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Gay-To-Straight Research Published In APA Journal

Warren Throckmorton, Ph.D.

An article by Dr. Warren Throckmorton, "Initial Empirical and Clinical Findings Concerning the Change Process for Ex-Gays," has been published in the June 2002 issue of the American Psychological Association's publication *Professional Psychology: Research and Practice* (2002, Vol. 33, No. 3, 242–248).

"I'm pleased that this research summary will reach an audience of psychologists and mental health professionals that may not be aware of ex-gay issues," says Dr. Throckmorton, the director of college counseling at Grove City College in Pennsylvania.

"My literature review contradicts the policies of major mental health organizations because it suggests that sexual orientation, once thought to be an unchanging sexual trait, is actually quite flexible for many people, changing as a result of therapy for some, ministry for others and spontaneously for still others."

In professional circles, the debate over the development of sexual orientation centers around two viewpoints. The more prevalent of these, known as the essentialist view, argues that sexual orientation is innate, "inborn," and therefore not subject to change. The APA has supported this view, and therefore has influenced the approach many mental-health practitioners currently take.

The second, and less accepted viewpoint, known as the contructionist perspective, posits that sexual orientation is a socially-constructed product of a client's life experiences and can therefore be modified. Dr. Throckmorton's research presents data consistent with this latter view.

"The APA's professionalism in handling this research is commendable and I think it demonstrates the APA's willingness to explore all sides of this important matter," Throckmorton said.

His analysis gathers previous studies of individuals who sought to change their sexual orientation. A majority of those responding to surveys of former gays indicate their experiences were positive and helpful.

This finding is in contrast to claims from some mental health professionals that efforts to change are always harmful.

Frequently religion played a major role in motivating a client to seek reorientation, Throckmorton notes, a fact that leads him to caution mental health professionals against assuming that the profession fully understands the potential and limitation for human change.

"For years, public and professional opinion of ex-gay ministries have been influenced by anecdotes from persons not helped by these ministries," he said. "Basing opinions on the

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The Pedophilia Debate Continues

— *And DSM Is Changed Again*

by Linda Ames Nicolosi

The very fact that APA admits to holding a moral viewpoint on a psychological issue ought to have opened up a broad new challenge to psychology's authority as our culture's secular priesthood.

For many years now, psychology has been locked into a philosophical quandary. Exactly what is a "psychiatric disorder"? Many critics despair of ever devising a catalogue of mental illnesses which can be considered to represent *science.*

Exactly how puzzling this quandary actually is, will be illustrated in an upcoming issue of the *Archives of Sexual Behavior.*

The *Archives* is the official publication of the International Academy of Sex Research. That journal will feature a symposium with at least one prominent psychiatrist arguing that pedophilia *is* in fact (at least in some contexts) a disorder—while another prominent clinician says that it *is not.*

But if pedophilia isn't a mental disorder, then just what ***is?*** If any man who violates the innocence and integrity of a child can be judged to "have nothing psychologically wrong with him"...then has the public in fact broadly misunderstood psychology's scope and explanatory power?

APA Reverses Diagnostic Change on Pedophilia

Although pedophilia remains illegal, and our culture still considers it morally wrong, recent changes in the APA's own diagnostic and statistical manual (DSM) have reopened the discussion of the psychological dimension of pedophilia.

History of the Diagnosis. In the DSM-III, the American Psychiatric Association contended that merely *acting upon* one's urges toward children was considered sufficient to generate a diagnosis of pedophilia. But then a few years later, in the DSM-IV, the APA changed its criteria so that a person who molested children was considered to have a psychiatric disorder only if his actions "caused clinically significant distress or impairment in social, occupational or other important areas of functioning."

In other words, a man who molested children without remorse, and without experiencing significant impairment in his social and work relationships, could be diagnosed by a clinician as a "psychologically normal" type of pedophile.

Challenged by NARTH to defend the change, the APA stated categorically that it had, in fact, no intention of normalizing pedophilia. However, "man-boy love" advocates cheered that DSM shift as good news.

Pedophile-Friendly Study Soon Follows

And a door indeed appeared to have been opened by the DSM change, because soon afterward, a journal of the American Psychological Association published the infamous Rind, et al. article—a study which downplayed the effects of, in particular, man-boy sex. Rind supported his argument with the finding that quite a few of the boys remembered their childhood sexual experiences positively.

As a result of the provocative Rind study's appearance in an APA journal, the American Psychological Association was struck with an embarrassing wave of criticism—what it called "the political storm of the century." That public-relations nightmare hit "with gale-force winds raging from the media, congressional leaders, state legislatures, and conservative grassroots organizations," according to the Association's journal, *The American Psychologist.*

The APA apologized for the study — following later with another statement which sounded like backpedaling (with the Association insisting that researchers have a right to scientific freedom). Then it issued a new and quite surprising official statement.

APA said that no matter *what* the research showed about the psychological effects of pedophile relationships—pedophilia remained, in its opinion, "morally" wrong.

Moral Philosophy and the Pedophilia Problem

Morally wrong? This was an odd statement indeed from a *scientific* organization. What, then, was the APA's moral position

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THE NARTH BULLETIN

Editor: LINDA AMES NICOLOSI

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"Victory on the Bow of a Ship"

THE TREATMENT OF EGO-DYSTONIC HOMOSEXUALITY: THE DEVELOPMENT OF A MASCULINE SELF-IMAGE

Steven A. Richfield, Psy.D.

Steven Richfield, Psy.D.

The treatment of ego-dystonic homosexuality in men poses many therapeutic challenges. From a technical standpoint, the patient typically presents with many conscious and unconscious resistances to growth. There are fears of heterosexual functioning that manifest themselves through sexual acting out, suicidal gestures, passivity, threatened premature termination, avoidance, rationalization, and so on.

The therapist must prepare for these and many other hurdles and readily ally himself with the side of the patient's personality that strives for change. Such an alliance requires that the patient feel safe, understood, and hopeful that change is possible. If these conditions are not met, or if ruptures in the alliance are not sufficiently repaired, the patient will not experience the therapist as "being on his side" and the outcome will be seriously undermined.

In the several years that I have been treating men with this condition they have taught me a great deal about themselves—about their internal turmoil and their efforts to cover up their secret lives; about their interpersonal sensitivities; and especially, about their deep sense of masculine inadequacy.

In my way of thinking, masculine inadequacy is a feeling state arrived at after years and years of wounds to a boy's developing masculine self-image. My experience has taught me that the overriding therapeutic aim in working with these men is to reverse this damage and ensure the integrity of masculine self-image. The evolution into this "phallic being" creates a safer context for these men to overcome their fears and feel more hopeful about growth because they can identify behavioral changes. Therapy provides the patient a second chance to receive the masculine mirroring via the therapist which is so vital to treatment outcome.

With this backdrop I will now enumerate the specific circumstances that spur the growth of this masculine self. Along the way I will anticipate the resistances that inevitably arise and pose specific interventions to address them.

The patient's success in this effort is directly related to his acceptance and recognition of the various factors that have interfered and continue to interfere with an adequate masculine self-image. Therefore, the therapist guides the patient in revisiting the significant situations of childhood, linking them up with past and present feeling states, and labeling the patterns. Once this is accomplished the groundwork is laid for leading the patient towards masculinization. Laying the groundwork involves using the patient's personal history to demonstrate how childhood situations left him with a sense of exclusion from the "masculine club" and produced deep feelings of "not measuring up."

The persistence of these scenarios led to strongly engrained patterns of submission and self-exclusion. Submissive behavior became a tool for temporary, albeit humiliating, entry into the male world, and self-exclusion was relied upon for protection from further wounding to the boy's fragile sense of masculinity.

The reconstruction of this boyhood disenchantment with masculinity provides reference points for the therapist to refer back to when the patient discusses the failures and disappointments of life today. A common language that incorporates the terms used by the patient, the specific circumstances surrounding damage to the masculine self, and the therapist's syncretizing comments provide the patient with verbal mechanisms to endure the surfacing of adverse feelings. In one case, a man's easily evoked feelings of victimization were lessened by telling himself that he was not helpless in the face of bullying by his cruel older brother and that he retained certain powers and choices to change circumstances if he so desired.

The Importance of Risk-Taking

Sometimes a form of "phallic" action is required to bolster the masculine self so that further self-inflicted damage can be averted, i.e., sexual acting out. Yet strong resistance to such action is typical since there is fear that either the action will fail to produce desirable results, or at worst, the man will feel humiliated.

In the same patient referred to earlier, workplace scenarios regularly evoked feelings of submission that he felt powerless to overcome. Analysis of these situations led to identification of specific actions or comments that he had avoided making which could have stemmed the tide of his feelings. For example, he could have given a superior direct feedback about the tone of voice used when addressing him, informed a co-worker that he would no longer take responsibility for the other's work, and he could have apol-

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ogized after an overreaction as a way of providing closure to an awkward interaction. When this patient protested that such actions would have futile or humiliating, I suggested that many actions do not produce the "right" results but nevertheless would have restored his sense of masculine dignity in the situation.

I have suggested that a man's masculinity is judged via the means he uses to interact with the world, rather than the outcome of those means. This intervention attempts to alter the "yardstick" of masculinity from a child's focus upon the external results, to an adult's internal set of standards and priorities. Although the boy had no choice other than to measure himself by the arbitrary standards and circumstances around him, as a man, he is free to develop his own "measuring stick."

The patient's passage through these masculine rites offers the therapist an opportunity to demonstrate visible pride and satisfaction at his phallic conquests. The therapist must feel free to offer admiring comments balanced by sensitivity to the fragile state of his patient's masculinity. This gentle affirming or mirroring of the patient's phallic assertiveness promotes internalization of the therapist's pride, and thereby, the patient's confidence that his masculinity is enhanced. In may respects, these therapeutic exchanges parallel the normal developmental dance between a proud and attuned father and an idealizing and vulnerable boy passing through the phallic-narcissistic phase.

The therapist's reinforcement of the patient' phallic assertiveness inevitably triggers some core childhood fears that stand in the way of sustained progress. For example, it is typical for these men to feel paralyzed by the fear of disappointing the therapist. They may become overwhelmed with shame and confusion about "what really is expected," as if a secret agenda is being used to measure them. They may angrily insist upon the unfairness of it all, since so much is upon them to do, or they may simply find one "logical" reason or another to avoid taking such risks.

These resistances must be viewed as windows of opportunity to speak directly to the boy within, and to provide the emotional supplies so scarce during childhood. The therapist's ability to empathically immerse himself in the patient's experience, much the way a "good enough" father can recall his own fears and insecurities as a boy, will determine whether these core fears become roadblocks or simply way stations for refueling.

In the same way that a boy who is filled with disappointment in himself needs his father to make it better, the patient needs reassurance, affection and containment from the therapist. Initially, the therapist must put himself in the patient's experience and communicate from there. Examples might include, "This is scary stuff...It probably looks pretty hopeless at this point...It is unfair that no one else is suffering but you...You're worried that each step you take will be the wrong one..." Such understanding is essential but not sufficient, since the "good enough" father/therapist must do more.

Broadening perspective, instilling objectivity, or offering concrete and specific handling of situations can build confidence where it is most needed. For instance, "You need to know that I'm proud that you've made it this far and that doesn't disappoint me, but tells me that we need to put our heads together and prepare you better next time...Of course it seems like a foreign land because you've never really been settled there before, but I will help you learn the terrain and before long, you'll feel like a native...The only thing expected is that you'll keep telling me about your feelings and confusion so that I can help you manage them and guide you to where you want to go...It's important to realize that your fear makes it easy for you to find excuses not to follow through, such as when you jump to conclusions about the entire female population based upon the experiences you've had with only a few...Now, let's talk about what you can realistically expect to happen and how you might want to handle it so you feel better prepared...I think that you'll feel less like you're submitting if you made those conditions clear and explain why you neglected to tell them earlier..."

Breaking Out of the Entrenched Pattern

These and other comments attempt to "make it better" by soothing the pain of the early wounds to masculinity and dismantling the entrenched patterns of submission and self-exclusion.

The therapist's ability to soothe some of the patient's fears often produces an interest in goal-setting on the part of the patient. Dynamically, the patient is now ready to risk further disappointment in return for the prospect of self-satisfaction because he knows the therapist will be there to offer solace if he should stumble. In essence, the therapist's empathic attunement provides a "safety net" to ensure that when the patient is let down, his feelings can be contained rather than subjected to a downward spiral.

Goal-setting must be handled with much caution and delicacy since it spurs action in one director or another. First it must be understood as both a catalyst for growth, and a potential resistance to growth. From a positive standpoint, defined and measurable goals are critical at certain points because men often need to see themselves as moving forward and "acquiring the masculinity" inherent in attaining each benchmark on their own "measuring stick." But from a negative standpoint, goal-setting can function as fertile ground for self-defeating patterns and provide further evidence of not "measuring up." Therefore, the therapist must anticipate how failure to meet one's goal at any given point will be experienced as a general failure in the man's quest for a masculine self.

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For instance, one man with a history of childhood obesity recalled many painful memories of being teased for his ineptitude in sports and his weight. Food became a ready source of comfort when he was beleaguered by self-hatred and peer ridicule. Although he was no longer obese when he began therapy, the symbolic value of food remained the same: it comforted him when he felt unmanly. Due to his childhood experiences he saw a soft, uncontoured body and self-indulgent eating habits as less than manly.

In positing goals, he placed weight lifting/working out and maintaining disciplined nutrition as especially important for his sense of masculinity. His attainment of these goals brought enhanced self-esteem due to their masculine value to him. He soon expected himself to fulfill both goals on a daily basis, and as a further condition, he allowed no "cheating" in his diet and he implicitly instituted minimums upon his workout times. This eventually led to his daily moods becoming tied to his ability to satisfy the goals. When he was unable to satisfy one he became disillusioned, depressed, and disinterested in the goals. Clearly, his sense of masculinity became dictated by meeting the goals without any consideration to his circumstances, energy level, rewards, and other issues that impacted upon goal achievement.

When goals become subverted as they did in this case, the therapist must offer comfort, interpretation, and objectivity. First, the patient needs to know that his feelings count even if they arise out of unrealistic expectations. For example, "I see how weak you feel when you eat something rich in calories or don't make it to the gym." Next, the therapist needs to make clear that the patient is doing to himself what others did to him as a boy: imposing arbitrary conditions for masculinity. For instance, "When you judge yourself so strictly you are only allowing another form of submission into your life, but this time, it's in the form of inflexible rules for masculinity."

Failures Alternate With Successes

Finally, the patient needs to be permitted to "come up short" sometimes due to the realistic constraints of his life. For instance, "I know it feels good when you achieve both goals on a daily basis but there's more to life than these goals: there are other demands, the need to reward yourself from time to time, and there are limitations upon your energy level. When you fall short of the goals, it's important to remind yourself that there are other successes that day and another chance tomorrow to work on them." These interventions attempt to instill in the patient a broader perspective for judging his masculinity.

No discussion of these problems would be complete without adequately addressing how homosexual fantasies disturb the lives of these men. The experience has taught me to treat such fantasies as very distinct from the behavior patterns and goal-setting that I have outlined thus far. My rationale is based upon the view that these fantasies grow out of the deep frustrations and unmet needs for masculine affection that occur during early childhood. Initially, these fantasies are attempts to compensate for this deprivation, and in time, other determinants reinforce their continued presence. Therefore these fantasies cannot be overcome in the same manner that these men overcome passivity and avoidance—that is, through assertiveness.

The reliance upon the fantasies subsides as the patient passes through the phallic-narcissistic phase of therapy and is rewarded by the therapists' admiring comments and a fuller sense of masculinity. Yet even with the most ideal outcomes, it is my belief that residual homosexual fantasies will emerge from time to time through the lives of these men. Therefore I believe that it is critical not to over-focus upon the presence of the fantasies in order to allow the evolution of the masculine self to take place.

By ascribing great importance to the presence or frequency of the fantasies, the therapist may inadvertently sabotage that process by communicating to the patient that no matter how masculine he behaves on the outside, he remains homosexual inside. One man who I had been treating for a few years made the following observation about he importance of realistic expectations: "I've come to accept that there is a homosexual part inside that I may never be able to get rid of. But maybe I can learn to live with it. The other day I was at the swim club with my wife and sons. A man in a very tight bathing suit walked by and I caught myself staring and beginning to have fantasies. But just as quickly, I stopped myself, told myself it was not such a big deal, and dove in the water. And it didn't ruin my day."

This man's experience captures what I see as the most realistic goal of psychotherapy of ego-dystonic homosexuality: the growth of a strong masculine self-image that provides for a satisfying heterosexual adaptation which is not jeopardized when there is a periodic intrusion of homosexual fantasies.

Yet I am aware that many men will have great difficulty embracing a goal that falls short of the *total* eradication of homosexuality from their inner and outer lives. In fact, I am often confronted by much disillusionment when I present this view at the beginning of therapy. Still, I believe it is a critical intervention in this type of work because it anticipates the fantasies, and attempts to demystify their meaning. If this is not accomplished, patients may easily give up hope even if they are progressing, due to the significance they have placed upon the lingering remnants of homosexual fantasy life.

Demystification begins by providing a new meaning to understand the fantasies. These men have felt stigmatized by their fantasies and have often understood them to signify their homosexuality. Yet they are typically relieved when I supply an alternate construction that weaves

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together the theories of early childhood development in boys, the circumstances of their early childhood, and the subsequent impact of internal and external forces.

For instance, the man most recently referred to recounted how his fantasies originated from the images of fathers and sons portrayed by such shows as "Lassie" in the early 1960's. He recalled having been five or six years old and soothing himself to sleep by imagining that he was the little boy receiving the paternal affection depicted on the TV program. Although these memories were recalled by him with great sadness and emptiness, he accepted his earlier dependency upon those fantasies due to the coldness and detachment of his father.

From this point of departure, I attempted to demystify the later homosexual fantasies through clarifications such as the following: "Deep down your fantasies serve as a security blanket in the same way they did when you were five. At that age your heart ached for your father's strong arms to hold you, but sensing his rejection, you turned away and inward in an attempt to create your own good father image. This helped you to endure his emotional detachment but laid the groundwork for your dependence upon fantasies for soothing your pain. With the onset of adolescence, you feelings of masculine inadequacy were intermixed with sexual urges, and once again you turned to your fantasies for soothing your pain. But this time, you had no choice other than to construct them in a blatantly sexual style due to the phase of life you were in. Heterosexual fantasies would not provide any type of relief and refueling, since you were still stuck in the arms of the good father, not ready to let go and too scared that you would not make it as a man."

Meaning Transformation

When the therapist makes it clear that the adolescent boy "had no choice" other than to rely upon homosexual fantasy for emotional relief, he helps his patient take a big step toward self-acceptance. From this point, the therapist can help the patient approach the fantasies not as the "enemy" but the little boy's safe haven.

Yet some men are threatened by this premise because it dramatically departs from the negative view they have held for so long. In most cases, these men have tried in vain to suppress the fantasies, especially during masturbation. They may be convinced that they must overcome the fantasies, because only then will they be able to comfortably pursue heterosexual relationships. Some men go so far as to set this as a precondition and thereby enforce an intractable resistance to growth.

The therapist's success in addressing this resistance plays a pivotal role in determining the course of therapy. By referring back to the little boy's dilemma of craving fatherly affection, he can enlist the patient's acceptance of how unmet needs seek relief. It is important to stress the notion that his "boy" inside should not be blamed for what he could not control, and he cannot be expected to just abandon his dependency upon fantasy because the adult on the outside dictates it.

Such a demand only echoes the harsh treatment the boy received as a child when others demanded that he "measure up."

Rather, the boy should be allowed to indulge in his fantasies during the times his needs require it, while the adult provides gentle encouragement to grow up. This encouragement comes in the form of goals and newly formed masculine attitudes that begin to exist side by side with the older child-based homosexual fantasy life. Essentially, the patient is told that the therapy aims for the evolution of a masculine self, not just a substitution to take the place of the old homosexual feelings and images.

The demystification of the fantasies can effectively remove any preconditions that the patient's resistances put into place. In so doing, the patient is freed up to develop a strong masculine self-image at whatever pace his fears allow.

When confronted by skepticism and complaints that these ideas make it sound like I am suggesting it is acceptable to fantasize about homosexuality, I have used the following metaphor: "If we go back to the boy's experience and remember how many times he had the door slammed before him when he wanted to join the other boys, to feel accepted as a boy, or just receive some affection for making his father proud of him, we get a picture of a shaky, insecure kid locked out of masculinity. His fantasies were the emotional band aids that helped him succeed in the other areas of his life. And now you're telling him to strip off the band aids and get ready to be kicked out of the house? I think it's better to first prepare him for what it's like out there and keep the door open when he ventures out so he knows he can still return if he finds it necessary. In time, he'll get a firmer feel under his feet for what masculinity is all about and build his own house. But there still may be times when he returns to visit the old house for one reason or another."

In closing, I would like to stress that this paper presents many interventions that I have had hours to ponder over during the writing process. The written words are at best, only approximations of what I really said in sessions when I had only seconds to produce a response. Still, the gist of my approach is presented here. Yet during those occasions when my therapeutic attunement failed me and my words were insensitive or, at worst, hurtful, I looked for signs of that in my patients and tried to elicit their feelings. When I was able to elicit those hurt feelings, and they expressed their anger at me and requests for an apology, I humbly offered it and returned to gauging their progress on their own "measuring stick." ■

Pedophilia Debate, continued from page 2

on, say...adultery or abortion? What about the morality of sexually open relationships? Would APA follow up with an official position on, say, the morality of polygamy?

The very fact that APA admitted to holding a *moral* viewpoint on a *psychological* issue ought to have opened up a broad new challenge to psychology's authority and its presumptions as our culture's arbiter of practically every social and moral issue now under debate.

Indeed, the time was then ripe for layman to issue a fruitful challenge to the entire concept of psychological health—its inherent limitations, its value-laden nature, and its meaninglessness without dependence on an underlying social-moral philosophy.

Most of all, the discussion could have addressed psychology's inability to *scientifically* answer the essential, basic questions upon which any meaningful psychology must be based...foundational questions such as, "What is good?" And, "What is the meaning and purpose of sexuality?" Or, "How does one define 'self-actualization'?" "What exactly is our distinctively *human* nature? How does our nature require that we live?"

In an age when even our culture's *moral* leaders feel obligated to look to *science* to defend their positions, such a discussion could clarify to the public what psychologists already know but tend to be loathe to publicly admit—that science alone has a limited capacity to either define or resolve our social-moral problems.

APA Recognizes the Threat to its Authority

The Psychological Association must have been aware of the implications of its own pronouncement that pedophilia was immoral, because the March 2002 issue of the *American Psychologist* carried an official article stating that the association had learned something from the Rind fiasco. Two of those lessons learned were that, first, the APA must build bridges to conservative groups, and second, in the future, psychology must be prepared to defend its validity as a branch of science.

The DSM Quietly Changes Again

Soon afterward, public outrage from the Psychological Association's fiasco may have moved on to touch the Psychiatric Association as well.

In fact, the Association has just quietly instituted a change in its most recent diagnostic manual—the Text Revision of the DSM-IV—regarding the definition of pedophilia. In a return to its previous standard, now, *merely acting upon* one's pedophilic urges is sufficient for a diagnosis of disorder.

NARTH Scientific Advisory Board member Russell Hilliard, along with psychiatrist Robert Spitzer, have just published a letter in the *American Journal of Psychiatry* which points out that in contrast to the DSM's statement that "no substantive changes" had been made in the latest DSM-IV Text Revision, "in fact, DSM-IV-TR has made a substantive change" in its criteria for pedophilia.

"Would it not have been better," Hilliard and Spitzer note about the APA's obvious silence, "for the DSM-IV-TR editors to have acknowledged that there were a few substantive changes in the criteria, and that for the Paraphilias they were correcting a mistake made in DSM-IV?"

The Missing Moral Dimension

But still, one thorny foundational question remains. How do we define the "harm" in pedophilia? Is that harm psychological, characterological, or both? How can psychology recognize harm resulting to the integrity of one's character? *And what can psychology know about character, anyway?*

Many religious traditions recognize pedophilia as an inherent affront to the *integrity of the person*—but such a characterological and spiritual concept may be difficult to conceptualize, and even more difficult to assess, in narrowly psychological terms.

Perhaps the harm done by pedophilia will be difficult to measure because it is subtle and values-laden. Maybe the molested boy will grow up to routinely sexualize his same-sex relationships. Maybe he'll have difficulty with marriage and mature intimacy. Maybe he'll not only have a distorted concept of gender differences, but a distorted understanding of generational distinctions as well—which could lead to the sexualizing of his own mentoring relationships with children.

How Social Science Studies Mislead

In fact, the molested child *who has been hurt the most*, in a moral and characterological sense, may actually be the boy or girl who grows up as an adult who truly believes—and who reports to researchers (as many of those cited by the Rind study did, in fact, state) that they "remember the sexual relationship positively."

The man whom these psychological studies trumpet as being "unharmed" by their childhood molestation may, therefore, have been the *most* harmed by the experience—and he may be the person most likely to reenact it on another child.

Perhaps, indeed, many of the deepest harms to the child, and to the perpetrator, are largely outside of scientific psychology's understanding. So, in a curious twist, maybe the APA—in throwing up its hands and saying pedophilia was "morally wrong"—was right.

Psychologist Gerard van den Aardweg has observed that the Rind study didn't find significant harm to all molested children because Rind was " looking through the wrong glasses."

Perhaps the pedophilia debate will challenge psychology to begin to openly incorporate the missing moral dimension—recognizing our human nature in all its intertwined psychological, moral and spiritual complexity. ■

PASTORAL CARE FOR SAME-GENDER ATTRACTED INDIVIDUALS

By Rev. / Chaplain Kent L. Svendsen

Rev. Kent L. Svendsen

Among the membership of your religious group, there are, no doubt, individuals who struggle with same-gender attractions. Unless your organization is gay-affirming—that is, it celebrates and accepts homosexual practice as moral when it is within a committed relationship—those struggling with such attractions may see their faith group as a place of hostility and rejection.

The usual "love the sinner, but hate the sin" approach may sound appropriate, yet the fear of being openly identified as one who *has* a sin that others *can hate* is often enough to keep such strugglers well hidden.

The "Fight or Flight" Dilemma

The issue of sexuality and sexual attraction has always been a touchy subject for religious groups, and one that is often avoided—even though it should be a central concern in today's sexually exploitative society. In the ongoing religious debate over the issue of homosexuality, the disagreements can easily become hostile and confrontational.

For many persons of faith, this results in what can best be described as a "fight or flight" mentality. The "fighters" charge after the "enemy," while the other members of the denomination run for cover—not wanting to be hit by the "friendly fire" coming from either side.

Meanwhile, those struggling with same-gender attractions often run for cover themselves, not wanting to be caught in the middle of a battlefield. They realize how quickly one can become a target for the anger and confrontational attitudes of those involved in the debate.

This means that they often do not receive the supportive ministry of the church, something that can be a powerful resource in helping to bring positive changes into their lives. Often the options are to either hide their struggle or turn instead to either a pro-gay therapist or one of the pro-gay supportive ministries for help.

Here is a typical description of what happens when a family seeks counsel from a pro-gay resource:

"I have seen a therapist, and he basically told me that homosexuality is genetic and I need to prepare for the inevitable. Once my husband is comfortable with who he is, the therapist says, and has accepted himself fully, he will want a divorce, and I will be left alone with our children to try to pick up the pieces." (Source: E-mail conversation the author held with a struggler's spouse.)

This type of attitude, which is found in both pro-gay affirming therapy and religious ministries, reveals the type of misinformation that is being offered to those seeking help. Yet there is in fact ample evidence to show that homosexuality is not genetic. One excellent resource to support this contention is the research book *"My Genes Made Me Do It"* by Neil and Briar Whitehead (copyright 1999, Huntington House Publishers, Lafayette, Louisiana).

Additionally, there are the many thousands of personal testimonies from those who have experienced an orientation shift (to various degrees of success) and relief from unwanted feelings and compulsions.

From what began as a movement for tolerance to end the brutalization and oppression of a certain element of society, the gay-rights movement has since been transformed into an agenda to normalize homosexuality.

For many within the gay-rights movement, this goal requires the elimination of any suggestion that orientation change can take place, or that same-gender attractions have as their root cause (among a list of other things) environmental factors or psychological trauma. This has resulted in a new form of oppression and bigotry against those seeking orientation change and against those therapists and pastoral counselors who desire to provide it.

This perspective is reinforced by the recent experience Dr. Robert Spitzer, the controversial psychiatrist who over two decades ago successfully lobbied for the removal of homosexuality from the diagnosis manual of mental disorders, but who has now come out in support of the possibility of change. In an interview with the *Wall Street Journal* he offered the following realistic scenario:

Client: *"I love my wife and children, but I usually am only able to have sex with my wife when I fantasize about having sex with a man. I have considered finding a gay partner, but I prefer to keep my commitment to my family. The homosexual feelings never felt like who I really am. Can you help me diminish those feelings and increase my sexual feelings for my wife?"*

Professional: *"You are asking me to change your sexual orientation, which is considered by my profession as impossible and unethical. All I am permitted to do is help you become more comfortable with your homosexual feelings."*

continued

As Spitzer observes, "The mental health professions should stop moving in the direction of banning such therapy. Many patients, informed of the possibility that they may be disappointed if the therapy does not succeed, can make a rational choice to work toward developing their heterosexual potential and minimizing their unwanted homosexual attractions. In fact, such a choice should be considered fundamental to client autonomy and self-determination." (Dr. Robert L. Spitzer, "Psychiatry and Homosexuality," *The Wall Street Journal*, 05/23/2001)

Over the years, I have closely studied the various groups that have attempted to minister to those with same-gender attractions. As a result, I have become aware of the tremendous complexity of the issue. It is for that reason I use the term same-gender attractions rather than "homosexuality." The term "homosexuality" has become a very divisive term, in addition to the fact that it also indirectly implies sexual activity. Yet there are many individuals who, while having attractions to members of the same sex, have never become sexually involved in a same-sex relationship.

Ministry Should Acknowledge Those Not Acting on their Attractions

It is especially important that we find a way to provide resources and offer support for those who are struggling with this issue, but have never acted out sexually. One way to begin the process is by providing education to our religious communities.

The drive for same-gender intimacy is one that is very much a part of who we are as individuals. The fact that it becomes sexualized for some, reflects an abnormal variant of this *natural* and *healthy* need for personality development and human fulfillment.

The process of reducing or eliminating unwanted same-gender attractions must involve not just a choice of the will, but a process that can take many years. What can be especially helpful is a support system which is understanding, non-judgmental, and willing to protect the privacy of those willing to openly share their personal struggles.

Degree of Change Varies From Individual to Individual

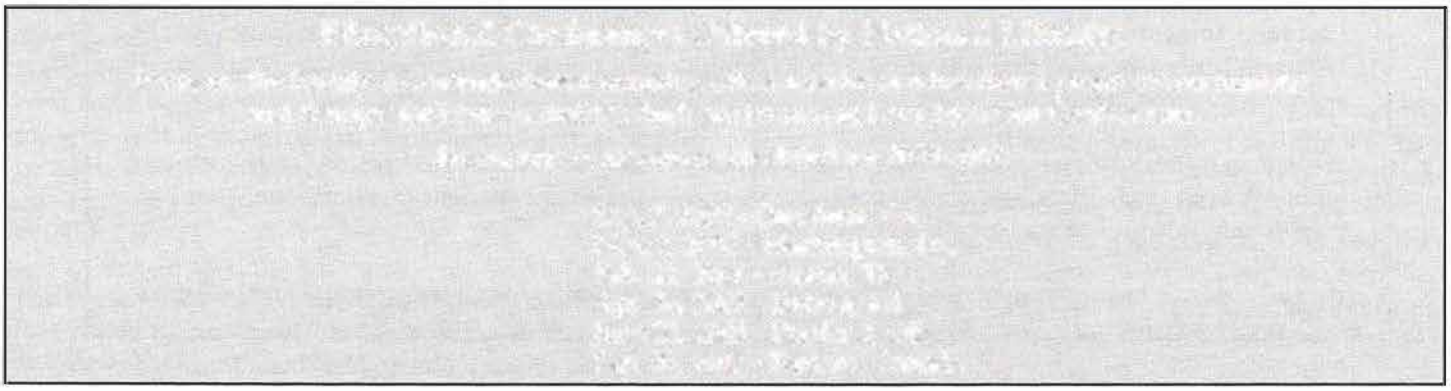
It has been shown that for many people, the complete elimination of same-gender attractions will never be a reality. The moral and theological concerns we have must address this reality. Even Scripture withholds the fulfillment of its promise of perfection until the final coming of God's Kingdom. Following is a typical response that is given to clients when they ask if orientation change will take place as a result of receiving reparative therapy, as reported by Dr. Joseph Nicolosi of the Thomas Aquinas Psychological Clinic:

"Of those who undertake therapy, about one-third experience no change (typically, they decide to leave therapy after the first few months); one-third learn the skills and achieve the self-insight to experience a significant reduction in the intensity and frequency of their homosexual attractions; and about one-third essentially overcome their homosexuality, with same-sex attractions no longer being a significant issue in their lives."

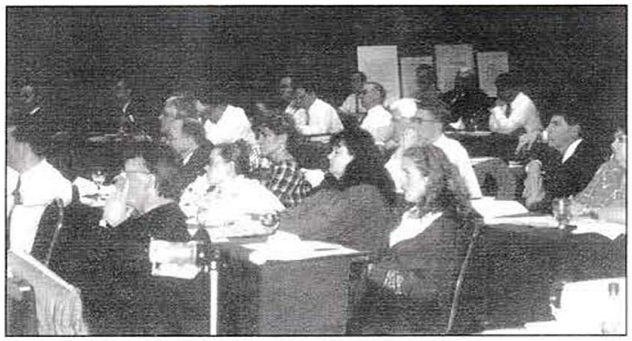
The goal of pastoral care and religious community support should be aimed at improvement of the individual's quality of life, the alleviation of self-destructive lifestyle activities, and providing a loving and caring community within which the individual can be open and honest about their struggle.

Next, we must recognize that while prayer and attempts at "faith healing by divine intervention" can be a useful tool and have some positive results, those results are rarely instantaneous. For many, the process is a long road with many obstacles to overcome along the way. In this regard, we must be willing to accept these limitations and not abandon or condemn those who cannot realize complete change. Instead, we must continue to be a source of loving ministry to them. It is my hope and prayer that some day we can offer ministries in every religious community which will provide longterm, loving care and understanding for those who struggle with same-gender attractions.

Rev. / Chaplain Kent L. Svendsen
NARTH Member
Interfaith Committee on Theological Concerns



Center for the Study of Gender Affirmative Therapy Hosts a Training Meeting



SALT LAKE CITY – One hundred and twenty-five therapists and academic professionals met in a clinical training seminar in March to study the issues relevant to treatment of unwanted same-sex attractions.

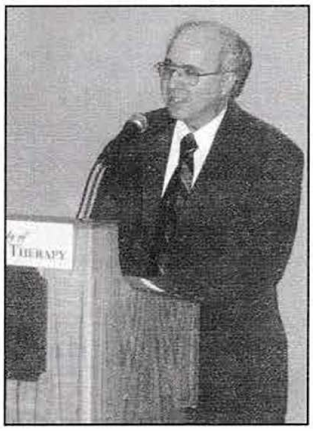
The newly formed Center for the Study of Gender Affirmative Therapy (The GAT Center) hosted the daylong event with several nationally respected clinical experts on homosexuality to instruct those gathered.

"This was a unique opportunity for therapists to receive clinical training from specialists with impressive clinical and academic experience," noted David Pruden, Center Director.

More than five hours of practical instruction was offered by Dr. A Dean Byrd, a clinical professor of psychiatry at the University of Utah, and Janelle Hallman, an adjunct professor at Colorado Christian University. Dr. Mark A. Yarhouse of Regent University delivered an address on professional ethics and the proper means to obtain the client's informed consent before treatment begins.

Dr. Byrd, vice-president of NARTH, used the morning session to talk about assessment issues. Following the luncheon which included a speech by Dr. Yarhouse, Dr. Byrd returned to the topic of successful treatment modalities. Those who attended were provided with numerous illustrations of clinical procedures that have assisted Dr. Byrd's own clients.

Janelle Hallman's audience was primarily made up of women therapists who were seeking help for their lesbian clients. "Women's issues are many years behind those of men both in the area of research and treatment," she said. "It is gratifying to participate in one of the largest training opportunities ever held on female concerns."



A. Dean Byrd, Ph.D. at the podium

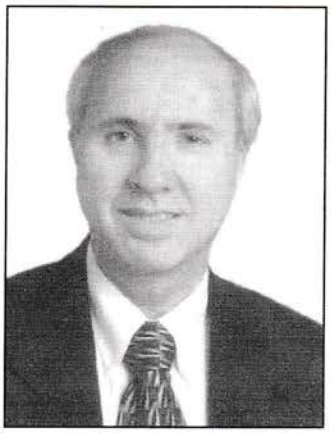
The Center for the Study of Gender Affirmative Therapy is planning to hold its next conference specifically for students enrolled in psychology, social work and marriage and family therapy programs.

Said the Center's director, David Pruden: "This early exposure to the current research and developmental issues surrounding ego-dystonic same-sex attraction could be key in insuring that the next generation of therapists is better prepared. They should not be subject to the information embargo that has left the current generation of professionals ignorant of the effective treatment of homosexuality."

TREATMENT OF MALE HOMOSEXUALITY: A COGNITIVE-BEHAVIORAL AND INTERPERSONAL APPROACH

A. Dean Byrd, Ph.D.

The author is Vice President of NARTH and holds a position as a clinical professor of psychiatry at the University of Utah.



A. Dean Byrd, Ph.D.

It is difficult to accurately label therapeutic approaches to treatment, because there are few purists among us. That is, although we might label what we do as reparative therapy, how we actually intervene may vary from therapist to therapist. The term I most often use for my own work is "gender-affirmative therapy."

Although I do not have extensive training in the psychoanalytic model of treatment, I do find the reparative, psychoanalytical approach to be helpful theoretically and conceptually. But the practical approach to treatment that I have adapted for use with homosexual men over my work of the past twenty years would most aptly be described as cognitive-behavioral/interpersonal.

I have found the cognitive-behavioral interventions to be useful in working with the symptoms, while interpersonal interventions provide the key to real healing. Although I appreciate the importance of childhood development, I have found it useful to place a greater emphasis on the bio-psycho-social explanations for homosexual development. Childhood development, in this model, likely provides the context in which temperament and personality traits interact with family and social surroundings to usher in the emergence of an individual's sexuality.

Perhaps I should first describe the patient population that I have treated for more than 20 years. They primarily have been men between the ages of 30 and 45 who have spent significant time in the gay lifestyle and have been unhappy. Many describe the lifestyle as being unfulfilling, lonely, depressing, distracting, and lacking in meaningful relationships. Frequently, I hear these men say that homosexual activity serves as an antidepressant for them.

Before I focus on several specific interventions, I will describe the treatment approach that I have found to be helpful. I have divided treatment into four phases. Please note that these phases are not discrete but are very adaptable and flexible; however, they do represent the general flow of therapy. As with all therapies, the patient must have some degree of motivation, must come to understand the origins of his homosexual attractions and must be fully committed to the therapy process.

PHASE I

The prerequisites noted above are determined during the first phase of treatment. During this phase, a thorough assessment is completed, taking into account the possible presence of psychological disorders that may co-exist with homosexual struggles.

I frequently find varying degrees of narcissism, dependency, hysteria, anxiety, and depression. A social/sexual history is a "must" during this phase and is routinely completed. I always conduct the sexual history in the contest of the social history because I want the patient to conceptualize his struggle in this perspective. For many, this provides a new look at an old struggle.

Emphasis during this phase is placed on the patient's global, social and emotional functioning and does not focus narrowly on the patient's homosexuality. Frequently, information is shared about the origins and treatment of homosexuality and questions are entertained about change and "cure." Journaling begins in this phase and is used throughout the treatment process.

PHASE II

Phase II is characterized by a strong behavioral approach. The goal of this phase of therapy is to help patients organize and stabilize their lives. A clear majority of these men are "out of control." Efforts are made through behavioral strategies to help them gain some control. In this phase, behavioral control is viewed as a prerequisite to behavioral change. Patients are helped to set behavioral goals to improve socially, intellectually, spiritually, emotionally, physically, and sexually. Specific interventions might include monitoring, reinforcement strategies, distraction, modeling, response inhibition and paradoxical strategies. The individual is empowered through self-control. The establishment of control, experience of success and some degree of stability are important in this phase of treatment.

PHASE III

Phase III focuses on interrupting homosexual arousal patterns. The emphasis during this phase of therapy is to help the patient explore, interrupt and eventually break the homosexual arousal processes. During this phase of treatment, the focus shifts from a behavioral to a cognitive emphasis. Cognitive interventions such as relaxation and guided imagery are used to help patients become more aware of and gain control over their cognitions, fantasies and feelings.

continued

Interventions such as emotional tracing, defragmentation, and discrimination of feelings are employed to interrupt the neuro-psychological processes. Many of these men have sexual addictions and emphasis is placed on correcting faulty belief systems, breaking myths, expanding options for being nurtured, handling anxiety and developing a lifestyle that is congruent with personal values. Patients are taught how to ask for help and how to develop self-affirmations.

PHASE IV

During Phase IV of treatment, a combination of individual, group and family therapy approaches may be used depending on the needs of the patients. The emphasis during this phase of treatment is quite affective and interpersonal and is geared at helping patients better understand and engage in the appropriate relationship process (i.e., friendship, non-sexual intimacy with men).

Problems with intimacy, self-worth, self-love, love of others, love of God, defensive detachment, distortions (unequal relationships with men as well as intensity in relationships), developing non-erotic support systems with men, assertiveness, anger (with men and women), masculinity, guilt, shame, loneliness and abandonment are explored and resolved in a group therapy context.

Frequently, during this phase, I introduce each patient to a married couple to function as special companions. Desired outcomes include the absence of homosexual behavior, reduction or elimination of homosexual attractions, a sense of congruence or inner peace resulting from integration, and development of comfortable and appropriate relationships with men and women. Spiritual (not religious) interventions are frequently used in this phase (although they may be employed in the other phases, too.)

Now, with this summary, I would like to briefly describe several of the interventions noted above.

- Journaling
- Emotional tracing
- Defragmentation
- Spiritual interventions

Journaling

Journaling is a useful way of helping homosexual men clarify their thought processes, experience and release their feelings, and generally explore issues in their lives. Instead of letting thoughts buzz around in their head, they make journal entries.

Initially, in the process, most of these men use journaling as a way to monitor their homosexual thoughts, fantasies and attractions. This awareness frequently results in a decrease of homosexual attractions. Later, journaling becomes a form of self-help as they are able to make connections, make shifts in perception and confront distortions.

Patients typically purchase two notebooks. Journal entries are made in the first book and given to the therapist for comment. They begin entries in the second notebook which is exchanged with the therapist during the next session. I make fairly extensive notes for them to consider.

One advantage to journaling is that it not only encourages greater involvement in the therapy process but empowers the patient to address significant issues regarding his struggles. At the end of the treatment, the patient edits the journals and this edited version is uses as a means of relapse prevention.

Emotional Tracing

Homosexual activity represents, symbolically or otherwise, attempts to meet legitimate needs. Many of these men are affectively governed and are quite reactive as they attempt to meet these needs through the eroticization of same-sex relationships. Many have a talent for histrionics. Emotional tracing is an intervention that is designed to identify and appropriately respond to primarily emotional needs. I simply ask them to explore what they were feeling prior to the homosexual attraction. Oftentimes, they report feelings of boredom, depression or anger, the latter most often being a reaction to hurt, pain, fear or frustration. I will have them re-experience these earlier feelings, and explore their origins. Frequently, this process helps them to clarify the origins of their homosexual attractions and results in a diminishing of these attractions.

Defragmentation

This intervention is related to emotional tracing but is more active. Its purpose is to assist in the de-eroticization of same-sex relationships. Van den Aardweg talks about the psychology of envy as central to the struggles of homosexual men. Homosexual men eroticize that which they are not identified with. Many of these men whom I have treated have multiple partners, with no ongoing relationships. Oftentimes, free-floating anxiety attaches itself to particular, desired characteristics. These men do not deal with other men, heterosexual or homosexual, in a holistic or complete way. I suspect that this is one of the reasons for the instability of their relationships. It's like incompleteness struggling with incompleteness.

The defragmentiaton process addresses the issue of fragmenting or incompletely dealing with others which I reflect back to them. It works this way: in an individual session, I will often ask that they focus on a past relationship and examine their attraction. This attraction is often focused on a particular trait or characteristic with which they are unfamiliar, they view as lacking in themselves or which they regard with simple envy. Most often these envied charac-

continued

teristics are perceived masculine traits.

I have them explore other traits, both physical and otherwise, so as to deal with this man in a holistic way. Questions such as, "What were his other physical traits?" "What was he like as a person?" are aimed at surfacing the emotional needs particularly as they relate to intimacy issues.

The need to get close to another man can be met without sexualizing that man. This intervention helps the client to equalize the relationship and focus on mutuality to develop non-erotic relationships with significant heterosexual men.

Spiritual Intervention

A clear majority of men I have treated have a deep sense of disconnectedness. They feel an alienation from God. Freud indicated that God was an extension of the father figure. This seems to hold true for these men's own view of God. When describing their relationship to a Deity, many of these men describe a "mean-spirited Santa Claus" image. There is a certain fear of God.

Individuals in positions of authority such as ecclesiastical leaders often unwittingly trigger feelings of anxiety and resultant responses of fear and detachment. I work very closely with ecclesiastical leaders who often provide father/son nurturing relationships for these men. Such relationships are very valuable in addressing issues such as forgiveness.

Specific spiritual interventions include:

- The personalizing of scriptures.
- Imagery involving God as a loving, caring father whose love is unconditional.
- Older, wiser self scenario. Service to others. Particularly, this intervention helps these men learn to give. They often feel unworthy to give of themselves. They often report wanting to feel that they are "acceptable to God."

Spiritual interventions help these men enjoy the process of discovery and to articulate the true self, their core values, and the basic purpose of life and to develop their spiritual nature to its greatest fulfillment. Such interventions help them clarify and trust their deepest values in a quiet way through attentive contemplation and mediation.

These interventions also allow these men to commit to their values and to identify with them in the present tense, and to find the strength to live by them. I help them to visualize themselves doing well and, through regular meditation, doing well comes to feel natural. Many of these men report experiencing love, joy, peace and fulfillment and help others to do the same. Spiritual interventions involve issues of integrity, personal empowerment and control, becoming connected with others, and finding greater purpose in life. It is through spiritual interventions that these men are really anchored and receive strength to resolve their struggles through what they call their "personal healing process." ■

New Evidence for Biological Influence on Gender

by Linda Ames Nicolosi

A study recently published in the Proceedings of the National Academy of Sciences (April 16, 2002) has added to a growing body of research which suggests that environmental toxins have a demasculinizing effect on some developing organisms.

The latest study[1] was conducted by a specialist in the hormone systems of amphibians at UC Berkeley. He found that male tadpoles exposed to a commonly used weed killer called atrazine tend to develop into demasculinized adult frogs. Some of the tadpoles became hermaphrodites, developing both male and female sex organs.

Hayes found that atrazine disrupted the endocrine systems of developing frogs by converting the male hormone testosterone into the female hormone estrogen.

Atrazine is the most commonly used herbicide in the U.S., and it has been detected in ground water consumed by humans, although its effect on humans is not yet fully understood.

The latest study adds to earlier evidence suggesting that some environmental pollutants may impair normal gender development. If these findings are replicated in the small but growing body of studies on humans, then a male fetus with a brain that was feminized by an environmental toxin such as atrazine would, after birth, be at particular risk to establish a weak masculine gender identity and thus to develop homosexual attractions in adulthood.

This latest study on frogs fits earlier findings in research on humans by LaLumiere et al.[2] That earlier study concluded that male homosexuals are about one-third (31%) more likely than heterosexuals to be left-handed, while lesbians are almost twice as likely (91%) to be left-handed as heterosexual women. LaLumiere believes this indicates that homosexuality, for a certain proportion of men and women, probably has an early, neuro-developmental basis tracing back to "disruptive events causing developmental instability" which have modified sexual differentiation of the brain, "perhaps through hormonal or immunological mechanisms."

Homosexuality is generally understood to result from a combination of psychological, biological, and social factors. In those homosexuals whose condition had a primarily biological rather than a psycho-social foundation, homosexuality would be, like left-handedness, a "biological developmental error."

Left-handedness has been associated with a wide range of indicators of reduced fitness, from the standpoint of natural selection. Left-handed people, La Lumiere et al. say, have a smaller number of offspring, higher number of spontaneous abortions, lower birth weight, higher number of serious accidents, higher rates of serious disorders, and a shorter life span. Left-handedness has similarly been linked to neural tube defects, autism, stuttering, and schizophrenia.

Two other studies reported earlier in *Archives of General Psychiatry* found significantly higher levels of pathology in the homosexual population than among heterosexuals. One of several possible explanations for the higher level of psychiatric pathology, said researcher J.M. Bailey in a published commentary that echoed the LaLumiere study, is that since natural selection leads to heterosexuality, then "homosexuality may represent developmental error."[3]

When gender-identity distortion becomes apparent in a young child, whether due to psychodynamic or biological factors, some therapists say, the at-risk child's gender distortions can be modified (see "Research Studies of Interest, the Childhood GID Diagnosis," at www.narth.com). Parental interventions that help to affirm appropriate gender identity would thus make a heterosexual adjustment more likely. ■

Endnotes

1. Hayes, Tyrone; Collins, Atif; Lee, Melissa; Mendoza, Magdalena; Noriega, Nigel; Stuart, A.A., and Vonk, Aaron, "Hermaphroditic, demasculinized frogs after exposure to the herbicide atrazine at low ecologically relevant doses," *Proc. Natl. Acad. Sci. USA*, vol. 99, Issue 8, 5476-5480, April 16, 2002.

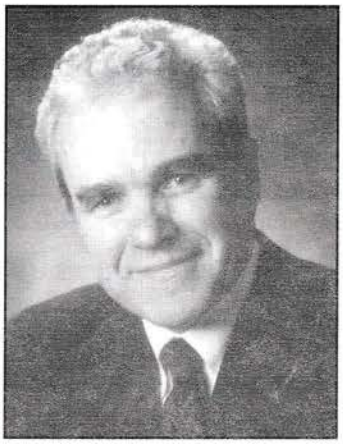
2. Lalumière, M.L.; Blanchard, R.; Zucker, K.L. (2000): "Sexual orientation and handedness in Men and Women: a meta-analysis." *Psychological Bulletin* 126, no. 4, 575-592.

3. Bailey, J.M., "Commentary: Homosexuality and Mental Illness," *Archives of General Psychiatry*, October 1999, vol. 56, no. 10, 876-880.

Letter to the Catholic Bishops

The following letter addresses the Catholic Church's sexual abuse crisis. It was authored by three members of the Catholic Medical Association who speak on its behalf, including psychiatrist Richard Fitzgibbons, a NARTH Scientific Advisory Board member; Eugene Diamond, M.D. and Peter Rudegeair, M.A.

As a Catholic psychiatrist and psychologist who have treated a significant number of priests from various dioceses and religious communities over the past 25 years for same-sex attraction (SSA or homosexuality) and for pedophilia and ephebophilia (homosexual behavior with adolescents), we believe that our particular expertise and those of our colleagues in the Catholic Medical Association may be of help to the American bishops as they seek to create effective long term strategies to prevent the recurrence of the problems in which the Catholic Church in the United States now finds itself enmeshed.



NARTH member Richard P. Fitzgibbons, M.D.

Many have pointed out that solving the problem of sexual abuse by clergy will necessarily involve addressing the problem of SSA among priests. Bishop Wilton D. Gregory, president of the U.S. Conference of Catholic Bishops, admitted at a press conference in Rome on April 23 the existence of an ongoing struggle to ensure that the Catholic priesthood is not dominated by homosexual men.

As the revelations of abuse have become public it has become increasingly clear that almost all the victims are adolescent males, not prepubescent boys. The problem of priests with same-sex attractions (SSA) molesting adolescents or children must be addressed if future scandals are to be avoided.

In treating priests who have engaged in pedophilia and ephebophilia, we have observed that these men almost without exception suffered from a denial of sin in their lives. They were unwilling to admit and address the profound emotional pain they experienced in childhood of loneliness, often in the father relationship; peer rejection; lack of male confidence; poor body image; sadness, and anger.

This anger, which originated most often from disappointments and hurts with their peers and/or fathers, was often directed toward the Church, the Holy Father, and the religious authorities. Rejecting the Church's teachings on sexual morality, these men for the most part adopted the utilitarian sexual ethic which the Holy Father so brilliantly critiqued in his book, *Love and Responsibility*. They came to see their own pleasure as the highest end, and used others — including adolescents and children — as sexual objects. They consistently refused to examine their consciences, to accept the Church's teachings on moral issues as a guide for their personal actions, or regularly avail themselves of the sacrament of reconciliation. These priests either refused to seek spiritual direction or chose a spiritual director or confessor who openly rebelled against Church teachings on sexuality. Tragically, these mistakes allowed these men to justify their behaviors.

The bishops, individually and collectively, should develop screening protocols which will identify men who may pose a risk to others and who cannot live the chaste celibacy required of a priest. This is essential to protect the Church and her children from further pain, sorrow and future scandals. While no screening system is absolutely foolproof, sufficient research is available to develop efficient tools for this task.

Bishops Are Misinformed About Homosexuality

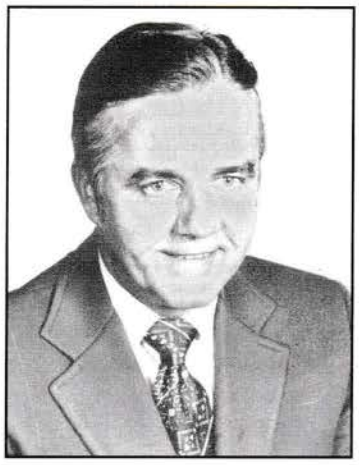
One of the major problems we have discovered in discussing this issue with the clergy and the laity is the enormous amount of misinformation about the nature, origins, and treatment of homosexuality/SSA. This is not accidental. For over twenty years, activists—intent on changing the laws on sexual orientation—have put forward a massive public-relations campaign specifically designed to spread misinformation that will aid in the social acceptance of homosexuality.

For example, many people sincerely believe that scientific research has produced conclusive evidence that homosexuality is a genetically inherited condition, determined before birth, and cannot be changed. In fact, no such evidence exists. Several studies have been promoted in the media as providing the "proof," but when one reads these studies, one discovers the authors themselves do not even claim to have presented such proof.

There is no verifiable evidence that same-sex attraction is genetically determined. If same-sex attraction were genetically determined, identical twins would always have the same sexual attraction pattern. Numerous studies of twins have shown that this is not the case. And there are numerous studies documenting change of sexual attraction pattern (see *Homosexuality and Hope*, available at www.cathmed.org).

continued

One of the reasons why people have been so willing to accept the idea that same-sex attraction is genetically determined is their own experience with men who are extremely effeminate and have been so since early childhood. This condition of extreme effeminacy is called Gender Identity Disorder (GID). The differences between boys with GID and other boys are so profound, that those observing them conclude that the boys with GID must have been born that way.



Eugene F. Diamond, M.D.

Those who treat GID have found that effective family therapy in which the father bonds more closely with the son and affirms his son's masculinity can result in the emergence of normal boyish behavior. Tragically, because this information is not widely known, most boys with GID do not receive treatment and approximately 75% of them will go on to develop SSA in adolescence.

Unfortunately, if these boys come from Catholic families, those around them may point them toward the priesthood. Because they aren't attracted to girls, people wrongly assume that the celibate life will be easy for them.

In our practice, we have seen many boys who suffered from distant father relationships, lacked hand eye coordination and subsequently were subjected to humiliating teasing from peers because of their inability to play sports. These and other factors lead to feelings of male inadequacy and loneliness and later to homosexual attractions. The sooner these problems are addressed in therapy, the more hope there is for a full recovery.

For example, a 26-year-old client had experienced severe peer rejection as child and teenager because of his inability to play sports. In addition, his father was distant, and his mother overly dependent. At age 10 he began to experience same-sex attractions which intensified in his adolescence. Fortunately, as a faithful Catholic he never gave into the temptations to act on these feelings. As the emotional pain was resolved, his male confidence grew, his same-sex attraction diminished markedly and later resolved. He came to realize that he was not homosexual, but a man who had been wounded emotionally in many relationships from early in his life, and who could be healed.

Michael (not his real name) was a seminary student when he came into treatment for same-sex attractions. He gradually understood that the origins of the same-sex attractions arose from a very negative body image which he had had from the time he was a young boy because he had been overweight. He was regularly picked on by his peers in elementary and middle school because of his physical appearance. He experienced intense loneliness in peer relationships from his childhood and adolescence.

During his several years in therapy, he worked at trying to forgive his peers who ridiculed his physical appearance. He also attempted to reject the culture's obsession with physical appearance, and began to thank God for his masculine gifts and body image. He also meditated upon the Lord being at his side as his best friend in elementary and middle school. He benefited by reflecting that his body is a temple of the Holy Spirit, in addition to asking for a certain sense of detachment, and by being thankful for his God-given body. Finally, he also worked out physically to prevent more weight gain. Slowly his masculine identity and body image improved. His deep inner loneliness lessened through a profound sense of being loved by the Lord.

The Catechism of the Catholic Church states that homosexuality's "psychological genesis remains largely unexplained" (#2357). While it is understandable that the writers of the Catechism would not wish to make a definitive statement about a question which is at the center of such a contentious public debate, this statement does not accurately reflect what is known about homosexuality. There is ample evidence that same-sex attraction has many different causes. These lead to significant childhood and adolescent emotional pain and psychological problems. Among males, these could include a weak masculine identity, social isolation and loneliness, peer rejection or a poor body image and in females, a mistrust of male love or a weak feminine identity.

No one can say "this is *the* cause" for same-sex attraction as though there were a single cause, but an individual can come to understand the origins of his or her own same-sex attractions through insight gained in therapy.

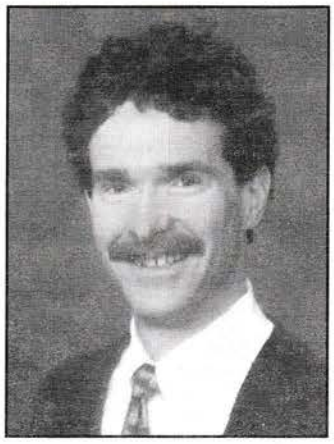
Feelings Don't Necessarily Tell Us "Who We Are"

Men and women experiencing same-sex attraction may rightly feel that they "have always felt different," but that doesn't mean they were born that way. Children are born either male or female, but they have to learn what it means to be a man or a woman. They have to identify with — and be accepted by — their same-sex parents and peers. If they are going to grow up psychologically healthy they have to feel safe and comfortable with their masculinity or femininity. If, for whatever reason, they fail to pass successfully through this essential developmental stage, they may in adolescence develop same-sex attractions.

There has been a massive campaign to hide this information from the general public and from those who sincerely wish to be free from same-sex attraction. In 2000, Dr. Robert Spitzer of Columbia University, who had been instrumental in the removal of homosexuali-

ty as a diagnosis from the American Psychiatric Association's Diagnostic and Statistical Manual in 1973, was challenged by men and women healed of their same-sex attractions to acknowledge that change is possible.

Spitzer interviewed 200 men and women claiming to have achieved significant change and found that 60% of the males whom he studied identified themselves as heterosexual five years after their treatment ended. Most of those who were successful also participated in faith-based support programs.



Peter Rudegeair, M.A.

While there are numerous reports of substantial change through therapy alone, programs which rely on God or which are specifically Christian provide significant help in dealing with the compulsive behaviors, loneliness and lack of confidence that accompany SSA.

No One Was Designed By God to Be Homosexual

This should come as no surprise to Catholics who already know the power of Christ's healing love. To those who wish to be free from same-sex attraction, it can be said with confidence that God didn't make them that way and He wants them to be free. The good news is that SSA attraction can respond to therapy and that membership in a support group such as Courage can help a person to find healing and freedom.

The road to freedom, however, is long and arduous. For many individuals, it is often accompanied by other serious psychological problems and addictions. Three recent well-designed studies (Fergusson, Herrell, and Sandfort) have shown that persons with SSA suffer from other psychological problems at a rate substantially higher than those without SSA. Some of these problems, such as pathological narcissism and borderline personality disorder are very difficult to treat.

Additionally, men with SSA are more likely to suffer from substance abuse problems, sexual paraphilias, and sexual addiction. Such problems complicate recovery. Also, men with SSA are more likely than other men to have a history of childhood sexual abuse (CSA). While arriving at an exact percentage is difficult, some experts suggest that about 16% of all men have experienced CSA. Several studies of men self-identified as homosexual revealed that 40% had a history of CSA. Given the high level of long term psychological problems associated with a history of CSA, it is not surprising that men with SSA have numerous problems.

There are other serious problems which need to be addressed. For example, sexual harassment exists at certain seminaries. Any Catholic institution which knowingly tolerates sexual harassment — heterosexual or homosexual — betrays the moral teaching of Christ and contributes to the suffering of others. It also risks incurring financial liability.

Recommendations: Treatment for Priests with SSA

We have observed many priests grow in holiness and in happiness in their ministry as a result of the healing of their childhood and adolescent male insecurity and loneliness and, subsequently, their same-sex attractions. This healing process has been described in Fr. John Harvey's book, *The Truth About Homosexuality* and in the statement of the Catholic Medical Association, *Homosexuality and Hope*, available at www.cathmed.org.

Bishops would also see this healing if they encourage priests with SSA to pursue appropriate therapy with those loyal to the Church's teaching. Most males with SSA had painful childhood and adolescent peer relationships. Under the stress of loneliness and insecurity in adult life, there can be an unconscious association to this adolescent and childhood pain. Attractions to children, adolescents or adult males then develop in an unconscious attempt to gain acceptance and lessen the pain of sadness, loneliness and lack of male confidence. The treatment of this emotional pain is essential in order to protect the Church and her children from further sorrow and scandal.

Priests, with or without SSA, who have themselves been the victims of childhood sexual abuse should receive counseling. Only a small percentage of victims of childhood sexual abuse will go on to abuse children, but a significant percentage will suffer from various problems which affect their ministry.

Our experience over 25 years has convinced us of the direct link between rebellion and anger against the Church's teaching, and sexually promiscuous behaviors. This appears to be a two-way street: those who are sexually active dissent from the Church's teaching on sexuality to justify their own actions, while those who adopt rebellious ideas on sexual morality are more vulnerable to become sexually active, because they have little to no defense against sexual temptations. Growth in forgiveness and growth in humility are essential in the treatment of such priests.

Finally, priests should be screened for homosexuality by their bishops or religious superiors prior to being considered for a position of responsibility in a diocese, religious community or in the U.S. Conference of Catholic Bishops. The previous attitude of "winking" at homosexuality in priests must end. Otherwise, all Church teaching on sexual morality is undermined. Also, complaints by priests of aggressive homosexual behavior in rectories and religious

continued

communities should be addressed and no longer ignored.

Screening of Seminarians

Protocols should be developed which will allow those professionals who screen candidates for the priesthood to identify those individuals with serious problems, to recommend therapy for those with correctable problems, and to accept those who can live chaste celibacy and pose no threat to others. Simply asking a candidate if he is a heterosexual or a homosexual, or if he is sexually interested in adolescents or children is not sufficient. Proper history taking, a clinical interview, and psychological testing correctly interpreted will uncover most current and potential problems.

Two different studies have found that the answers to a small number of questions about childhood and adolescent experiences included within a larger questionnaire allowed the clinical interviewer to conclude, with 90% accuracy, whether the subject was a heterosexual or a homosexual.

When screening reveals probable SSA, the candidate is not automatically excluded from consideration. If he is willing to do the hard work required to come to freedom from his emotional pain, his same-sex attractions will be resolved and then he can reapply later. The Church should not take the moral risk of allowing someone with SSA to enter the seminary. Also, a period of sexual abstinence for five years should be required of those with SSA prior to entering the seminary.

It should be noted, that many men with SSA will have problems besides their SSA which could make admission to the seminary inadvisable. For example, men with SSA are more likely to have problems with compulsive masturbation, other sexual addictions, substance abuse problems, history of childhood sexual abuse, and depressive illness.

It is essential that mental health professionals involved in any way with screening candidates for seminary or with treating seminarians or priests, as well as the faculty at the seminaries, support the teaching of the Church on sexuality, particularly on homosexuality. In our experience, there are some dioceses and religious communities relying upon the work of mental health professionals who actively disagree with the Church's sexual morality.

Seminary Formation/Faculty

Many faculty members of seminaries and religious houses do not adhere to the truth on matters of sexual morality and faith. For decades moral relativism, proportionalism, and situational ethics have been taught in these centers of formation. These teachings have contributed to the present crisis in the Church.

Seminarians who support Church teaching on sexual morality, Scripture, the liturgy, and fundamental moral theology have been labeled as rigid and often expelled from seminaries. Seminary faculty members and members of formation teams in religious communities who have a homosexual agenda are driven to remove from the seminary males who are loyal to the Church's teachings on matters of faith and morals.

We recommend that Cardinals, Bishops and religious superiors either personally interview or send visitation teams to interview all faculty members of seminaries and formation teams. They need to be certain that these individuals are loyal to the Holy Father and the Church's teaching on faith and morals and that they refrain from intimidating seminarians into questioning the value of orthodoxy. The purification of the seminaries is essential to the protection of the Church and her children.

The Availability of Treatment and Education in Every Diocese

Courage is the only recovery program for those with same-sex attractions which adheres to the Catholic moral teaching on homosexuality and has been endorsed by the Vatican. This program should be available in every diocese for both laity and priests. If priests and laity do not have access to therapy which can help them come to the freedom proper to the children of God and support groups like Courage, they may fall into despair and feel that the Church has placed upon them a burden that is impossible to bear. Unfortunately, in some dioceses groups, such as Dignity, which do not accept the Church's teaching on sexual morality, have a voice, while Courage is not welcome.

Priests need to understand the origins of SSA and the healing approaches which have been demonstrated to be effective. In addition, because of the tremendous confusion over homosexuality, it would be beneficial that conferences for priests and seminarians be given by experts such as Fr. John Harvey, O.S.F.S., the founder of *Courage*, and by other mental health professionals who accept the Church's teaching on homosexuality and are experienced in the successful treatment of SSA. Education for priests concerning the nature, origins, and treatment of SSA should increase their compassion and help priests who regularly deal with these problems in the confessional.

Unfortunately, conferences have been offered to priests and seminarians in which homosexuality is presented as being genetically determined and no hope for healing is offered. The recognition of chastity as a healthy virtue is rejected. Chastity, in the experience of many mental health professionals, is, in fact, a positive quality in any individual's life.

At the present time, a number of treatment centers to which priests are sent for sexual disorders treat homosexuality as an identity to be embraced. Influenced by the politics within the American Psychiatric Association and American Psychological Association, the possibility of healing is censured. Patients are encouraged to participate in 12-step groups for compulsive sexual behaviors, but the emotional origins of their same sex attractions are not explored nor is a

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plan offered for healing unresolved emotional pain.

Since training in the treatment of SSA and GID in conformity with the Catholic understanding of the human person is not being provided at most secular institutions, it is important that this training be available either in Catholic institutions or through separate programs.

On April 23, 2002 the Holy Father encouraged the American Cardinals: "We must be confident that this time of trial will bring a purification of the entire Catholic community, a purification that is urgently needed if the Church is to preach more effectively the Gospel of Jesus Christ in all its liberating force. Now you must ensure that where sin increased, grace will all the more abound (Romans 5: 20). So much pain, so much sorrow must lead to a holier priesthood, a holier episcopate, and a holier Church."

There are reasons for hope. The problems of homosexuality in the priesthood have been painfully uncovered and need to be addressed. There is no proven genetic basis for homosexuality. The emotional wounds which cause same-sex attractions can be identified and healed. Large numbers of people, including clergy, who had SSA are now substantially cured, especially if they brought the power of faith into the healing process. These men and women no longer view themselves as being homosexual.

The statement of the Catholic Medical Association on homosexuality, *Homosexuality and Hope* (www.cathmed.org), should be made available to all priests, educators and Catholic families. With the Lord's help, the Catholic priests who struggle with homosexuality can be healed.

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NARTH Member Elected to Psychological Association Office

Psychologist Christopher Rosik, Ph.D. was recently elected president of CAPS-West, a division of the Christian Association for Psychological Studies.

Christopher Rosik, Ph.D.

Dr. Rosik is the author of "'Outing' the Moral Dimension in Research on Homosexuality," an article published in the association's *Journal of Psychology and Christianity* in 1996, as well as "Conversion Therapy Revisited: Parameters and Rationale for Ethical Care," published in 2001 in the *Journal of Pastoral Care*.

CAPS' purpose is to promote the integration of Christianity and the behavioral sciences at both theoretical and applied levels, and to provide educational and research opportunities for its members. Founded in 1956, CAPS has some 2000 members in the U.S., Canada, and 25 other countries.

The association's members serve as psychologists, marriage and family therapists, professional counselors, pastoral counselors, psychiatrists, professors & researchers, social workers, guidance counselors, and students and professionals in training.

The association publishes the quarterly *Journal of Psychology and Christianity*. Dr. Rosik's article appeared in the journal's Vol. 15, No. 4 issue on pages 373-384. Information on membership can be obtained by calling (830) 629-CAPS or visiting the CAPS web site at www.caps.net.

Call for Papers
for the NARTH Conference

The 2002 NARTH Conference will be held on November 9-10 in Orlando, Florida. A committee is now soliciting speakers and workshop leaders for that conference. If you are interested in being considered as a speaker, please submit an outline of your proposed topic along with your resume to NARTH and it will be passed along to the committee.

Caring for Gay and Lesbian Youth in a Pediatric Practice:

"Safe Office Kit" Provided for Pediatricians

By Daniel Byrne, PhD

The 2002 Annual Meeting of the Pediatric Academic Societies was held at the Baltimore Convention Center on May 4-7, 2002. I attended this meeting, which hosted about 4000 pediatricians and pediatric researchers who had convened to attend the professional education workshops.

The American Academy of Pediatrics recently sparked widespread controversy when it voted in a new policy to support gay adoptions. Emboldened by that success, gay activists from the University of Massachusetts and Tufts University School of Medicine led a workshop at the pediatric convention to introduce doctors to their newly developed "Safe Office Kit."

Physicians at the workshop were provided with packets which contained an AAP brochure perpetuating a discredited Kinsey myth. Billed as "facts" for teens and their parents, the brochure states that "Some estimates say that about 10% of the population is gay."(Not even close—try 1% -3%!)

The workshop leaders briefly discussed the recent controversy over the AAP statement. A gay pediatrician from Hawaii expressed concern that the AAP might reverse its policy, but Dr. Martin Greenberg, who was familiar with those individuals who had developed the policy, stated that a reversal was unlikely. However, he indicated that the AAP had received more than 200 emails and letters, most expressing disapproval of the new policy.

A panel was offered which included a 17-year-old "gay" teenager, the boy's mother, a lesbian college student and lesbian mother who is also an attorney. The lesbian attorney indicated that the recent AAP statement was proving useful in her legal briefs. The 17-year-old boy said that he "came out" as gay at the age of twelve! All blamed the problems of gays and lesbians on homophobia and heterosexism.

One pediatrician revealed (without apparent concern) that his 7th grade son "came out of the closet" at school, publicly proclaiming to his teacher and classmates that he was bisexual.

Adolescence is time of instability and confusion. I know of *no* adolescent who knows who he or she is. Yet research literature is clear on the matter of early homosexual self-labeling: the risk of suicide decreases by 20% for each year that a young person delays homosexual or bisexual self-labeling.

The workshop leaders offered extensive recommendations for creating a "safe" office place for gay, lesbian, bisexual, transgendered and questioning youth which included the posting of rainbow and "safe space" stickers and the displaying of posters, brochures, and magazines in the waiting room to demonstrate the doctor's personal support for gay issues.

The workshop leaders warned that some staff and parents might object to such obvious advocacy, but their objections could be effectively neutralized if sexual orientation was included in the same category as advocacy for two, much less controversial subjects—race and gender equality.

The workshop ended with suggestions of ways the pediatricians could further the acceptance of homosexuality in their communities. Seizing upon a tragedy in the community is one highly effective means to galvanize public support, they agreed.

I believe the recent AAP statement supporting gay adoption was the result of vigorous gay activism at work within the association. It was more a political position than a scientific one, because AAP's policy statement does not reflect the scientific literature—which demonstrates that non-heterosexual parenting places children at risk for gender confusion and a host of other problems.

Most disconcerting was the apparent unwillingness of AAP to thoughtfully consider the objections to their policy from their own constituents. Why not put the new policy to a vote of the membership? Most disturbing of all was the inaccurate information presented in the workshop—ranging from the discredited Kinsey myth being offered as fact, to the statement that homosexual attraction is immutable.

The AAP has placed itself in a precarious position: *it purports to heal,* and yet encouraging early self-labeling as "gay" by teenage patients may be directly responsible for early sexual experimentation and the suicide of some young people.

In the future, he AAP would be best advised to listen to its members and obtain their input prior to issuing policy statements. And such workshops as this one would be best labeled political activism—not science. ■

The following societies participated at the AAP convention: The American Academy of Pediatrics, American Society of Pediatric Hematology/Oncology, American Society of Pediatric Nephrology, Association of Pediatric Program Directors, Lawson Wilkins Pediatric Endocrine Society, North American Society for Pediatric Gastroenterology, Hepatology and Nutrition, Pediatric Infectious Diseases Society, Society for Developmental Pediatrics.

Some Gay Advocates Acknowledge Reorientation Therapy as a Legitimate Option—

Simon LeVay Joins Douglas Haldeman in Qualified Support

by Linda Ames Nicolosi

Some gay advocates—including noted researcher Dr. Simon LeVay and psychologist Douglas Haldeman—say that reorientation therapy should be permissable out of respect for client choice and autonomy.

Douglas Haldeman is a gay man, an activist for gay causes, and a psychologist who has strongly advised against reorientation therapies. Still, he has conceded that—

> "not all supporters of conversion therapy seek to interfere in the lives and freedoms of gay people, or...are out to do us harm. Rather...there is a religious basis from which these people are operating, not malicious, but rather in the service of their own religious beliefs....This is not to say that I endorse these beliefs or share them myself; but neither do I endorse the prospect that we, as gay scholars and activists, should interefere with people's choices." [1]

Out of respect for personal autonomy, Haldeman grants that the client with strong religious convictions therefore has the right to pursue change:

> "A corollary issue for many is a sense of religious or spiritual identity that is sometimes as deeply felt as is sexual orientation. For some it is easier, and less emotionally disruptive, to contemplate changing sexual orientation, than to disengage from a religious way of life that is seen as completely central to the individual's sense of self and purpose." [2]

Therefore, Dr. Haldeman says, such therapy is not necessarily harmful or unethical:

> "There appear to be many dissatisfied homosexually-oriented individuals who seek psychological guidance or spiritual intervention to achieve a goal they identify as a change in sexual orientation... some...particularly those who have experienced less invasive styles of conversion therapy, seem not to have been affected adversely."

LeVay Agrees with Haldeman

Likewise, the same qualified support for reorientation therapy comes from noted researcher Simon LeVay. LeVay garnered worldwide attention about ten years ago with a study that found a difference between the brains of a small group of homosexual men, most of whom had died of AIDS, and heterosexual men who had died of other causes. Although LeVay's study has not been replicated, it is said to offer evidence suggesting that for an unknown percentage of homosexual men, a disruptive prenatal hormonal event could have feminized a portion of the brain called the hypothalamus.

LeVay observes that the concept of psychological normality is a value judgment, ultimately outside the realm of science. *Science cannot tell us* what constitutes "core identity," LeVay says—that is, whether a person can legititmately claim that "homosexual is *who I am*."

Biological Error — Or Normal Variant?

LeVay's statement followed his expressed concern that the prenatal hormonal influences that may predispose some people to homosexuality could be viewed as a "biological error." And if those prenatal influences are biological errors, then a homosexual orientation could, following the same reasoning, be conceptualized as a developmental disorder.

But that conclusion need not follow from the evidence, he says. Because the issue of sexual identity is a philosophical rather than narrowly *scientific* matter, LeVay says, people who believe gay is "who they are" are free to consider their sexuality a normal variant. Similarly, people who choose sexual-reorientation therapy should have the right to choose change—even though he himself considers their choice to be misguided. As LeVay explains it:

> "First, science itself cannot render judgments about human worth or about what constitutes normality or disease. These are value judgments that individuals must make for themselves, while possibly taking scientific findings into account.
>
> "Second, I believe that we should as far as possible, respect people's personal autonomy, even if that includes what I would call misguided desires such as the desire to change one's sexual orientation. [3]

Endnotes

[1] From a paper presented by Douglas Haldeman at a symposium entitled "Gays, Ex-Gays, ***Ex***-Ex-Gays—Examining Key Religious, Ethical, and Diversity Issues," American Psychological Association Annual Meeting, August 7th, 2000, Washington, D.C.

[2] Ibid.

[3] From "Sexual Orientation: The Science and its Social Impact," by S. LeVay, to be published in *Reverso*, a gay and lesbian studies journal in Spain. NIH website. (http://members.aol.com/_ht_a/slevay/page12.html)

Despite gay and feminist efforts to deconstruct them...

Gender Differences Are Real

By Frank York

It's time to root out the imposition of gendered behavior stereotypes from all aspects of our lives. Ending gender oppression means encouraging our children to experiment with alternative gender expressions...

> – Nancy Nangeroni, a transsexual activist quoted in *Transgender Warriors*

It is fundamental that individuals have the right to define, and to redefine as their lives unfold, their own gender identity, without regard to chromosomal sex, genitalia, assigned birth sex, or initial gender role.

> – From *The International Bill of Gender Rights*, approved by the International Conference on Transgender Law and Employment Policy, 1993

Are men and women different? They're different anatomically, of course, but are they different in any other ways? Do their hormonal differences influence their behaviors and attitudes? Do they process information differently?

Feminists and gay theorists often say "no" to these questions. They maintain that the differences between men and women are mostly the result of socialization in male-dominated societies, and that it is patriarchal oppression that has relegated women to feminine gender roles. Biology is said to have little to do with abilities or sex roles in our society.

Some feminist writers actually believe that the idea of "two sexes" (male and female) is a myth. Dr. Anne Fausto-Sterling, writing in "The Five Sexes: Why Male and Female Are Not Enough," says that western culture is defying nature by maintaining a "two-party sexual system," for "biologically speaking, there are many gradations running from female to male; and depending on how one calls the shots, one can argue that along the spectrum lie at least five sexes—and perhaps even more." (1)

Not content with denying the reality of two sexes, a subgroup within the gay rights movement—the "transgendered"—is attempting to normalize crossdressing and transsexualism (where the person has a sex change from male to female, or female to male). Some of these transsexuals actually prefer to live as "she-males" – having the physical characteristics of both men and women.

The effort to erase gender distinctions and redefine deviant behavior as "normal" is evident in the efforts of transgender activists to remove "Transvestic Fetishism and Gender Identity Disorder" from the *Diagnostic and Statistical Manual, Fourth Edition,* (DSM-IV). If transvestites are successful in removing this disorder from the diagnostic manual, they may well prevail in arguing that because their behaviors are psychiatrically "normal," their condition should be affirmed and protected by society.

Efforts to that effect are already well underway. In 1996, for example, Katherine Wilson with the Gender Identity Center of Colorado, presented a paper, "Myth, Stereotype, and Cross-Gender Identity in the DSM-IV," to the Association for Woman in Psychology, a feminist psychologist group. According to Wilson:

> "The pathologicalization of transgendered people in the DSM-IV raises substantive questions of consistency, validity, and fairness and serves to enforce notions of essential gender role that denigrates all too many human beings." (2)

In effect, Wilson is saying that cross-dressing and transvestism are simply another normal sexual-identity variant.

Sexual Mythology Versus Scientific Facts

Professor Steven Goldberg, Chairman of the Department of Sociology at City College of New York, has written a book with the provocative title, *Why Men Rule—A Theory of Male Dominance*. In the book, he debunks much of the feminist mythology surrounding the issue of differences between males and females.

Goldberg maintains that although males and females are different in their genetic and hormonally-driven behavior, this does not mean that one sex is superior or inferior to another. Each gender has different strengths and weaknesses. However, he believes the neuro-endocrinological evidence is clear: The high level of testosterone in males drives them toward dominance in the world, while the lack of high levels of this hormone in women creates a natural, biological push in the direction of less dominant and more nurturing roles in society.

Goldberg writes:

> "There is not, nor has there ever been, any society that even remotely failed to associ-

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ate authority and leadership in suprafamilial areas with the male. There are no borderline cases." (3)

Feminist theorists maintain that socialization is a primary reason why males have dominated the world's cultures, but Goldberg counters:

> "...if socialization alone explains why societies are patriarchal, there should be any number of societies in which leadership and authority are associated with women, and one should not have to invoke examples of non-patriarchal societies that exist only in myth and literature." (4)

Biological Differences

To say that men and women are the "same" is to deny physical reality. Child psychologist Dr. James Dobson relates a humorous story about men and women in his best-seller, *Straight Talk to Men and Their Wives.* Several years ago a drug company conducted an experiment with all of the women in a small fishing village in South America. The women were all given an experimental birth control pill. They were given the same pill on the same date, and the prescription was terminated after three weeks to permit menstruation.

"That meant, of course," he says, "that every adult female in the community was experiencing premenstrual tension at the same time. The men couldn't take it. They all headed for their boats each month and remained at sea until the crisis had passed at home. They knew, even if some people didn't, that females are different from males . . . especially every twenty-eight days." (5)

Science makes plain that males and females are different from the moment of conception. As Amram Scheinfeld notes in *Your Heredity and Environment,* these differences between men and women are evident in the chromosomes which carry inherited traits from the father and mother. Humans have 23 pairs of chromosomes within each cell; twenty-two of these are alike in both males and females. But, says Scheinfeld, "...when we come to the twenty-third pair, the sexes are not the same. . . every woman has in her cells two of what we call the X chromosome. But a man has just one X-—its mate being the much smaller Y."

It is the presence of this influential Y chromosome, says Scheinfeld, "that sets the machinery of sex development in motion and results in all the genetic differences that there are between a man and a woman." (6) Right down to the cellular level, males and females are different.

Sex differentiation takes place immediately as the male or female begins to develop within the womb. The sex hormones—primarily estrogen and testosterone—have a significant impact on the behavior of males and females. Why do boys typically like to play with trucks and girls like to play with dolls? Feminists usually claim this is the result of socialization, but there is growing scientific evidence that boys and girls are greatly influenced by their respective hormones.

Hormones Trigger Aggression or Nurture

In an ABC special, "Boys and Girls are Different," television host John Stossel described several studies conducted by universities on what appear to be innate differences between males and females. He explained the following:

At the University of Wisconsin, researchers injected testosterone into unborn female monkeys. Monkeys engage in very sex-stereotyped behavior, according to Stossel; the males are aggressive and fight, while the female monkeys typically groom and nurture the young. When the testosterone-injected females were born, they didn't groom or nurture their children. They fought and behaved like males.

In one out of 100,000 pregnancies, a genetic defect causes human female babies to be exposed to a bath of the male hormone androgen. These are CAH girls—short for a condition called congenital adrenal hyperplasia. These children are born female, but they behave like "tomboys." The male androgen influences their behaviors and desires. These girls typically play with "boy" toys more than their female counterparts.

Child psychologist Michael Lewis conducted an experiment with one-year-old boys and girls to see how they would react to being separated from their mother by a barrier. The boys tried to knock the barrier down while the girls stood passively, crying for help. (7)

Brain Differences

Males and females are not only markedly different in the hormones that drive them, but they are also different in the way they think. The brains of men and women are actually wired differently.

George Mason University professor Robert Nadeau, the author of *S/he Brain: Science, Sexual Politics, and the Feminist Movement,* describes significant differences between male and female brains. In an essay on this subject in *The World & I,* (November 1, 1997), Nadeau observes:

> "The human brain, like the human body, is sexed, and differences in the sex-specific human brain condition a wide range of behaviors that we typically associate with maleness or femaleness." (8)

Nadeau says that the sex-specific differences in the brain are located both in the primitive regions, and in the neocor-

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tex—the higher brain regions. The neocortex contains 70 percent of the neurons in the central nervous system, and it is divided into two hemispheres joined by a 200-million fiber network called the *corpus callosum*.

The left hemisphere controls language analysis and expression and body movements while the right hemisphere is responsible for spatial relationships, facial expressions, emotional stimuli, and vocal intonations.

Men and women process information differently because of differences in a portion of the brain called the splenium, which is much larger in women than in men, and has more brain-wave activity. (9) Studies have shown that problem-solving tasks in female brains are handled by both hemispheres, while the male brain only uses one hemisphere.

Differences in the ways men and women communicate is also a function of sex-specific areas of the brain. Women seem to have an enhanced awareness of "emotionally relevant details, visual cues, verbal nuances, and hidden meanings," writes Nadeau. Similarly, while male infants are more interested in objects than in people, female infants respond more readily to the human voice than do male infants.

Different Brains: Different Abilities

The difference between the male and female brain is not evidence of superiority or inferiority, but of specialization. Michael Levin, writing in *Feminism and Freedom*, notes that, in general, males have better spatial and math skills than females. While feminists often claim that these differences are due to social expectations—and if girls were encouraged to be mathematicians, they would have the same ability as boys—there is evidence that these differences are inherited and appear in childhood, actually increasing during puberty. On the other hand, girls tend to be more vocal than boys, are better at hearing higher frequencies, and do better than boys in reading and vocabulary tests.

Males have a vastly superior ability to visualize a three-dimensional object than do women. This gives the male his often-observed superior abilities in math and geometrical reasoning. In addition, males are better skilled in gross motor movements than are girls. (10)

Strength and Endurance

Not only are men and women fundamentally different in the way their brains are wired, they are also vastly different in physical strength and endurance. The differences are rooted within both the genes and the hormones of males and females. Michael Levin notes that women only have 55-58 percent of the upper body strength of men and on average, are only 80 percent as strong as a man of identical weight. Sex differences also appear by the age of three in the ability of males and females to throw a ball far and accurately. (11)

Feminist leaders naively believe that physical differences between males and females should not be taken into consideration when hiring women to become policemen, firemen, or combat soldiers. Yet as Levin points out, females simply do not have the strength or endurance necessary to be effective combat soldiers. Yet in order to accommodate women who desire to be combat soldiers, the military has designed less stressful physical exercises and standards which would allow them to participate in roles for which they have sought inclusion.

Facing Reality

Contrary to the wishful thinking of feminists, bisexuals, and transsexuals, there are profound differences between males and females—and those differences are programmed within the DNA from the moment of conception. The brains of females and males are clearly "sexed," and testosterone and estrogen are the juices that augment maleness and femaleness.

To be sure, gender-distorting prenatal abnormalities do affect some individuals, and may increase the likelihood that such an afflicted person will later self-identify as transgendered or transsexual (and in some cases, homosexual).

But barring such unfortunate developmental errors—which we should not normalize as if they were *not* disruptions in normal growth and development—the simple truth remains: *maleness and femaleness are innate and integral parts of our human design.* ■

Endnotes

1. Leslie Feinberg, *Transgender Warriors*, Beacon Press: Boston, Massachusetts, 1996, p. 103.
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3. Steven Goldberg, *The Inevitability of Patriarchy*, Open Court, Peru, Illinois, 1993, p. 15.
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5. James Dobson, *Straight Talk to Men and Their Wives*, Word Publishing, Dallas, Texas, 1991, p. 181.
6. Amram Scheinfeld, *Your Heredity and Environment*, J. B. Lippincott, New York, 1965, p. 43.
7. John Stossel, "Boys & Girls Are Different: Men, Women, and the Sex Difference," ABC News Special, January 17, 1998, tran script from the Internet, The Electric Library.
8. Robert Nadeau, "Brain Sex and the Language of Love," *The World & I*, Nov. 1, 1997, p. 330.
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11. Ibid., p. 210.

Homosexuality and Mental Health Problems

By N.E.Whitehead, Ph.D.
(Author of "My Genes Made Me Do It")

Summary: *Recent studies show homosexuals have a substantially greater risk of suffering from a psychiatric problems than do heterosexuals. We see higher rates of suicide, depression, bulimia, antisocial personality disorder, and substance abuse. This paper highlights some new and significant considerations that reflect on the question of those mental illnesses and on their possible sources.*

The American Psychiatric Association removed homosexuality from its diagnostic list of mental disorders in 1973, despite substantial protest (see Socarides, 1995). The A.P.A. was strongly motivated by the desire to reduce the effects of social oppression. However, one effect of the A.P.A.'s action was to add psychiatric authority to gay activists' insistence that homosexuals as a group are as healthy as heterosexuals. This has discouraged publication of research that suggests there may, in fact, be psychiatric problems associated with homosexuality.

In a review of the literature, Gonsiorek (1982) argued there was no data showing mental differences between gays and straights—or if there was any, it could be attributed to social stigma. Similarly, Ross (1988) in a cross-cultural study, found most gays were in the normal psychological range. However some papers did give hints of psychiatric differences between homosexuals and heterosexuals. One study (Riess, 1980) used the MMPI, that venerable and well-validated psychological scale, and found that homosexuals showed definite "personal and emotional oversensitivity."

In 1991 the absolute equality of homosexuality and heterosexuality was strongly defended in a paper called "The Empirical Basis for the Demise of the Mental Illness Model" (Gonsiorek, 1991). But not until 1992 was homosexuality dropped from the psychiatric manual used by other nations—the International Classification of Diseases (King and Bartlett, 1999)—so it appears the rest of the world doubted the APA 1973 decision for nearly two decades.

Is homosexuality as healthy as heterosexuality? To answer that question, what is needed are representative samples of homosexual people which study their mental health, unlike the volunteer samples which have, in the past, selected out any disturbed or gender-atypical subjects (such as in the well-known study by Evelyn Hooker). And fortunately, such representative surveys have lately become available.

New Studies Suggest Higher Level of Pathology

One important and carefully conducted study found suicide attempts among homosexuals were six times greater than the average (Remafedi et al. 1998).

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Then, more recently, in the *Archives of General Psychiatry*—an established and well-respected journal—three papers appeared with extensive accompanying commentary (Fergusson et al. 1999, Herrell et al. 1999, Sandfort et al. 2001, and e.g. Bailey 1999). J. Michael Bailey included a commentary on the above research; Bailey, it should be noted, conducted many of 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, conduct disorder, and nicotine dependence...The strength of the new studies is their degree of control."

The first study was on male twins who had served in Vietnam (Herrell et al. 1999). It concluded that on average, male homosexuals were 5.1 times more likely to exhibit suicide-related behavior or thoughts than their heterosexual counterparts. Some of this factor of 5.1 was associated with depression and substance abuse, which might or might not be related to the homosexuality. (When these two problems were factored out, the factor of 5 decreased to 2.5; still somewhat significant.) The authors believed there was an independent factor related to suicidality which was probably closely associated with some features of homosexuality itself.

The second study (Fergusson et al. 1999) followed a large New Zealand group from birth to their early twenties. The "birth cohort" method of subject selection is especially reliable and free from most of the biases which bedevil surveys. This study showed a significantly higher occurrence of depression, anxiety disorder, conduct disorder, substance abuse and thoughts about suicide, amongst those who were homosexually active.

The third paper was a Netherlands study (Sandfort et al. 2001) which again showed a higher level of mental-health problems among homosexuals, but remarkably, subjects with HIV infection was not any more likely than those

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without HIV infection to suffer from mental health problems. People who are HIV-positive should at least be expected to be anxious or depressed! The paper thus concluded that HIV infection is not a cause of mental health problems—but that *stigmatization from society* was likely the cause—even in the Netherlands, where alternative lifestyles are more widely accepted than in most other countries. That interpretation of the data is quite unconvincing.

The commentaries on those studies brought up three interesting issues.

1. First, there is now clear evidence that mental health problems are indeed associated with homosexuality. This supports those who opposed the APA actions in 1973. However, the present papers do not answer the question; is homosexuality *itself* pathological?

2. The papers do show that since *only a minority* of a non-clinical sample of homosexuals has any diagnosable mental problems (at least by present diagnostic criteria), then most homosexuals are not mentally ill.

In New Zealand, for example, lesbians are about twice as likely to have sought help for mental problems as heterosexual women, but only about 35% of them over their lifespan did so, and never more than 50% (Anon 1995, Saphira and Glover, 2000, Welch et al. 2000) This corresponds with similar findings from the U.S.

Relationship Breakups Motivate Most Suicide Attempts

Next, we ask—do the papers show that it is gay lifestyle factors, or society's stigmatization, that are the motivators that lead a person to attempt suicide? Neither conclusion is inevitable. Still, Saghir and Robins (1978) examined reasons for suicide attempts among homosexuals and found that if the reasons for the attempt were connected with homosexuality, about 2/3 were due to breakups of relationships—not outside pressures from society.

Similarly, Bell and Weinberg (1981) also found the major reason for suicide attempts was the breakup of relationships. In second place, they said, was the inability to accept oneself. Since homosexuals have greater numbers of partners and breakups, compared with heterosexuals, and since longterm gay male relationships are rarely monagamous, it is hardly surprising if suicide attempts are proportionally greater. The median number of partners for homosexuals is four times higher than for heterosexuals (Whitehead and Whitehead 1999, calculated from Laumann et al 1994).

A good general rule of thumb is that suicide attempts are about three times higher for homosexuals. Could there be a connection between those two percentages?
Another factor in suicide attempts would be the compulsive or addictive elements in homosexuality (Pincu, 1989) which could lead to feelings of depression when the lifestyle is out of control (Seligman 1975). There are some, (estimates vary, but perhaps as many as 50% of young men today), who do not take consistent precautions against HIV (Valleroy et al., 2001) and who have considerable problems with sexual addiction and substance abuse addiction, and this of course would feed into suicide attempts.

The Effect of Social Stigma

Third, does pressure from society lead to mental health problems? Less, I believe, than one might imagine. The authors of the study done in The Netherlands were surprised to find so much mental illness in homosexual people in a country where tolerance of homosexuality is greater than in almost all other countries.

Another good comparison country is New Zealand, which is much more tolerant of homosexuality than is the United States. Legislation giving the movement special legal rights is powerful, consistently enforced throughout the country, and virtually never challenged. Despite this broad level of social tolerance, suicide attempts were common in a New Zealand study and occurred at about the same rate as in the U.S.

In his cross-cultural comparison of mental health in the Netherlands, Denmark and the U.S., Ross (1988) could find no significant differences between countries – i.e. the greater social hostility in the United States did not result in a higher level of psychiatric problems.

There are three other issues not covered in the *Archives* journal articles which are worthy of consideration. The first two involve DSM category diagnoses.

Promiscuity and Antisocial Personality

The promiscuous person—either heterosexual or homosexual—may in fact be more likely to be antisocial. It is worth noting here the comment of Rotello (1997), who is himself openly gay: "...the outlaw aspect of gay sexual culture, its transgressiveness, is seen by many men as one of its greatest attributes."

Ellis et al. (1995) examined patients at an clinic which focused on genital and urological problems such as STD's; he found 38% of the homosexual men seeking such services had antisocial personality disorder, as well as 28% of heterosexual men. Both levels were enormously higher than the 2% rate of antisocial personality disorder for the general population (which in turn, compares to the 50% rate for prison inmates) (Matthews 1997).

Perhaps the finding of a higher level of conduct disorder in the New Zealand study foreshadowed this finding of antisocial personality . Therapists, of course, are not very likely

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to see a large number of individuals who are antisocial because they are probably less likely to seek help.

Secondly, it was previously noted that 43% of a bulimic sample of men were homosexual or bisexual (Carlat et al. 1997), a rate about 15 times higher than the rate in the population in general—meaning homosexual men are probably disproportionately liable to this mental condition. This may be due to the very strong preoccupation with appearance and physique frequently found among male homosexuals.

Ideology of Sexual Liberation

A strong case can be made that the male homosexual lifestyle itself, in its most extreme form, is mentally disturbed. Remember that Rotello, a gay advocate, notes that "the outlaw aspect of gay sexual culture, its transgressiveness, is seen by many men as one of its greatest attributes." Same-sex eroticism becomes for many, therefore, the central value of existence, and nothing else—not even life and health itself—is allowed to interfere with pursuit of this lifestyle. Homosexual promiscuity fuels the AIDS crisis in the West, but even that tragedy it is not allowed to interfere with sexual freedom.

And, according to Rotello, the idea of taking responsibility to avoid infecting others with the HIV virus is completely foreign to many groups trying to counter AIDS. The idea of protecting *oneself* is promoted, but protecting *others* is not mentioned in most official condom promotions (France in the '80s was an interesting exception). Bluntly, then, core gay behavior is both potentially fatal to others, and often suicidal.

Surely it should be considered "mentally disturbed" to risk losing one's life for sexual liberation. This is surely among the most extreme risks practiced by any significant fraction of society. I have not found a higher risk of death accepted by any similar-sized population.

In conclusion, then, if we ask the question "Is mental illness inherent in the homosexual condition?" the answer would have to be "Further research—uncompromised by politics—should be carried out to honestly evaluate this issue."

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experience of only those who have not been helped gives an incomplete and therefore inaccurate picture of the potential for alteration of human sexual identity."

Dr. Throckmorton's article summarizes the experiences of thousands of individuals who believe their sexuality has changed as a result of reorientation ministries and counseling.

His article is a continuation of a paper presented at the American Psychological Association conference, Washington, DC, in August 2000 in a standing-room-only symposium, entitled "Gays, Ex-Gays and Ex-Ex Gays—Examining Key Religious Ethical and Diversity Issues." The article adds additional current research and recommendations for mental health professionals.

The final recommendation in Throckmorton's paper is that "Practitioners should not refuse service to clients who pursue an ex-gay course, but rather, should respect the diversity of choice and consider a referral to an ex-gay ministry or practitioner."

In addition to serving as Grove City College's director of college counseling, Dr. Throckmorton is an associate professor of psychology at the college. A past president of the American Mental Health Counselor's Association, he also holds membership on the Magellan Behavioral Healthcare's National Provider Advisory Board representing licensed professional counselors.

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Other papers on sexual-reorientation therapy published in the same APA journal issue (some in opposition) are:

1. "An Inclusive Response to LGB and Conservative Religious Persons: The Case of Same-Sex Attraction and Behavior" *by Mark A. Yarhouse and Lori A. Burkett*

2. "Changing Sexual Orientation: A Consumers' Report" *by Ariel Shidlo and Michael Schroeder*

3. "Gay Rights, Patient Rights: The Implications of Sexual Orientation Conversion Therapy" *by Douglas C. Haldeman*

4. "Implementing the Resolution on Appropriate Therapeutic Responses to Sexual Orientation: A Guide for the Perplexed" *by Margaret S. Schneider, Laura S. Brown, and Judith M. Glassgold* ■