Since their caregiver does not help them to understand what is happening in the moment and why, the child is forced to make his own meaning and draw his own conclusions, which often results in these exaggerated negative Self-beliefs. When uncorrected, these beliefs are often carried implicitly in the person’s mind and somatically in their bodies, ready at any moment to be activated by other life stressors. (Ogden)

In response to this present-day triggering of sensations, feelings, memories and beliefs, the person's nervous system habitually goes either into a high level of activation called "hyperarousal" also known as "flight/fight", or a low level of activation called "hypoarousal" or "freeze/submit". In a hyperaroused state, the person experiences high anxiety, panic, manic drives and significant bodily tension. In the hypoaroused state, the person feels collapsed, helpless, empty, dissociated, ashamed, and lacking in motivation.

Because the triggering is strongly felt, but not yet encoded as explicit conscious "data", the person's "emotional brain", called the amygdala, and "the reptile brain", called the limbic system, misperceives these diffuse experiences as familiar signs of danger that must be immediately dealt with. As Janina Fisher describes in her 2017 book Healing the Fragmented Selves these primitive brain structures act on survival instincts and on the "better to be safe than sorry" principle. In that sense, their "job" is to send a quick urgent message to the nervous system to either go into fight or flight mode or into freeze-submit mode, depending on what will be most beneficial for survival.

From either of the two extreme nervous system modes – hyper or hypoarousal - compulsive urges can automatically set in to help the person restore balance and bring them back to the present so that they can go on functioning normally. A sexual experience will typically reach an end-point after orgasm, and so this acting-out functions as a final "exclamation point" to the sequence, helping them to quickly exit these more extreme nervous system modes and enter a more calm and present mode of functioning. Both of these extreme nervous system modes do not invite calm mental focus and strategic problem solving. In these modes, the "thinking and planning brain", called the prefrontal cortex, is not as sharp. The desire for natural and spontaneous connection is also minimal, if not entirely absent.

In this process, the endocrine system is also involved. For example, in hyperarousal, the regulatory function of the sexual urge and action is to try and bring the person into a more relaxed state through the release of hormones like serotonin, which typically set in after orgasm. And in hypoarousal, the regulatory function of the sexual urge and action is to try and "wake the person up" by injecting a dose of excitement and adrenaline into their system, so that they can be "on" enough to function after the release.

For children, this nervous system regulation process can indeed be highly adaptive and even life-saving, because they are vulnerable and often facing formidable odds. For them, fight/flight or submit-freeze can be highly adaptive positions. Their compulsive lust-trigger behaviors, which develop as a strategy to exit these extreme states, can also be highly effective and helps return them to normal functioning. After all, they may be living in an abusive, neglectful or chaotic environment - but they need to get to school, make friends and play sports and need some way of getting their nervous system back to normal. Their sexual acting out helps them do this.

But if this nervous system operating persists through adulthood - once the actual danger has passed and once they have more mature coping skills - it may no longer be as adaptive. The cost of the compulsive behavior can outweigh the benefits. Furthermore, while the intent of the sexual urge is to put an end to the dysfunctional mode of hyper or hypoarousal, it doesn't always work in actuality to restore balance.

The sensorimotor treatment model for such compulsions is generally to slowly and carefully review triggering moments, to think through what is bothering the person before the urge set-in. What happened right before? What thoughts, feelings, memories and sensations did that specific frustration bring up? What old beliefs got activated? By making all of this implicit content more explicit, the person's prefrontal cortex is engaged and they become more empowered to think about their frustrations and how to avoid them and manage them more directly and strategically.

When this cycle of nervous system imbalance and acting out is more chronic and/or activated frequently in familiar times and places - such as each time the person comes to their office in the morning, or each time a person feels forced to socialize with certain friends – therapy can help them examine these patterns, to think through what is working for them in their daily life and what is not, and whether larger adjustments are needed, whether internal, social, relational or occupational.

In this kind of therapy, clients are helped to both preempt moments of intense hyper or hypo arousal states, and to learn other ways of restoring balance nervous system balance. For example, if they are in a hyper-aroused state, they can do intense activities like working out, speed-walking, or punching a pillow that can quicky discharge some of their fight/flight energy so that their bodies can then return to a relaxed place. Or if they are in a hypo-aroused state, they can do activities that perk them up, whether eating a tasty snack, stretching, splashing cold water on their face or watching a funny video to bring their bodies back to feeling more alive and rational.

These activities may not be as accessible or exciting as sexual activity, but a motivated client will be relieved to learn what is actually happening inside of them, which then opens up the option of doing something different and more adaptive. Since sexual behaviors also come with some very reinforcing positive emotions- such as feeling desired, taken-care of, powerful, admired, alive, in-control or just momentarily relieved of all life-burdens - helping a person to walk away from these secondary gains and to more get their emotional needs more directly and in real life with real people, can also be an important element of treatment.

Psychoeducation as Treatment:

In my experience, clients with same-sex lust-triggers tend to present with three different types of distress: a) shame and confusion about the trigger "object" itself, b) distress from comparing their potent lust-trigger arousal to their less consistent intimate relationship desires, c)

sexual compulsions. Here I will describe each type of distress along with a brief vignette, showing how psychoeducation can be used as a first intervention for all three types.

a) Shame and Confusion:

When the client presents with shame and confusion, the focus of their distress is often about the same-sex object of their compulsions, more than the compulsions themselves. They may describe themselves with terms like "a failure", "a degenerate" or "a disgusting human being". They may believe that they are inherently gay or same-sex-attracted or at least inherently incapable of feelings sexual excitement with the opposite sex. Their shame may be explicitly discussed or implicitly "held" in their silence, defensiveness, anxiety and body language.

In this case, teaching clients about the term lust-triggers early on the treatment, including a general discussion of its developmental etiology and present-day function, can quickly decrease their shame and help them feel seen and understood. In this discussion it can be especially useful to disclose how lust-triggers are all psychologically the same, whether they feature specific elements of same gender, opposite gender, object or interaction.

In my experience this information alone can also give clients much perspective and hope. Especially when the client's shame is an obstacle to a calm and rational discussion in therapy, it can be important to teach these principles to clients even before knowing about their specific history. Doing so can immediately reduce their shame, because it implicitly tells them that this is an actual diagnosis, that they are not alone in it, and that this pattern may be less puzzling and more resolvable than they think.

> *John, age 25, reported distress around a secret that he kept for several months in his therapy: he had a strong arousal reaction to a recurring fantasy of being undressed by his male classmates ever since he was in 6th grade. While he felt compulsively drawn to these fantasies during times of stress, he sought therapy to make sure that he was not inherently gay and to get some understanding of these arousing fantasies. When discussing this pattern, the therapist noticed John's collapsed body language, his embarrassed chuckles and his lack of eye contact. Without knowing more about its specific etiology, the therapist chose to teach him about the idea of lust-triggers, how it generally develops and why a person might feel compulsively drawn to it. In response to this information, John's whole body straightened, he began to make eye contact and he smiled. He reported immediate relief and wished that he had brought this up earlier on.*

Many of my clients described this kind of psychoeducational process as key to allaying their fears that they were deplorable people, inherently gay or unfit for heterosexual marriage, fears that they carried inside of them for years and often decades. They had a new name to accurately describe their patterns, which they understood as fairly common and not all that different from people with other kinds of lust-triggers, including for the opposite sex. Some clients reported so much relief and freedom that they did not even feel the need to continue

therapy. They got what they were looking for, and often after years of seeking help from different therapists.

This client, for example, described how the diagnosis itself was able to quickly lift his shame and increase his self-esteem.

My core issue was feeling like there is something inherently wrong with me, that I am different, not like everyone else - (even though everyone else has their own struggles). This was something that bogged me down, kept getting me back in the rut - I felt like I can never move forward. By learning about "Lust Triggers", I learned to accept myself for who I am, and to realize that although my lust might not be the same as the next persons, I can still learn to deal with my triggers and navigate them, just like everyone else - and ultimately get control of myself. For that I am forever grateful.

Another client described how the term "lust-trigger" helped him move on with his life.

The answers you have provided have given me a degree of confidence in my ability to move forward that I haven't had since these feelings first emerged. I had been drowning in confusion surrounding my sexual feelings and what it means about me, due, in no small part, to interventions suggested by various therapists and psychologists. Based on what you've taught me, I now know in the deepest way possible that this is the way forward. I know I can develop a deeply meaningful and romantic relationship with a woman. I know that this isn't who I am as a person but rather a quirk that I latched onto as a child. I know that stress will continue to urge me to find that safe space in my fascination, where no problems exist. But I can learn to manage that, to see it for what it is, and what it's trying to do.

b) Relationships Comparisons:

Clients with lust-triggers may experience confusion and distress when they compare their consistently powerful and immediate lust-trigger arousal to their feelings with other people or in real intimate relationships, which are typically not as immediate and powerful. Clients often try to make meaning about these comparisons, concluding that there is either is something unfixable about their intimate relationships or something unfixable about themselves, such as being gay or just too dependent on their same-sex lust-triggers.

Here again psychoeducation is used to help teach them about lust-triggers, highlighting the qualitative difference between "immediate arousal for strangers" vs. "desire with real partners". They can also be reassured that they are not inherently unfit for heterosexual marriage just because their lust-trigger involves members of the same-gender.

Peter, age 27, had a lust trigger to get hugs from large heavyset men with beards whom he referred to as "bears". He very much wanted to get married and start a family, but avoided dating women because he would not get this similar arousal to attractive women

on the street or on the internet. He falsely believed that until he was able to feel this strong arousal toward random women, he would be unfit for heterosexual relationships. In therapy John learned to distinguish his "lust channel" from his "intimacy channel" so that he could focus on dating and meeting his potential spouse without questioning himself and without looking at new dates and relationships through his "arousal lens". This lens would typically lead him to test, compare and measure his sexual excitement when meeting new girls to see if he could have the same powerful and immediate reaction with them as he had with his male lust-triggers. The new information helped him to realize that this was a set-up for failure and the wrong way to approach real intimate relationships.

Regardless of the frequency and intensity of the person's lust trigger urges, many male clients will notice that they are not as attracted to females as they are to males, and this usually is a cause of concern. For some, this pattern may lead them to quickly conclude that they are inherently gay. But with our understanding of lust-triggers, we can give clients new information to explain this discrepancy.

Therapists might say something like: *With our lust-triggers, whether to the same-gender, opposite-gender, object or idiosyncratic interactions, we feel immediate, powerful and consistent sexual excitement. In real relationships, on the other hand, desire is different. Two people have to truly know and like each other and spend time forming a bond. Even once the bond forms, there is the stress of real life, the dynamics of the relationship and willingness of the couple to create intimate moments.*

Though it can feel more exciting to pursue and engage our lust-triggers, intimate relationships with such a person, whether of the same or opposite gender, can quickly fade as they become more of a whole person and less of a fantasy fulfilment object. If the relationship is solely based on this lust-connection and is lacking in other fundamental ways, it is unlikely to remain satisfying.

However, any person with any type of lust-trigger can develop satisfying intimate and sexual relationships with non-lust-trigger types of their choosing. This is because relationship attraction is generally not supposed to be grounded in "lust-energy" but in the emotional connection between two people, which is infinitely more exciting, grounding and lasting than just a quick-fix. When there is a "chemistry bond" – an easy "meshing" of personalities – as well a basic level of comfort, any two people can develop feelings of physical, romantic and sexual attraction, which are much more fulfilling and lasting.

When discussing a male client's dating and relationship history with women, therapists may also have the opportunity to validate, normalize and reassure men around other concerns as well. For example, many men that I've worked with have reported that they either dislike dating, feel anxious about it, or don't ever feel a connection to a woman.

In my experience, neutral or negative experiences with heterosexual dating is completely normal and is not a sign that the person is inherently unfit for heterosexual relationships. Anxiety,

boredom and discomfort is sometimes a necessary part of dating, especially when the two parties are meeting for the first time and then expected to spend a few hours talking.

There may be other normal complicating factors at play. For example, some men are bored or uncomfortable on dates because they haven't found the right person yet. Some never feel any interest, pleasure or excitement because they are consistently meeting the wrong type of woman. And others come into their dates highly anxious, wound-up and not present, because of other stressors that they carry into their dates. When this happens, their goal is not to connect, but just to get through the experience. And still others are so busy in their heads "measuring" their arousal to new women and evaluating each body part, that it becomes impossible to relax and develop feelings of interest and connection. Exploring these more common-sense reasons for not feeling interested in dating women, can help to offset their worry that they are just inherently gay or incapable of heterosexual relationships.

Some Orthodox male clients with same-sex lust-triggers may ask therapists "how can I switch my arousal from men to women so that I get aroused when seeing a pretty woman on television or in public". This, they believe, would reassure them that they are just like "all other straight guys" and are able to have heterosexual relationships. Should they expose themselves to heterosexual erotica in the form of porn use, casual hooks or even hiring prostitutes, as a way to develop their arousal?

In response to this question, the therapist can offer two pieces of information. First, that not all "normal straight" men feel immediately and powerfully aroused by random pretty women in the media or in public and, if they did, it is likely that this too, is a reflection of a deeper problem. Two, the therapist can reassure them that they don't need to have these arousal reactions to women in order to be "normal". I sometimes tell clients that when our lust-triggers find a comfortable "parking spot" early on in life, it generally will not want to later move to other "spots" or types of people and situations. In that sense, trying to force a powerful arousal to random women, may be futile. The therapist can reassure them that they are normal men because they are capable of connection, intimacy and attraction with a woman who they mesh with, just like anyone else in the world.

c) Compulsive Urges:

When clients struggle to understand and reduce their lust-trigger compulsions and acting out behaviors, psychoeducation can give them a helpful roadmap to understand what is happening internally – emotionally and somatically – which can help them better avoid and manage the stressors that lead to the urges in the first place.

> *Paul, age 32, entered therapy because he felt overtaken by his sexual fantasies and urges where he imagined being controlled, humiliated and sexually violated by an older and larger aggressive man. He found himself using these fantasies or pornography sites on a*

daily basis and wanted to gain some understanding and control of these, so that he could begin to consider dating women.

When the person struggles with compulsive and addictive urges to engage their lust trigger, psychoeducation can help them understand the function of their compulsive urges: to help them manage present frustrations and regulate their nervous system so that they can go on functioning normally. Therapists can explain from the get-go that the key to reducing urges and behaviors is to slowly and calmly analyze present moments of triggering. What happened right before? What's not working in their life? Where and when do they tend to get most triggered? What changes can they make to avoid getting frustrated and overwhelmed in those moments?

Clients may wish to start a diary or log to become more familiar with their patterns of lust-trigger urges. With several of my own clients, just teaching these fundamental principles and giving them these questions was enough to help them feel as if they could go on themselves without therapy. By understanding why these compulsions were out of control, and how their urges were triggered, they felt empowered to reflect on their specific stressors and take action on making concrete changes in their life.

If clients feel chronically triggered, their home or work environments may be triggering them in ways that they don't even realize because they have become habituated to it. Working with clients to make their implicit distress more explicit, can then give the person more access to their prefrontal cortex thinking, planning, and strategizing functions.

Many clients who I've met have been taught to see their lust-trigger urges as signs of their ongoing insecurities. That if they just improved their overall confidence, toughness, "masculinity" and self-worth, these urges would magically disappear. This belief can lead clients to work-out obsessively to strengthen their body and body-image, for example, or to try and put-on a more "macho" and stoic stance in dealing with stress, all with the hopes that if they become more like their tough and confident lust-trigger, they would no longer need to seek-out these qualities from others in a sexual way.

In my opinion, this line of thinking is misleading and can lead clients on endless quests for improved physical strength and self-confidence, while ignoring the present stressors in their life that continue to trigger them no matter how muscular and tough they are on the outside. Only by addressing these triggers, what they bring up in the person, and how they can be strategically avoided or managed, will these lust-trigger urges start to go away.

Lust-triggers are never chosen. And they always develop in childhood out of the person's control and awareness. In that sense, therapists do not need to worry about the client's core identity based on their sexually preferred type of person, gender or situation. (Of course, if some lust-triggers are illegal or involve harm to oneself or others, different types of management strategies may be needed to establish safety.) In general, therapeutic interventions should target

the compulsive urge, and not focus on trying to change or eliminate the desire for the specific object, which is both unnecessary and usually impossible.

Conclusion:

This article provides a conceptualization of same-sex compulsions to guide therapists and clients who wish to diminish these urges and forge satisfying heterosexual relationships. This information can be particularly helpful for clients who are poor candidates for both gay-affirming approaches and change-oriented approaches. Both of these approaches tend to focus on the gender-preference more than the compulsivity itself. And both insist on seeing attractions to the same-gender as manifestations of something deeply ingrained in the personality.

I would hypothesize that this conceptualization may also be useful in counseling other populations like Orthodox religious women with same-sex urges as well as any man and woman with traditional family-values where same-sex lust-triggers can be a source of similar distress.

This conceptualization can also potentially apply to any type of unwanted sexual urge, whether for a specific type of man, women, body part, garment, interaction, object, etc. and not just for urges toward specific types of men. Indeed, in my own practice I do not distinguish between those clients who report compulsive urges for various types of same-sex situations, vs the opposite-sex, an object or specific interaction, whether culturally normative, legal or idiosyncratic. Whether they are suffering with shame, compulsive urges or confusion about their lack of immediate and powerful lust with non-lust-trigger types, a psychoeducational approach can bring immediate and significant relief.

Especially now, since there is so much attention in the broader culture around homosexuality, I believe that therapists need to actually be *more* responsible with religious clients who either take on the gay identity, or who fear that they are "inherently gay". Where these men are often applauded by the culture-and even by their own religious communities, it is more and more the therapist's responsibility to make sure that they are not just getting swept up in this trending wave and applying an easy-to-access label to something more complicated but highly treatable.

Just as a therapist is trained to do a careful differential diagnosis with other emotions and symptoms, like sadness, distractibility or sleeplessness, which can all be quickly but superficially labeled with a pat diagnosis, here too, therapists can make sure that clients are using accurate and individualized terms and theories.

I have directly heard, for example, about children, teens and young adults who prematurely consider themselves gay if they sexually experiment once with the same gender or have fleeting fantasies and experiences with them. With the media's stereotype of "the flamboyant and sensitive gay man" young people are also being misled to consider themselves "inherently gay" simply because they are a creative, introverted or unathletic. It cannot be

overemphasized just how vulnerable young people are to these stereotypes and impressions, especially if they come from communities that lack openness to direct conversation about intimate relationships and sexuality, such as is typical in the Orthodox community.

For Orthodox Jewish clients especially, taking on these false identities really matters, for it typically goes along with life-long conflict and complication for the religious person, as well as distress for their family and community. Hopefully with more information, more therapists will be armed with the confidence and tools to help these men achieve their cultural and personal goals of satisfying heterosexual marriage.