NARTH BULLETIN

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IN THIS ISSUE

Spitzer Study Results to be Announced at Psychiatric Association Meeting

Dr. Robert Spitzer has been conducting a study of individuals who report a substantial change in sexual orientation which has lasted five or more years.

He will report the results in a panel discussion at the American Psychiatric Association Convention in New Orleans on Wednesday, May 9th from 2-5 p.m, in Room 267-268 on level 2 of the convention center.

The five-panelist discussion will also include Mark Yarhouse, Psy.D. and is entitled, "Clinical Issues and Ethical Concerns Regarding Attempts to Change Sexual Orientation."

NARTH members are encouraged to attend.

New Study Confirms Higher Level of Psychiatric Disorders Among Men and Women Engaging in Same-Sex Behavior

Two recent studies published in the *Archives of General Psychiatry* found higher rates of psychiatric disorders among homosexually oriented men and women than among the heterosexual population (Herrell 1999 & Fergusson 1999). Those articles mentioned that a third study, not yet published, had confirmed their findings.

That third study (Sandfort et al.) is now available. The Sandfort research is particularly significant because it surveyed a large sample of the Dutch population (about 7,000 individuals), avoiding convenience samples and the potential for bias that such samples can introduce. Of those individuals surveyed, 2.8% of the men and 1.4% of the women were classified as homosexual.

"The findings," says the authors, "support the assumption that people with same-sex sexual behavior are at greater risk for psychiatric disorders."

The lifetime prevalence of one or more Diagnostic Manual (DSM-III) disorders among gay men was found to be 56.1%, versus 41.4% among men who do not engage in such behavior. The rate for two or more DSM II disorders is 37.8% (versus 14.4%).

For women engaging in same-sex behavior, the rate for one or more DSM III disorders is 67.4% (versus 39.1%) and for two or more disorders 39.5% (versus 21.3%).

Differentiating the homosexual population by gender, there was a higher prevelance of substance-abuse disorders among lesbians, and a higher prevalence of mood and anxiety disorders among gay men. Both groups exceeded the incidence of those problems in the heterosexual population.

Significantly, the study sampled residents of the Netherlands, where social acceptance of same-sex behavior is high. This would call into question the assumption that the disproportionate rate of psychiatric problems is

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Does "Born That Way" Mean "Designed That Way"?

When a person says that only heterosexuality is normal—and that all other forms of sexuality are *abnormal* variants—-he is often dismissed with the statement, "Wrong—gays are born that way."

The "born that way" argument has now been widely refuted as false, and the current scientific consensus is that biological, family and social factors work together to set the stage for homosexuality.

But to understand the ultimate significance of what biological research there is, an important distinction should be remembered: that between the concepts of "born that way" and "designed that way."

Temperament and Prenatal Influences

We continue to see a small but steady stream of research studies linking homosexuality with various biological factors. Even though researchers do not claim these factors *predetermine* homosexuality, such factors cannot simply be dismissed as utterly irrelevant to causation. (For a comprehensive review of this question, see "What Causes Homosexuality? Biological Theories," in *Homosexuality: The Use of Scientific Research in the Church's Moral Debate,* by Stanton Jones and Mark Yarhouse.)

Reports in the clinical literature continue to link male homosexuality to a sensitive temperament. Those writers theorize that a sensitive, passive nature (along with a lack of athletic ability) set a boy apart from his peers. When combined with the classic "distant father, over-involved mother" family dynamic, the stage is set for the boy to eroticize–rather than internalize–his natural longing for masculinity.

And in some cases, research also suggests another scenario: the influence of prenatal hormones in abnormally masculinizing or feminizing some developing fetuses. When a pregnant woman is exposed to certain environmental pollutants which have a hormone-like effect on the body, physician John R. Lee explains, they may blur sex differences in her developing fetus. The resulting gender distortions could affect the child's sense of himself or herself as male or female, which could account for some of the biological "push" toward homosexuality.

Yet although we recognize that such individuals were "born that way" (in the sense of being biologically influenced toward a certain identity and behavior), it would not follow that they were in fact designed that way. *Such a condition would represent a biological error.*

Recently, an article in the prominent journal *Psychological Bulletin* recently linked both male and female homosexuality to a higher-than-normal incidence of left-handedness (1). The authors noted that both left-handedness and some forms of homosexuality may originate from prenatal "**biological developmental errors.**"

In theorizing that homosexuality would, in such cases, also be an "error," the authors explain that left-handedness has also been linked with a higher number of spontaneous abortions, lower birth weight, higher rate of serious accident and serious disorders, and a shorter life span. Left-handedness has similarly been linked to neural tube defects, autism, stuttering, and schizophrenia.

A second study—this one in *Archives of General Psychiatry*—found significantly higher levels of pathology in the gay population than among heterosexuals (2). One hypothesis for the finding of higher levels of emotional disturbance—offered by prominent gay twin-study researcher J.M. Bailey—was that homosexuality may represent a developmental error.

Developmental Errors and Genetic Misfortunes Are Common

Many people are born with genetic predispositions that we clearly recognize as problems. An alcoholism gene—an obesity gene—and a gene for shyness, violence, hyperactivity, or short temper are recognized as setting the stage for a lifetime of challenges. The same would be true of a

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THE NARTH BULLETIN

Editor: LINDA AMES NICOLOSI

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"Victory on the Bow of a Ship"

More Balance Needed in the Journal of Marital and Family Therapy

by Mina O'Connell, M.A., M.S.
Licensed Mental Health Practitioner, Certified Marriage and Family Therapist

Over the past decade, Student, Associate and Clinical Membership in the American Association for Marriage and Family Therapy (AAMFT) has created a valuable pathway for my growth and development in the practice of marriage and family therapy. Research and publications seemed value-neutral and respectful of the wide range of views held by the many members of the association.

Mina O'Connell, M.A., M.S.

However, the October 2000 issue of the *Journal of Marital & Family Therapy* took a distinctly different approach with a special section entitled "Gay, Lesbian, and Bisexual Issues in Family Therapy." This collection of writings by nine authors, who were invited by a homosexual guest editor from the editorial board, provided "Perspectives for the Contemporary Therapist." Those perspectives labeled our culture "homophobic and heterosexist," warning of "the threat of anti-gay/lesbian violence."

The guest editor regretted the lack of articles in the AAMFT literature addressing the gay civil rights movement over the past twenty years, and decried the "so-called 'Defense of Marriage Acts'" which define marriage as between one man and one woman. He stated, "We still have a long way to go...."

Other authors provided anecdotal case studies of therapy sessions. In one disturbing account, a 13-year-old oppositional girl spoke of wanting to marry and have children. The consultant asked, "But I'm curious, what would happen if in fact you fell in love with another woman and not a man?" "The girl confirmed, 'Then I'd be gay.'" Eventually, the girl learned about lesbianism from the consultant.

In my first semester of training, I learned therapists do not lead clients. Yet this young, oppositional teenager had been introduced to lesbianism in therapy, and soon after, defined herself as gay. This author claimed that 10%-12% of youth are gay, so "homophobia and heterosexism" within families and among teachers and health care providers contribute to poor self-esteem and suicidality.

Another writer described a session with a 6-year-old boy and his parents. The child's affectionate play at recess, hugging another little boy while trying to kiss his cheek, caused concern in the parents, who wondered if he were transsexual. This child came to the family through adoption when he was one year old; therefore, he would have had primary attachment deficits to overcome. But the story of his therapy sexualized the child's needs and motives and discounted his parents' "fear of recruiting young people into the gay lifestyle" as a stereotype. The therapist sought to educate the family about successful gay and lesbian persons, with the goal that "heterosexism and homophobia" would be countered.

After reading this heavily biased material, I was discouraged that my professional association would publish such a collection of articles, allowing name-calling of those with traditional moral values. Many clinicians, in fact, still treat homosexuality based upon the body of research on sexual disorders (such as Bieber's) which has never been disproven.

My prior training through the AAMFT generally emphasized respect for clients' and therapists' values. I immediately called the editor and discussed the biased nature of the issue. She responded that this was clinical research which had passed the editorial board's review, and then she added that I was the only person who had disapproved within the AAMFT's broad readership, which extends to Canada, South America and overseas.

After collaboration with Dr. Nicolosi at NARTH, I gathered ten other clinicians from the U.S. and South America and we sent letters to the editor asking for a special section, equal in length to the prior one, publishing the exciting new research regarding the effectiveness of change therapy for homosexuals. We stated that such knowledge is necessary for professional competence in working with this population. We also sent her additional research, along with the Michael Johnston videotape, "It's Not Gay."

The journal's editor, Karen Wampler, replied,

> "A review of the videotape you sent as well as the two reprints of articles published in *Psychological Reports* and the five fact sheets from the National Association for Research and Therapy of Homosexuality that you enclosed with your letter did not provide any evidence that would change my mind....
>
> "I take responsibility for my decision to not publish the special section you requested....I invite you to direct your concerns directly to the Board of Directors of AAMFT."

Dr. Wampler sent copies of her response to me to the Board of Directors, including James Morris, President of AAMFT, Michael Bowers, Executive Director of AAMFT, Froma

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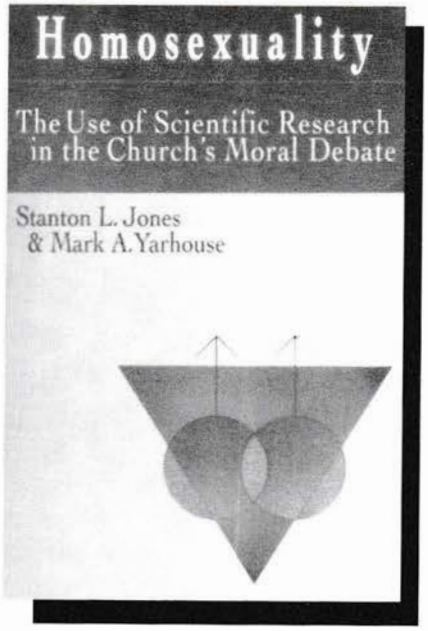
What Does Science Tell Us About Homosexuality?

***Book Review — Homosexuality: The Use of Scientific Research in the Church's Moral Debate**, by Stanton Jones, Ph.D. and Mark Yarhouse, Psy.D.*

This new book by Stanton Jones, Ph.D., provost of Wheaton College and Mark Yarhouse, Psy.D. of Regent University makes a most important contribution to the literature for a number of reasons. First, the book is accessible, because of its low price ($12.99) and relatively clear style, which is suitable for the educated layman.

Second, the book covers the basic (and much misunderstood) scientific issues fairly and very even-handedly. The authors summarize their conclusions about the data in a cautious and measured manner which any social scientist would be hard pressed to criticize.



Jones and Yarhouse wrote the book out of concern for a growing problem. In the theological debates about homosexuality, "new discoveries by science" are repeatedly cited as grounds for revising centuries-old standards for sexual behavior. "Too many individuals have glibly concluded," the authors say, "that contemporary science research makes 'old fashioned' Christian morality obsolete."

But the traditional moral stance cannot be dismissed so easily, they explain. Rather than relying on simplistic sound-bite science that attempts to "batter the church into submission to the views of the world," theologians must be prepared to engage in "much harder logical and ethical thinking" about the difficult ethical issues now confronting them.

First, theologians must understand that psychology's contemporary view of psychological health is not value-free, but has been fashioned out of the profession's own vision of what constitutes the "good life." Second, they must realize that the simplistic science that has been popularized by the media omits the nuances that are essential to provide an accurate view of the homosexual condition.

To flesh out some of those nuances, their chapter, "What Causes Homosexuality?" carefully reviews the many factors thought to contribute to homosexual causation.

An exceptionally useful section delves into the many biological theories, including the possibility of a gay gene, hormonal differences, the prenatal hormonal hypothesis, the influence of maternal stress during pregnancy, differences in brain structure (including LeVay's studies of the hypothalamus), and temperamental factors.

But even if homosexuality had been proven to be strictly genetic, they say, this would not be grounds *per se* for changing the biblical sexual ethic. Otherwise "the pedophile who desires sex with children, the alcoholic who desires the pursuit of drunkenness, and the person with Antisocial Personality Disorder who desires the thrill of victimization and pain affliction would all have equal case for moral approval." Clearly, moral deliberation cannot be concluded based on a condition's unchosenness.

Another chapter, "Is Homosexuality a Psychopathology?" answers those social critics who insist that science settled the question of the normality once and for all, in 1973.

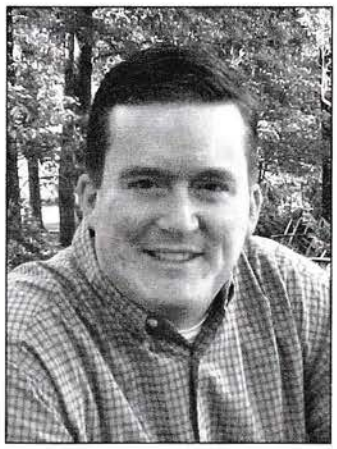
The authors also consider scientific evidence for the changeability of homosexuality, weighing that evidence and concluding with a guarded optimism for motivated clients who have not become heavily immersed in gay life. In the context of a biblical morality, Jones and Yarhouse believe those who fail to change their feelings and attractions are called to behavioral change ("the costly discipleship of chastity in singleness")—that can, even when same-sex attractions remain, still be freely chosen.

They close with a discussion of the orthodox Christian vision of sexuality, which does not focus on self-actualization as secularists understand it, but on an ethic of obedience to scripture, loyalty to spouse, virtue (including the call to self-control and purity), and the understanding that the purpose of sexuality is not something we choose ourselves in response to our own felt desires. Instead, sexuality's purpose is seen as the creation and sustaining of "one-fleshedness" in a male-female married couple.

All in all, this short but informative book assures that both clergy and laity will possess accurate information with which to debate the scientific and ethical issues. ■

Reviewed by Linda A. Nicolosi

Stanton Jones, Ph.D.



Mark Yarhouse, Psy.D.

Interview with Stanton Jones and Mark Yarhouse

(Courtesy of InterVarsity Press)

How did you come to write this book?

We (Stan and Mark) have watched for years as the supposed "scientific evidence" has been used in the ethical/moral debates of the various Christian denominations over the divisive topic of homosexuality. The majority of the time, the "evidence" has been used against the traditional moral position that sees homosexual behavior as sin.

This book was conceived as a way to explain the scientific evidence to pastors and educated Christian laypersons so that they could be better informed about two major areas: first, what the scientific evidence really says, and second the real bearing of this scientific evidence on the ethical/moral debate about homosexuality.

Why did you decide to focus on this particular topic?

There were really three reasons for choosing to focus on homosexuality. First, as scientists, we were deeply disturbed by the way that the supposed "findings of science" were being used in this ethical conflict within the church.

"Science" is seen as having more relevance to what the church should believe ethically and pastorally about homosexuality than about any other topic that is currently being debated in the church.

Second, as evangelical Christians, it seemed to us that homosexuality is the area where more pressure is being put on the church to depart from the explicit moral teachings of scripture than any other area.

Third, we have also been concerned for the well-being of individuals who we know who struggle with homosexual orientation and who themselves receive very confusing messages from church and society about how they are to live their lives. Often, it is "science" that is given as the reason for advice that departs from the teachings of scripture.

How prevalent is homosexuality today?

The prevalence of homosexuality is widely estimated to be 10% or more of the general population. This estimate stems from a terrible misinterpretation of the badly biased Kinsey studies of the 1950s. Gay rights advocates have used this statistic to overestimate the prevalence of homosexuals in order to accentuate the significance of this sub-population as a political and socioeconomic force.

The best research is very clear, however, in suggesting a much lower prevalence, likely somewhere in the range of 1.5% - 3% of homosexual individuals in the general population.

What does scientific research actually show about homosexuality?

To answer this question would actually require that we summarize the entire book! Perhaps one of the most crucial questions that is being asked is the question of causation: "What causes homosexual orientation?" What we attempt to show in the book is that there is no simple or conclusive answer to this question at this stage in the evolution of science.

After a number of years when genetic causes have been celebrated and proclaimed as "THE cause," it now seems clear that genetic influences are weaker than has been suggested in recent years, and are probably only present for a subpopulation of homosexual individuals. It is possible that there are other biological influences at work for some people, including the possibility of prenatal hormones having some influence.

It is likely that familial, psychological, and experiential variables influence the development of homosexuality, though there is no conclusive evidence about how this happens.

In short, we do not have any conclusive answers to the question of what causes homosexuality. We do have a number of tantalizing clues that genetics, prenatal hormones, and early childhood environment and experiences, along with adult choice, can all be participants in the mix of causal factors. ■

Is Homosexuality a Mental Disorder?

The following excerpt of the new book (reviewed on p. 4) by Stanton Jones, Ph.D. and Mark Yarhouse, Psy.D. offers a careful reconsideration of a matter that was assumed to have been settled in 1973.

Gay advocates are quick to point out that "science says that homosexuality is normal and healthy." But as these authors explain, the matter is much more complex.

The short answer to the question, "Is homosexuality a psychopathology?" is no, if a person were to mean that the answer can be found by a quick look through the *Diagnostic and Statistical Manual of Mental Disorders; Fourth Edition* (DSM-IV) of the American Psychiatric Association. Homosexuality is not listed as a formal mental disorder in the DSM-IV, and hence it is not a "mental illness." But, as we will see in this chapter, answering the question, "Is homosexuality a psychopathology?" is much more complicated than simply checking a manual...

> "Lurking behind every definition of adaptiveness is a hidden, implicit model of wholeness and health."

A Review of the Scientific Literature

It is widely known that in 1974 the full membership of the American Psychiatric Association (APA) followed the 1973 recommendation of its board by voting to remove homosexuality as a pathological psychiatric condition *as such* (or "in itself") from the DSM, which is the official reference book for diagnosing mental disorders in America (and through much of the world).

The removal of homosexuality from the DSM was in response to a majority vote of the APA. The original APA vote was called at a time of significant social change and was taken with unconventional speed that circumvented normal channels for consideration of the issues because of explicit threats from gay rights groups to disrupt APA conventions and research.

However, it appears that in contrast to the results of the vote, the majority of the APA membership continued to view homosexuality as a pathology. A survey four years after the vote found that 69% of psychiatrists regarded homosexuality as a "pathological adaptation." A much more recent survey suggests that the majority of psychiatrists around the world continue to view same-sex behavior as signaling mental illness.

The removal of homosexuality from the DSM does not answer the thorny question of the morality of homosexual behavior, as we will discuss later. It also does not answer the question of whether or not homosexual orientation is "healthy." Removal of the diagnostic category from the DSM is not the same thing as an endorsement of homosexual orientation or lifestyle as healthy or wholesome, as the two surveys conducted since the APA vote would indicate. By analogy, a person can certainly be in a condition where he or she fails to manifest an identifiable physical disease, yet also fails to be an exemplar of health and fitness.

The removal of homosexuality from the DSM does not conclusively decide the issue of the pathological status of homosexuality. There is no absolute standard for judging normality or abnormality. Four empirical (or at least partially empirical) criteria are commonly used to define behavior patterns as abnormal:

- statistical infrequency
- personal distress
- maladaptiveness
- deviation from social norms

Before we look at the research in each of these areas, we want to discuss the limitations or challenges of the research in this area.

Methodological Challenges

Perhaps more than in any area we have examined so far, deciding the question of whether or not homosexuality is pathological hinges on making valid generalizations about homosexuals as a group. To make such generalizations validly, you must have good information about the entire group. The major challenge that comes up again and again in making generalizeable statements about homosexuality is the challenge of finding a *sample* of homosexual persons that is representative of *all* homosexual persons.

The first major study that challenged the view that homosexuality was intrinsically abnormal was the study by psychologist Evelyn Hooker, who administered psychological tests on a group of "healthy" homosexuals and compared those results with results from a group of heterosexuals. To the surprise of the mental health establishment, skilled psychologists, who were trained to make such diagnoses, could not distinguish the heterosexuals from the homosexuals on the basis of their test results alone. By their test findings alone, this group of homosexuals appeared to be no different and had no worse problems than the heterosexuals.

The prevailing wisdom at that time was that to be homosexual was to manifest obvious signs of pathology. Common wisdom dictated that the homosexuals should have obviously differed from the heterosexuals. Hooker's study challenged this commonplace assumption. In this study Hooker refuted the generalization that all homosexuals are manifestly disturbed. This study was the logical equivalent of refuting the judgment that "all women are intellectually inferior to men" by demonstrating that a select sample of intellectually gifted women performed as well as a sample of men on a math test.

But, as we mentioned above, Hooker's study is often interpreted as having accomplished much more. Remember the church document on human sexuality we cited earlier? It stated that researchers have been unable "to differentiate homosexual from heterosexual subjects, suggesting that there is no greater pathology or tendency toward psychological maladjustment among homosexuals than heterosexuals."

Research on maladaptiveness is inconclusive, primarily because of the lack of agreement in defining it.

Is this interpretation of Hooker's research accurate? No. We would argue that it is valid to say that the findings from Hooker's study demonstrated that *it is not the case that all homosexuals are manifestly disturbed.* But many popular reports suggest or give the impression that what Hooker's study has proven is that homosexuals are as emotionally healthy as heterosexuals, or that homosexuality per se is not psychopathological.

Logically and methodologically, her study neither proved that homosexuals are as emotionally healthy as heterosexuals, nor did it prove that homosexuality per se is not pathological...

We are still left with the question, "Is homosexuality abnormal?" To answer this question we will now review the research on each of the four criteria for defining pathology to further our understanding of whether homosexuality is abnormal.

Statistical Infrequency

We mentioned in the chapter on prevalence rates that a lifelong exclusive or near-exclusive homosexual orientation is not common. Perhaps 2% of the combined male and female population manifest this pattern. Compare this percentage to the estimated lifetime incidence rates of some other major psychopathological disorders. In comparison, the prevalence of homosexuality is much less frequent than such common disorders as phobias (14.3%) and alcohol abuse and dependence (13.8%), about as frequent as some disorders that are less common, as is the case with panic (1.6%) and schizophrenia (1.5%), and much more frequent than somatization disorders (0.1%).

In comparison to these prevalence rates, homosexuality is not so common as to be eliminated as a possible pathology on frequency alone. But even with a lower estimate of homosexuality than public perception might indicate, we have no absolute cutoff for judging pathologically by frequency or infrequency alone; there is no rule stating that a pattern cannot be judged a pathology if it is manifested by more than X% of the population.

Personal Distress

Psychopathology is often accompanied by personal distress as is the case with depressive disorders and sexual dysfunctions. However, personal distress is not a necessary aspect of psychopathology. Some problems that we all recognize as pathological are also characterized by patterns of denial and minimization of distress, as is the case with some experiences of alcoholism or drug addiction.

Think of the alcoholic who refuses treatment and adamantly claims to have his or her drinking under control. The alcoholic may not report personal distress, and some alcoholics will be able to manage their various responsibilities, at least for the time being, which is why some professionals refer to them as "functional alcoholics." Some disorders, such as Antisocial Personality Disorder, are actually characterized at a fundamental level by a failure to be distressed about the patterns of behavior one manifests.

With homosexuality the claim is often made that "there is no evidence of higher rates of emotional instability or psychiatric illness among homosexuals than among heterosexuals." This claim has been made so often that it has taken on the status of a truth that "everybody knows"; however, the factual basis for this assertion is debatable.

The two most frequently cited studies in support of this claim are the studies by Hooker and by Saghir and Robins. As we discussed earlier, the study conducted by Hooker proved that a select sample of homosexuals were no more distressed than (and could not be distinguished based on psychological testing from) a hetero-

continued

sexual sample. We also demonstrated that because of the nonrepresentativeness of her sample, she *did not in fact prove* the conclusion that Masters and his colleagues claim.

The Saghir and Robins study has the same limitations as Hooker's. Their sample was also selected to minimize or exclude psychopathology. The authors note that their subjects were recruited from "homophile organizations," and presumably there was some self-selection operating given the announced objective of the project as the study of emotionally stable homosexual persons. They explicitly set out to recruit healthy homosexuals. After volunteering, subjects were further screened and excluded on the basis of prior psychiatric hospitalization.

Interestingly, 14% of the male homosexual sample and 7% of the female homosexual sample were excluded from the study because of prior psychiatric hospitalizations, yet none of the heterosexuals who volunteered (the control group sample) were excluded on that basis.

The best estimate we can obtain of lifetime psychiatric hospitalization comes from Robins, Locke and Regier, who report a lifetime prevalence of diagnosable mental disorder for women of 30% and report that on an annual basis only 2.4% of those with a diagnosable disorder are hospitalized for a psychiatric disorder. If we double this estimate of hospitalization to be conservative in our estimate and to compensate for the higher psychiatric hospitalization rates for women, these findings would suggest that no more than 1.5% of the American female population is hospitalized for psychiatric reasons in their lifetime (30% x 5%). This is probably an overestimate because many of the psychopathologies included in the study by Robins et al. (e.g., phobias, generalized anxiety, dysthymia) infrequently result in hospitalization.

So while Saghir and Robins conclude that the homosexual population experiences no increased incidence of psychopathology, their study must be interpreted within the context of their having screened out previously hospitalized individuals that, if included, would suggest a hospitalization rate for homosexuals approximately 450% higher than the general population, which in turn would suggest a conclusion opposite of that stated.

Ironically, then, this study, which is touted as proving that homosexuals are just as healthy as a group as heterosexuals, actually provides evidence suggesting higher rates of psychiatric disorder among homosexuals.

A recent study provides similar evidence. Bradford and her colleagues reported findings from the "National Lesbian Health Care Survey." They minimized differences between homosexual and heterosexual women. The authors argued that the two groups were similar except for elevated use of alcohol and drugs and elevated use of counseling for lesbians (77.5% for the lesbian sample). But a closer look at their results tells a different tale. The data actually suggest that the lesbians studied experience elevated incidence of a number of significant problems.

The authors reported that 37% of the lesbians surveyed had experienced significant depression in their lifetime, that 11% were experiencing depression at the time of the survey, and that 1% were currently in treatment for their depression.

The best estimate for the general female population are 10.2% lifetime incidence of major depression, 3.1% current major depression, and probably less than 1% obtaining treatment for that depression in the year before the survey. The lesbian sample actually appears to experience significantly more depression.

Related to depression, Bradford and colleagues reported that 57% of the lesbians surveyed had experienced thoughts about suicide in their lifetime and that 18% had attempted suicide at least once. The best estimates for the general population are that 33% of women report lifetime "death thoughts" (a category much milder than thoughts about suicide, as it included answering yes to having "thought a lot about death" at any point in life, something that you can do when a grandparent dies), while the frequency of suicide attempts was so infrequent that it was not reported.

Finally, Bradford and colleagues reported that 30% of the lesbians surveyed currently abused alcohol more than once a month, 8% abused marijuana more than once a month and 2% abused cocaine, tranquilizers or stimulants more than once a month.

In contrast, Robins and Regier estimated for the general population that 4.6% of women had abused alcohol in their lifetime and 1% in the last month, while 4.4% reported lifetime abuse of marijuana and less than 1% reported current abuse and abuse of other substances was very infrequent. These comparisons are consistent in suggesting over 300% increases in incidence of serious personal distress among lesbians.

Objective assessment of other research suggests a similar pattern. Studies have found higher rates of depression and loneliness among male homosexuals, as well as "more paranoia and psychosomatic symptoms." Further, 18% of white homosexual males (like the 18% of lesbians) reported attempting suicide at least once, compared to a much lower rate among heterosexual respondents. In addition, Kus reported elevated substance abuse rates among homosexual males. ...

Clearly some behaviors that suggest distress are more common among homosexuals. Still, it cannot be generally concluded that *all* homosexuals experience personal distress, nor can it be concluded that such distress is an *inevitable* part of the homosexual experience. Most homosexuals in the Bell and Weinberg study (which was not a random sample) did not regret being homosexual and were not judged to exhibit psychopathological symptoms. But this conclusion begs the question of whether they are, on average, more disposed than the heterosexual population to experience distress. All of the available empirical evidence would seem to point in that direction.

It was thus for good reason that Baumrind, speaking only of gay and lesbian adolescents, remarked that "non-heterosexual youths manifest many symptoms of distress and problem behavior peculiar to, or exacerbated by, their lifestyles."

We should note too that some pro-gay authors do not deny these indications of elevated distress. They move the argument, perhaps rightly so (at least in part), in a different direction. Perhaps, they suggest, distress is not the result of homosexuality itself, but the result of the way *society* treats homosexuals; perhaps elevated levels of distress among homosexuals are a reality but occur not because of any discomfort inherent to the orientation itself, but rather in response to the interaction of gays and lesbians with a rejecting and punitive society. They liken these responses to those of other persecuted or rejected minority groups.

Although this explanation is a *post hoc* interpretation of research, there is an important point here: few heterosexuals know the stress of living under persecution for their sexual feelings, and social hostility toward homosexuals is bound to be an influencing factor in any measure of emotional stability.

Gays and lesbians have higher rates of depression and substance abuse.

Maladaptiveness

A behavior pattern or characteristic is "adaptive" when it is constructive, helpful, healthy and contributes to the person moving in a valued direction. If you are in college and value academic success, good study skills and self-discipline are adaptive, while alcohol abuse or learning disabilities are maladaptive. Maladaptiveness refers to behavior or characteristics that sabotage rather than abet a person's moving in a positive, healthy direction.

Maladaptiveness can only be judged against some standard of "adaptiveness." We share many common judgments of what is adaptive, and by logical extension, what is maladaptive. It is maladaptive to kill yourself, to hallucinate or be psychotic, to be unable to hold a job and contribute constructively to society and so forth.

But any standard of adaptiveness can be challenged: Is success at work or high income or relational stability or even the absence of self-injurious behavior really an utterly reliable standard of adaptiveness? Lurking behind every definition of adaptiveness and its opposite is a hidden, implicit model of wholeness and health, a vision of what constitutes a "good life."

Summary

- Homosexuality is not formally recognized as a mental disorder in the DSM. However, some mental health professionals disagree: a few years following the removal of homosexuality from the DSM, the majority of psychiatrists in America viewed homosexuality as a pathology, and the majority of psychiatrists around the world continue to see same-sex attraction as signaling a mental illness.

- Research has shown that it is not the case that *all* homosexuals are *inherently* pathological. Sometimes these findings are misrepresented to suggest that homosexuals do not experience any greater distress than heterosexuals.

- Research supports a relationship between homosexuality and personal distress (e.g., rates of depression, substance abuse and suicidality), though not all homosexuals are distressed. Some view the distress as indicating something inherently wrong with homosexuality; others view homosexuals who are distressed as a reflection of societal prejudice.

- Research on maladaptiveness is inconclusive primarily because of the lack of agreement as to what constitutes maladaptiveness. The clear evidence of relational instability and promiscuity among male homosexuals must figure as problematic for Christians.

- Homosexuality violates societal norms; however, mental health organizations have taken the formal position that societal norms have to be changed toward accepting homosexuality as a normal sexual variant.

- Research on whether homosexuality is a pathological condition is not formally relevant to the moral debate in the church. Psychological abnormality and immorality are two different things, although sometimes they overlap. ■

Questions and Answers

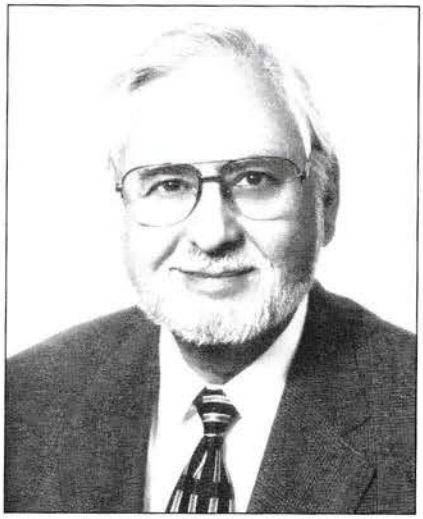
by Sander Breiner, M.D.
Farmington Hills, Michigan

Question: My 20-year-old son just told me he is homosexual. What can I do to change him?

Answer: Your son is no longer a small child, and your major influence and impact on his life is past. So at this point in his life, you can no longer want things *for* him; he must want those things for himself. You can't want him to be a doctor if it is his choice to be an architect. Neither can you want him to be heterosexual if he wishes to be homosexual. However if he himself seeks a change in sexual orientation, then your support—coinciding with his own wants, not mere compliance with our wishes—can often come to a successful conclusion.

Your best contribution to his life today, and in the future, is in your loving kindness toward him, and in his awareness of your respect for him.

The knowledge that his mother and father care for each other—and that there is an intact, loving family always there for him—will now be your major contribution to his welfare.



Sander Breiner, M.D.

Question: What is the most effective type of treatment?

Answer: The most effective therapy is one based on the working relationship between the therapist and the patient, respecting the patient's conscious and unconscious goals for change in his life.

Assuming that the patient is well-motivated and capable of participating in the intense and difficult process of dynamic psychotherapy, I believe that psychoanalysis will produce the most beneficial result. At the very least, some form of insight-oriented and psychologically supportive psychotherapy should be part of the course of treatment the patient chooses. Without in-depth dynamic psychotherapy, the benefits will likely be temporary and some other form of psychological symptomatology will eventually emerge.

In my experience I have found that dealing with the underlying anxiety and depression is the most efficient way of reaching the patient's unconscious conflicts, whether the patient is dealing with homosexuality or another problem.

Question: What are the most common causes for male or female homosexuality?

Answer: Since homosexuality is a complex emotional and behavioral response to a variety of internal conflicts, there is no one good answer. However, certain facts emerge.

First, certain family influences may bring about homosexuality in one child, but not in another. This is why it is important not to blame parents for a child's homosexual development.

Second, it is necessary for the child to identify with and love an adult member of the same sex as he or she advances in early childhood. Without that normal experience, the individual will not develop normally (although the result will not always be homosexuality).

Third, since mothers are the most important person in a child's life prior to three years of age, how the mother responds to that child and how the other adults (particularly the father) in that household respond to the mother will prepare the child for its orientation to itself and for all future interpersonal relations. Homosexuality can result as a defense against the anxiety that has been evoked.

Fourth, between 15 to 20 months of age, a little girl comes to see herself as a female, and for little boys, gender identification occurs between 18 and 24 months. Both boys

continued, next page

and girls require the benign relationship of father as a loving caretaker for healthy gender-role establishment.

Fifth, the three-to five-year age period is the time when both boys and girls learn basic social interactions with their parents and peers. Successfully passing through this time of development establishes their gender role, in which they should identify with a parent (or surrogate) of the same sex. Failure to successfully pass through this stage may conclude in a homosexual outcome.

In summary, though many problems can lead to a homosexual expression, the outstanding elements are as follows: hurt self-esteem (damaged self-image); incomplete or conflicted gender-role development; conflict over identifying with a member of the same sex, and conflict over being needful of a member of the opposite sex.

Question. I am a gay man, and most of the time I feel depressed and unhappy. What can I do?

Answer: Despite the term "gay," depression is a common experience (both conscious and unconscious) of most homosexuals, both male and female. But before you proceed in therapy, you must understand that there are two parts to the question. First, is your major concern the depression, or your homosexual orientation? If your concern is primarily about your homosexual orientation; and you wish to understand yourself further, and thereby work on changing that orientation, then therapy is available to assist you.

Or if your main concern is depression, with homosexuality being of less significance for you, then there is also psychotherapy aimed at alleviating depression. If you are able to participate in intensive dynamic psychotherapy (e.g., psychoanalysis), you can expect a favorable outcome.

Since hurt self-image, injured self-esteem, and blocks to emotional freedom are common conscious and unconscious experiences of the homosexual, the resolution of the depression may also include a resolution of the homosexual orientation into heterosexuality—but not necessarily.

Whatever the choice, you decide what route you will take, and how far you will travel. The wishes of society, family, therapist—even professional organizations—do not enter into that choice.

Also be aware that when a patient comes in for an initial evaluation, their diagnosis and treatment will not be determined solely by the unwanted symptom. Accurate diagnosis is reached through a complex understanding of the patient's psychodynamics. After the diagnosis is made, we embark on a course of treatment which takes into consideration the patient's level of psychological development, capacity to tolerate psychological stress without significant decompensation, and motivation to understand themselves and make the appropriate changes. Finally, the type of treatment chosen and the extent of that treatment will be a decision initiated by the patient with the therapist concurring.

In my 45 years of work in this field, I have found that the most significant predictor of success has been the patient's motivation to understand themselves. Some patients' motivation is simply to relieve the symptom in order to feel better, but enduring success in therapy will require that the patient strongly desire to understand and resolve the underlying conflicts.

Designed that Way, continued from page 2

gene for near-sightedness, mental retardation, or attention-deficit disorder. And there are also prenatally induced, non-genetic conditions that we recognize as problems, such as fetal alcohol syndrome and fetal cocaine addiction. All of the affected persons must struggle to adjust in life.

But we do not respond to such conditions by assuring the person, "You were born that way, so *this is who you are*."

The crux of the issue is as much philosophical as scientific: "What is human design and purpose?" The answer to the question will tell us whether we were merely "born that way," or in fact "designed that way."

We would not conclude that homosexuality is a normal variant if we held to this simple definition, offered by a clinician more than fifty years ago: Normality is **"that which functions in accordance with its design."**

—*Linda A. Nicolosi*

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

Understanding The Lesbian Client

By Andria L. Sigler-Smalz,
Clinical Pastoral Counselor

Andria L. Sigler-Smalz is the founder and Director of Journey Christian Ministries. Her ministry is located in Lake Elsinore, California, where she also makes her home with her husband and son. As a clinical pastoral counselor, she specializes in Christian-oriented therapy for individuals distressed by a conflict between their lifestyle and values.

During her 14-year career, Andria has worked with several hundred men and women struggling with homosexuality, lesbianism, related lifestyle issues, and substance abuse problems. She also counsels parents of high-risk adolescents. Among her credentials Andria counts her education, extensive training, and personal life experience. She is a frequent speaker at conferences and seminars, and has been interviewed by television, radio and news media.

Andria L. Sigler-Smalz

Recently, I was asked to critique an assessment tool used to measure change among individuals who had utilized psychotherapy to move from homosexuality to heterosexuality.

In the first draft of the assessment's interview form, the questions appeared primarily oriented toward male homosexuals. Women responding to the questions as formulated would have measured a higher degree of change than actually achieved. The questions truly reflected an assumption that male and female homosexuality are essentially the same, and simply involve same-gender, physical and sexual attraction.

But while there may be etiological similarities in male and female homosexuality, there are gender-specific differences in the nature of these problems and in their outward manifestations. The gay community itself recognizes these differences. For this reason, many women prefer to be referred to as "lesbian" instead of "gay" or homosexual, and the popular public service organization is called "The Gay and Lesbian Center."

Characteristics of Lesbian Relationships

Recognizing that there are exceptions to the common psychodynamics, I will briefly describe some of the distinct characteristics of female homosexual relationships.

The first—reflecting a basic difference between men and women—is that sex and sexual attraction are not necessarily key components of lesbian relationships. In many instances, the role of sex is minor and occasionally, nonexistent. Instead, the physical activity more highly valued is holding and affection. In the cases where sex is a critical component, it is because of the emotional intimacy that it symbolizes. The propelling drive in the lesbian relationship is the woman's same-sex emotional and nurturing deficits, and these deficits are generally not sexualized to the same degree as seen in male homosexuality. For the female homosexual, "emotional attraction" plays a more critical role than does sexual attraction.

Next, within these relationships there appears to be a capacity for particularly strong attachment. However, a closer look reveals behaviors that indicate a fragile relational bond ridden with fear and anxiety. Core conflicts are evidenced in the recurrent themes of abandonment, engulfment, control, and identity formation, and they are displayed in very specific and noticeable ways.

Female relationships lean toward social exclusivity rather than inclusivity and it is not unusual for a lesbian couple to increasingly reduce contact with family members and previous friends. This gradual withdrawal serves to insure control, and protects against separateness and perceived threats to their fragile bond.

Core conflicts are evidenced in recurrent themes related to identity formation. For example, we see fears of abandonment and/or engulfment, struggles involving power (or powerlessness) and control, and desires to merge with another person to obtain a sense of security and significance.

While lesbian partnerships generally are of longer duration then male relationships, they tend to be fraught with emotional intensity and held together by the "glue" of jealousy, over-possessiveness and various manipulative behaviors. During the course of the relationship, the "highs" are very high, and the times of conflict, extreme. Excessive time together, frequent telephoning, disproportionate card or gift-giving, hastily moving in together or merging finances, are some of the ways separateness is defended against. In such relationships, we see the counterfeit of healthy attachment—that is, emotional dependency and over-enmeshment.

It is not uncommon for lesbian lovers to have a "can't live, if living is without you" kind of feeling toward each other. A client once said to me, "I don't know how I would live without her. Before she came into my life, I was so empty. Now she is my life."

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There is often a desperate quality to the emotional attraction in women that struggle with lesbianism. One client, who recognized that her lesbian relationships re-enacted her need for maternal love, explained to me, "When I meet a woman that I feel drawn to, it is as if a place inside me is saying, 'Will you be my mommy?' It is a compelling and powerful feeling, and a helpless one. Suddenly, I feel little. I want to be noticed by her, I want to be special to her, and that want takes over my mind."

Another client shared with me what it felt like during times of separation from her lesbian girlfriend. She said, "I remember feeling this terrible feeling—this gnawing, anxious feeling deep in the pit of my stomach. This is the same feeling I had as a child whenever I had to be away from home, or on the rare occasion I would attend a sleepover. The other girls would be having a blast, but all I wanted was to be home. It was always so hard to leave my mother."

Gender Identity and Lesbianism

What is easily observed among the lesbian population is a broad divergence of gender traits and outward appearances. Just as there are (paradoxically) heterosexually oriented women who are not "at ease" in their femininity, so too, are there homosexually oriented women who enjoy being a woman and are highly feminine in appearance. I say this to dispel common thinking that a "boyish" appearance or the enjoyment of traditionally non-feminine activities equals lesbianism.

Gender identity has to do with a woman's comfort with herself as a female person, her level of ease in relating and identifying with other women, and the extent of her freedom-of-choice regarding feminine-oriented activities. Lesbianism is about a woman's same-gender preference for fulfillment of unconscious psychological longings and her fear of intimate connection with the opposite sex.

> Lesbian bonds tend to be exclusive and possessive, with extreme highs and lows.

In lesbianism, a woman is developmentally "stuck," and therefore unable to move forward into healthy heterosexuality. However, when and how healthy development is thwarted would influence the degree of gender-identity problems experienced.

Anti-Male Attitudes

Some lesbian women experience negative feelings and inner conflicts when relating to men, and this contributes to their inability to embrace heterosexuality. In addition, some strongly identify with radical feminism. Women may be seen as gifted and desirable, while men are viewed as inferior, sex-crazed and somewhat useless. Describing a scene of a man and woman with their arms around one another at a baseball game, one lesbian client said, "It was so disgusting. All I could think was, 'What does she see in him, and how could she let him touch her!'"

It is not uncommon for those who have been involved in the lesbian lifestyle for a long period of time, to increasingly experience an aversion to heterosexual relating.

Treatment Considerations

In order to treat the lesbian client who desires to embrace the change process, it is important to view her individually and to assess her as a whole person. Most importantly, the therapist must assess her personality organization. For example, does she have the separation-individuation conflicts of a borderline, the fragile self-esteem of a narcissist, or the attachment fears of a schizoid? Understanding the core conflicts will provide the therapist with the meaning behind her behaviors. With this information, it is possible to proceed utilizing appropriate interventions for this particular client.

Also important to notice is the degree of the client's compulsive or obsessive feelings, thoughts and behaviors. The higher the compulsivity, the more anxiety and/or depression may surface as the client begins to separate from her lesbian partner or chooses to not "act out" their same-sex emotional attractions. This is often the most difficult part of treatment and strongly resembles the treatment required with a person struggling with substance addiction.

The gender of the therapist is critical; however, the lesbian client typically handles that concern herself, as her emotional attraction guides her to a woman therapist in the selection process. Over time, the client will attempt to act out, with the therapist, the same themes she enacted with her lesbian partners. For this reason, the therapist should demonstrate a relational but boundaried style, and an ability to differentiate between providing appropriate care and gratifying the client's wishes. Effective utilization of the transference and counter-transference within the client-therapist relationship will provide the most healing interventions.

The client's gender-identity issues should be understood by the therapist prior to initiating discussion about them. Understanding the meaning behind the client's personal appearance can help determine if and when this topic will be approached. For example, as a child, did she "defensively detach" from her mother as a way of protecting from further (real or perceived) rejection? Are there some cultural influences? Is the client defending from male advances due to past sexual abuse?

Other essential interventions may include spiritual support, monitoring of depression, offering practical relationship skills, and encouraging the client to cultivate a support system in addition to her therapy.

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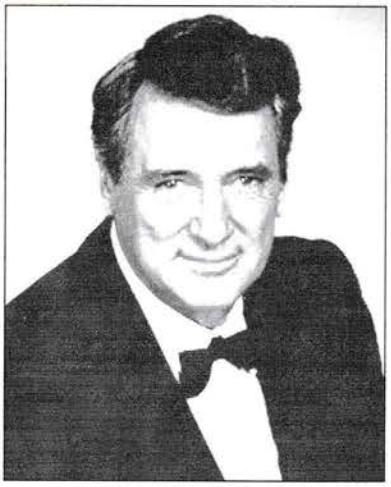


Rock Hudson

Two Biographies of Gay Public Figures

-- Rock Hudson --

A NARTH member recently brought to our attention the intriguing biographies of two prominent gay men: Rock Hudson and Quentin Crisp. Neither story likely tells a "typical" tale of the family factors leading to same-sex attractions–Quentin Crisp's, in particular, is extreme to the point of caricature. Nevertheless we do hear many common themes which our readers will recognize as familiar, and about which the popular media studiously avoids analytic commentary.

Rock Hudson's biography (*Rock Hudson: His Story*, published in 1986), describes the life of a good-natured, fun-loving man who rose from poverty and a traumatic childhood to become a world-renowned film star.

The biography tells the story of Hudson's difficult childhood, which evidences the classic triadic family pattern. "When he was growing up," his story relates, "it had been the two of them against the world."

Mother and son had an unusual relationship which blurred the normal boundaries. Hudson says his mom was "mother, father and big sister to me." He in turn was "son and brother to her, regardless of who she was married to."

In stark contrast to the intimacy he experienced with his mother, relationships with the significant men in his life were disappointing--Hudson hated his father, who eventually left both mother and son to manage on their own. He did not get along any better with his stepfather, who he says sometimes beat him. During a period of particular financial pressure, when his mother worked as a live-in housekeeper, Hudson and his mother shared a bed together in the servants' quarters.

The book explains, not surprisingly, that in later life "Rock was to become close with many of the women he starred with-—Doris Day, Carol Burnett, Juliet Prowse—and almost none of the men." Although he did not develop close friendships with his male co-stars, he fell in love with and idealized some of his directors, who he described as "father figures" or "like a god" to him.

After he became successful, Rock bought a house which he called "the castle." He filled the house with bold, "determinedly masculine" décor and artwork.

Hudson reportedly told his lover Mark Miller, "There's a little girl in me that I just trample to death." He made a squashing motion with his foot. "You will not come out!"

His friends described him as shy and non-confrontational, but thoroughly affable—always ready to laugh, tell jokes, and have a good time. "When he was sober," the book says, "he was kind, loyal, generous, and incredibly charming."

But after his mother's death, his life went into a period of decline. "His temperament, which had always been buoyant, was turning dark." He became increasingly cynical and angry, and sought to numb this growing unhappiness through heavy drinking and promiscuous sex, which eventually culminated in his death of AIDS.

-- Quentin Crisp --

While Rock Hudson was described by his friends as being emotionally as "impenetrable as a sphinx"—-for in spite of his affability, few people knew much of his personal life--the autobiography of Quentin Crisp (*The Naked Civil Servant*, 1968), tells a much more revealing story.

In that book we hear the devastatingly frank, self-told tale of a bright, witty, and thoroughly self-mocking personality. Crisp describes his own narcissism, grandiosity, and ostentatious attention-seeking, as well as self-hatred.

"No one has ever been in love with me even faintly," he says. "Yet I can write this sentence with nothing more than a feeling of wounded vanity. I experience no keen sense of loss because I, myself, was never in love with anyone...I stumble toward my grave confused and hurt and hungry..."

He describes his mother's indulgence of him, his possessive fixation on her, and his wetting and soiling of himself to draw her attention—a problem which did not stop until he was twelve years old. His mother indulged and babied him, allowed him to dress up as a girl, and even bought

him a pair of toe shoes for ballet. Although her indulgence of his femininity cemented their emotional bond, at the same time, it fed an increasing self-hatred, a love-hate feeling toward her, and a growing anger he had begun to feel toward the world.

Indeed, Crisp says that as a young boy he "adored" ballet, but not for esthetic reasons. "For me," he admits, "its charm was that one of the dancers might break his neck."

"My father hated me—chiefly because I was revolting, but also because I was expensive," he says. "Every car that my father bought was broken down. He bought them like this deliberately, so that he could spend almost all the weekend in the garage repairing them. This was a way of avoiding being with his family."

Crisp's effeminacy kept him close to his mother, but it separated him from the rest of the world. "I had no friends who were boys, because boys wanted to fight," he says. Neither would other boys indulge him in his flights of fantasy. "Also," he admits, "they would not play my games of make-believe...All these games I played with the little girls were really only one game. We dressed up in their mothers' or even grandmothers' clothes, which we found in box rooms or attics, and trailed about the house and garden describing in piercing voices the splendors of the lives that in our imaginations, we were leading."

"Occasionally," he says, "I tried to drag my brother into my world of make-believe. I rarely succeeded. No wiles of mine...could buy his companionship for long."

He describes a schoolmate who he had sex with—a homely boy whose expression was "brutish and mocking"—which he considered "very desirable." "What I wanted most," he says, "was to use sex as a weapon to allure, subjugate, and if possible, destroy the personality of others." Most of his schoolmates disliked him, so he sought to seduce his schoolmasters—a project which was particularly attractive because it would bring them down to his level.

He tells of his willing descent into hatred of the world, hatred of himself, and a fascination with sado-masochism. "On hearing of the death of anyone I have known well," he admits,"I have usually experienced a slight thrill of pleasure...When the telegram announcing my father's death arrived, I felt nothing except irritation at the thought of having to go home, attend the funeral, and come back."

Of his ever-growing indulgence in exhibitionism, Crisp explains, "Exhibitionism is like a drug.. Hooked in adolescence, I was now taking doses so massive that they would have killed a novice."

"I began to wear makeup," he says. "My lust for praise was inordinate...power was what I craved most ravenously." He describes himself as "blind with mascara and

Quentin Crisp

dumb with lipstick," with a "haughty bearing...I felt superior to the rest of the world." And yet, he says, "squalor was my natural setting."

Eventually he became completely absorbed in a lifestyle of debauchery and anonymous sex. Portraying his experience as not untypical, Crisp said that as soon as a gay man's erotic habits are completely formed, "the main, and finally the only interest" in his life is "the devouring preoccupation with the male sexual organ."

For this reason, he says, such men seek out poorly lit meeting places where strangers can be encountered for acts of "astounding physical intimacy without the intervention of personality."

In the inner life of every gay man, he believes, "is the same wounded, wincing psyche." This is because, he says, every gay man searches for a partner who is a "real man," who will still passionately desire him as a lover--and such idealized lovers rarely if ever exist, he says.

After writing this almost astoundingly frank autobiography, Crisp closes by blaming his parents' and society's puritanical attitudes for burdening him with a lifelong sense of guilt he has felt about his homosexuality. Still, he admitted with apparent sadness, "No one forced me into the role of victim."

Many of the themes in the lives of Quentin Crisp and Rock Hudson are familiar ones. We see a love-hate attachment to the mother, poor relationship with the father, gender distortions, and distance from—but fascination with—same-sex peers. Both lives culminated in cynicism about enduring relationships. But rather than investigate what it is that doesn't "work" about homosexuality, the authors take a resolutely anti-analytical approach and simply report the sad facts of their lives without seeking to understand them. ■

Risky Sex and the Adolescent Brain:

Implications for School Counseling Programs

Recently, neuroscience has begun to give us a better understanding of the high-risk habits of teenagers. According to the *Family Therapy Networker*, a magazine for marriage and family therapists (1), adolescents' reckless experimentation represents more than a struggle to individuate.

During adolescence, psychobiologists say, the brain actually undergoes a profound remodeling. The prefrontal neural cortex, which functions as the brain's command center, loses nearly half of its neural connections. Subsequently decision-making "shifts toward brain regions that are governed by emotional reactivity."

These massive changes, says psychobiologist Linda Patia Spear, predispose adolescents to take more risks. At the same time there is a drop in the brain's dopamine level, which decreases the ability to experience pleasure. As a result, teens are powerfully drawn toward destructive behaviors such as drinking, taking drugs and experimenting with risky sex.

Dr. Spear's finding converges with the latest news from San Francisco, where new HIV infections have more than doubled in the last three years as safe-sex practices are being abandoned. In Los Angeles and five other cities, says the *Los Angeles Times*, one in ten young gay or bisexual men is infected with HIV (2).

Among young gay African-Americans living in large cities, according to another report, the infection rate is even more alarming: one man out of every three is HIV-positive (3). The Los Angeles County Health Services Department interviewed 53 HIV-positive gay and bisexual men and found that half of them, despite their HIV status, "had sex in public places such as bath houses or clubs with multiple partners without informing their partners of their status. Some did not use condoms." An AIDS Project Los Angeles survey similarly found that 31% of 113 bisexual men continued to engage in risky behavior, "even after being informed of their HIV-positive status."

In another article, the *Times* reported that the rate of rectal gonorrhea among gay and bisexual men in San Francisco rose 44% during a recent three-year period, while in Los Angeles, new syphilis cases among gay and bisexual men rose more than 1,680% (4).

San Francisco is considered to be a "bellweather for sexual activity among gay men" around the nation, predictive of trends nationwide.

NARTH's Joseph Nicolosi commented on the latest findings. "These two news items have particular significance," he said. "We now have evidence that the adolescent brain leads teenagers into high-risk behavior, and that young gays are increasingly engaging in unsafe sex.

"Taking both findings together, it would seem that educators should seriously reconsider the wisdom of introducing sexually questioning teenagers into the gay community through school-based programs.

"Schools work hard to keep underage students from obtaining cigarettes and alcohol. They should also understand the wisdom of postponing the adolescent's exposure to a very, very high-risk lifestyle."

— by Linda A. Nicolosi

Endnotes

(1) "The Adolescent Brain: A Perilous Renovation," *Family Therapy Networker*, January/February 2001, p. 15.

(2) "L.A. Studies Show Increase in Risky Sex by Gay Men," *Los Angeles Times*, Feb. 17, 2001, p. 11.

(3)"Young Gay Black Men Suffer High HIV Rates," *Associated Press*, Feb. 6, 2001.

(4) "HIV Rate Rising Among Gay Men in San Francisco," *Los Angeles Times*, Jan. 25, 2001, p. A3.

Wanted: Expert Witnesses

NARTH is currently soliciting applications from professionals who are available to serve as expert witnesses in court cases.

Issues that present themselves from time to time involve gay parenting, homosexuality, transsexualism, transgenderism, child custody, and same-sex partnership and marriage legislation. If you are familiar with the scientific literature, please make us aware of your availability.

Ethical Issues in Psychotherapy:

NARTH's Studies Contribute in the Right-to-Treatment Debate

The following letter-to-the-editor was addressed to the American Psychological Association's Monitor. Dr. Tabin discusses ethical issues underlying treatment, drawing support from the NARTH studies published in Psychological Reports.

To the Editor:

One of today's most controversial topics involves the interest particularly of clinical psychologists. It is the problem of whether and how to treat people who—for whatever their reasons—find their own homosexual impulses to be distressing.

If at one time mental-health clinicians felt enjoined to convince every patient to embrace heterosexuality, now the situation is in some cases reversed. Clinicians are under pressure to encourage homosexuality. Aside from further controversy as to the origins and personal significance to a patient of having homosexual impulses, this practical problem is bothersome.

Johanna Krout Tabin, Ph.D.

We seem to be devoted in so many ways, as a profession, to helping people to find their own answers. It feels odd to me to take a firm stand to impose our own values on a patient, and to be inflexible about what the meanings of the behavior are to the particular patient.

While I applaud APA's backing the preservation of civil rights for all people, I deplore a tendency to put any human behavior beyond the scope of scientific investigation. Somehow, this has happened with homosexuality, with fallout that constrains clinicians. I was glad to see at least one careful and scholarly journal prove willing to publish new, decently designed studies even on so controversial a matter as homosexuality happens to be at this time.

Psychological Reports, a respected, peer-reviewed journal, published a two-part study on homosexuality and treatment in May and June of this year. The first part was based on reports of therapists who treated people who had stated that they wanted to be heterosexual (sometimes among other reasons for entering into therapy).

I was especially interested in the second study, an anonymous survey of former patients who reported that they sought help to become heterosexual—or at least not actively homosexual—because they were unhappy being homosexual. The authors acknowledged the design difficulties in this kind of research, but they apparently tried to make as objective a survey as they could.

Eight hundred and eighty-two persons returned the survey. The mean time that had elapsed since they were in therapy was six years. Roughly a third of the respondents described themselves as having been exclusively homosexual before deciding to enter into therapy. The most interesting findings to me were from these respondents. A quarter of them entered into therapy with a conversion therapist, the rest with various therapists across the spectrum of mental health specialists. Their average age when they completed the survey was 29.9 years. Their average length of time in therapy was 3.4 years (median: 2 years).

My interest in their self-reports rests on the fact that they all entered into therapy because they wanted to become heterosexual. I think it matters that this was an old enough cohort to have experienced a good deal of living homosexually first, and in the present climate. It was not surprising that most of them reported they now considered themselves to be heterosexual, according to their stated goal.

What particularly drew my attention was that under circumstances of anonymity that made it easy to complain, only 7% of the total number of participants who received conversion therapy said that they were doing worse psychologically, interpersonally, or spiritually. This is in keeping with MacIntosh's (1985) finding that 85% of the patients he learned about who treated by psychoanalysts experienced a significant increase in their sense of well-being, whether or not they remained homosexual.

I am not trumpeting that there are absolute truths in these publications. The authors of the study in *Psychological Reports* are themselves very cautious in interpreting the significance of what they publish. Nonetheless, it is heartening to see that some people in the field are beginning to try to explore this fraught subject with open minds.

—Johanna Krout Tabin, Ph.D., ABPP

NARTH Notes

A.P.A. Opposes Boy Scouts

The American Psychological Association recently filed a legal brief in *Boy Scouts vs. Dale,* offering extensive evidence in favor of gay scoutmaster James Dale. The A.P.A. opposed the Boy Scouts in that lawsuit, who were defending their right to define the concept of "morally straight" for their own membership.

Court Upholds the Right of Students to Speak Out Against Homosexuality

In a decision that could have far-reaching consequences for public schools around the country, a Pennsylvania court ruled that students do have a right to share their religious beliefs about the harmfulness and immorality of homosexual behavior.

David Warren Saxe, a Pennsylvania State University professor, sued the State College Area School District on behalf of his children, who had been prevented from expressing their beliefs about homosexuality due to the school district's anti-harrassment policy.

But in trying to prevent harassment of gay students, the school district ran afoul of the First Amendment, the court ruled. This violated the First Amendment free speech rights of the students. The court said that the District's anti-harassment policy was "overly broad," banning much speech that is not considered harassment under federal or state law.

Marriage: *Conformed To, Or Transformed?*

Several years after gay conservative Andrew Sullivan first made his plea for gay marriage, he explained how he envisioned the transformation.

In *Virtually Normal,* Sullivan revealed that gay men would not likely conform to the expectations of marriage as we know it, but would in fact likely transform the institution. Gays, Sullivan wrote, have a "need for extramarital outlets."

Then in a later book, *Love Undetectable,* Sullivan spoke of the "beauty and mystery and spirituality of sex, even anonymous sex."

Men Can Breast Feed, Too

In an article entitled, "Breast is Best—for Adoptive Moms and Dads, too!" the magazine *Alternative Family* tells gay parents how they can imitate biological parents. Using this method, men can breast feed.

"A lactation supplementer is a bottle or plastic bag hung around the breast-feeding parent's neck. Tubes lead from the bottom of the bottle to the parent's nipple. The baby then sucks the tube and the nipple, and gets milk."

"Physically sucking on breasts," the article explains, "is a different action than bottle feeding...As we build families, we increase choices for everyone. We deserve to know what choices exist for our adoptive children's health and for our emotional growth as adoptive parents."

——*Alternative Family,*
March / April 20000, p. 11.

New Website for Youth

Exodus International and The Portland Fellowship now offer a high-quality, comprehensive website (www.reachtruth.com) with a section for youth called "Free To Be Me." With its attractive graphics and well-written, informative articles, this site is a "must see" for Christian youth and youth leaders seeking information and support.

...And Don't Forget NARTH's Website

NARTH also offers an educational website (www.narth.com), with a search engine which offers new, concise summaries to help the reader find particular topics and authors. Monthly usage of the website ranges from 23,000 to 30,000 visitors.

Parents' Manual for Confronting Gay Activism

A Colorado organization called Family First has produced a low-cost, "how-to" manual advising parents how to defend their values and promote a common-sense approach in the public schools. "A Parent's Manual to the Homosexual Agenda in Public Education" describes ways to work with educators when they are dealing with gay issues.

The pamphlet describes the early sexualization of children through school sex-education and what it calls "The Trojan Horse" of safe-sex programs; the promotion of homosexuality and sexual experimentation; the misuse of the terms "tolerance" and "diversity" to mandate approval; and the criminalization of attempts to resist gay activism.

The pamphlet then describes what parents and schools can do to discourage gay programs—how to organize as a coalition and how to approach educators; working with the media; and holding a press conference. Sample conversations with educators are provided, with suggested responses to their most common arguments. There is a lengthy section on "How to Work with Your School Committee."

For a copy of this pamphlet, write Family First at P.O. Box 260131, Littleton, Colo. 80163 or call (303) 471-8067.

A. P. A. Supports Same-Sex Marriage

Source: LifeSite Daily News (lsn@lifesite.net)

The American Psychiatric Association, which led the revolution to normalize homosexuality in 1973 by deleting the practice from its Diagnostic and Statistical Manual of Mental Disorders, has once again adopted a radical activist position---this time by sanctioning homosexual unions.

"The American Psychiatric Association supports the legal recognition of same-sex unions and their associated legal rights, benefits and responsibilities," says a Dec. 10, 2000 press release issued by Dr. Jack Drescher, of the APA's committee on Gay, Lesbian and Bisexual Issues.

He told *New Mass Media* in an interview that "children in same-sex marriages do just as well as children in heterosexual marriages."

Drescher's history on the issue shows him to be a homosexual activist who has successfully worked his campaign within professional associations. The APA last year issued a position paper condemning reparative therapy, recommending "that ethical practitioners refrain from attempts to change individuals' sexual orientation."

The position paper lists in its references two pro-homosexual books by Drescher. Moreover, Drescher was involved in the 1998 decision by the American Psychoanalytic Association to endorse a resolution in favor of same-sex marriages.

"Not Crying for Dad"

Yet another autobiographical story by a gay man tells the story of early father-son estrangement, offering the revealing observation by the author that father- son estrangement is typical for gay men.

In "Not Crying for Dad," a story published in the Spring 2000 version of the *James White Review*, author Philip Gambone admits, "I did not have much of a relationship with my father...Gay friends tell me that this is simply the way it is with gay sons and their dads..."

Gambone goes on to describe gay psychiatrist Richard Isay's explanation for the estrangement, which relies on the "born that way" assumption: "A father intuitively senses his son is homosexual and distances himself, rather than directly confronting the discomfort and shame he feels about this queer presence in the family."

Gambone admits his father was a good man, and he seems puzzled that he could never feel love for him, or even cry at his funeral.

"In his own quiet way," Gambone says, "he never gave up on me. Through all the years that I remained silent about my homosexuaity, he never wavered in the willing affability with which he greeted the guys—'my roommates'—whom I brought home."

"I have scoured the memories of our relationship, looking for clues as to why I never totally felt at ease with my father," he says. Sometimes he thinks the problem was his father's unconscious homophobia (seeing the problem from the perspective of Isay's theory), while at other time Gambone blames his mother's and grandmother's deliberate efforts to cause an estrangement—"They were telling me to stay away from him."

Still, Gambone admits, "none of these generalizations feels adequate." Looking back, he realizes that his father was a kind and caring man who reached out to him and wanted the best for him, challenging his son to take more risks and to tackle the problems of life more aggressively.

"In retrospect," Gambone laments, "I wonder if I just wasn't ready for the kind of intimacy my father had always been willing to have with me."

An Argument Against Same-Sex Marriage

The website of the Episcopal Church recently posted an essay, "Homosexuality in the Light of Reason," by Dr. J. Budziszewski, author of *Written on the Heart* and *The Revenge of Conscience*. Dr. Budziszewski explains why the Episcopal Church should not bless same-sex unions:

> Some people argue that if only homosexuals were allowed to "marry" people of the same sex, they would become more like heterosexuals. In the final chapter of his book *Virtually Normal*, the most well-known proponent of this view, homosexual activist Andrew Sullivan, lets the cat out of the bag: it turns out that what he envisions from homosexual "marriage" is not a change in homosexual behavior, but a change in the meaning of marriage itself.
>
> Recognition of homosexual liaisons would be good for

the broader society, he says, because there is "more likely to be a greater understanding of the need for extramarital outlets between two men than between a man and a woman." What this means is plain: By virtue of the homosexual example, heterosexual wives and husbands will lose their silly hang-up about faithfulness.

In another book, *Love Undetectable*, Sullivan releases still more cats from the bag, defending "the beauty and mystery and spirituality of sex, even anonymous sex."

Are there happy homosexuals? There are certainly homosexuals who consider themselves happy; Sullivan says that even anonymous sex is happy. The laws of Nature force us to ask whether there is something wrong with such "happiness."

...Human nature is not an accident but an Order, not a chaos but a Creation – not a canvas for our own designs, but a Design.

How Do Scientific Revolutions Come About?
Consensus Builds for a New Intuitive Leap

Philosopher Bertrand Russell once said that science starts "not from large assumptions, but from particular facts discovered by observation or experiment."

Not so, says Thomas Kuhn in his book *The Structure of Scientific Revolutions*. Scientific progress comes not so much from slow and gradual change, but from large, intuitive leaps. These leaps provide a new insight through which reason, observation and experiment can then do their slow and meticulous work.

When evidence is first discovered which suggests that the reigning paradigm is false, it will usually be a very long time—even generations—before scientists give up the old paradigm and make an intuitive leap to accept the new one.

In the meantime, many years pass during which disconfirming evidence is either ignored, or reinterpreted in a way that makes it seem to "fit" the reigning model.

Reorientation therapists may find a familiar theme here. When psychiatry decided in 1973 that human sexuality need not function in accordance with design—rejecting the old view of sexuality—the disconfirming evidence (that homosexually oriented people showed higher levels of emotional dysfunction and relational stability) was systematically denied or "explained away" through the assumption that it could all be attributed to internalized homophobia.

Meanwhile, new evidence slowly begins to accumulate which links homosexuality to emotional dyfunction. Those researchers finding higher levels of emotional dysfunction have begun to postulate that (among other theories) homosexuality might constitute a developmental error.

When a scientific revolution is brewing, advocates of the new, emerging model struggle with the advocates of the old one as to how new evidence should be interpreted.

Eventually, evidence builds for the new intuitive leap which brings about the revolution.

A Warning:
When the Client Idealizes the Therapist

In his article "Fathers and Brothers," ex-gay ministry leader Alan Medinger warns about the homosexual man's need to be "reparented" by an older male so that he can complete his journey into heterosexual manhood.

"The needy one," Mr. Medinger explains, "like a little boy, often demands a father who will be his all-in-all. This Dad must offer security, guidance, comfort, authority, direction...all the things a small child needs."

However, in reality, "it is a rare man who can fill such a role."

"Furthermore," he adds, "as adults, to look to a man to fulfill all this is to risk drifting into idolatry. Men who seek such a relationship are likely setting themselves up for disappointment. In our ministry, I have had a number of men and women seek to put me in such a father role. Almost always, I failed them. I could not be to them what a father is to a little child...Typically, they could not stand to see my flaws and weaknesses...Often, this led to anger on their part. Another man, just like their father, had let them down."

Another solution for the struggler, Mr. Medinger explains, is for to look for men outside of the counseling relationship with whom there is mutuality—"brothers" who will one day be supportive mentors and guides, but perhaps on another day, or in another way, require mentoring themselves. The older brother should first be manly—strong, encouraging, accepting and affirming—and secondly he should share with the struggler a genuine friendship (and not be his "project").

This older brother will not be a "daddy," which would cast the struggler in a little-boy role, but a manly friend who will help to fill in some of the struggler's "empty places." When the struggler comes to know this friend well, most likely that any counter-productive sexual tension will eventually diminish.

——"Fathers and Brothers," *Regeneration News*, December 2000, p. 1.

More on the Pedophilia Question

Two years ago, NARTH produced a paper called "The Problem of Pedophilia" which was criticized in some quarters as alarmist.

In that Fact Sheet, NARTH brought public attention to an article published in *Psychological Bulletin* which downplayed the damage done by man-boy sexual relationships as long as they were "not coerced." After publication of the Fact Sheet, Dr. Laura Schlessinger carried the controversy into the realm of major media.

The issue appeared to fade into the background again until January of this year, when *The Weekly Standard* ran a cover story on the same problem ("Pedophilia Chic Reconsidered," by Mary Eberstadt, January 1 and 8, 2001) which reexamined the same trend: the gradual breakdown of the social consensus against man-boy pedophilia.

Ms. Eberstadt identifies gay culture as to some extent, harboring—and in the best-case scenario, failing to condemn—the man-boy "love" movement as it gradually gains visibility. "Many, many leaders and members of that movement [gay activism] draw a firm line at consenting adults," Ms. Eberstadt says. "Then," she adds, "there are other opinions."

As she explains:

"Today instead of standing foursquare with the rest of the public against this evil, the gay rights movement appears divided. A few proclaim boys to be sexual fair game. Influential others disavow pedophilia per se, but tolerate its advocacy on the grounds of political solidarity with persecuted groups.

"Still others, in a relatively new development noted earlier, appear to have opted for a kind of anti-anti-pedophilia, according to which the 'real' problems for the movement are somehow Dr. Laura and the religious right, rather than the facts to which such critics draw attention: e.g., that efforts are being made to destigmatize the sexual exploitation of boy children; or that positive portrayals of 'intergenerational sex,' which are extremely rare in the rest of the culture, are not rare in gay literature and journalism."

The problem is particular to the gay movement. "Nobody, but nobody," Ms. Eberstadt notes, "has been allowed to make the case for girl pedophilia with the backing of any reputable institution...contemporary efforts to rationalize, legitimize, and justify pedophilia are about boys."

While the response from traditionalists to the *Psychological Bulletin* study was outrage, the reaction from the gay community was (as Family Research Council observed) "notably muted...Some, including prominent author and activist Andrew Sullivan and respected reporter and political analyst Jonathan Rauch, defended the study."

Most defenders of that study said that traditionalists should be pleased the meta-analysis found little or no harm in most man-boy sexual relationships. Many were in fact harshly critical of the traditionalists' outrage. Jonathan Rauch, for example, said that it was the *critics* of the piece who were the ones who were turning out the 'stomach-churning stuff.'"

"According to that view," Ms. Eberstadt wrote, "the problem is less sex with minors, than the people who declare themselves against it."

Ms. Eberstadt found new evidence for concern in the *Washington Post*'s "effusive praise" of a novel portraying sexual predation upon teen-agers, in which the reviewer said the novel "takes off from a sensational subject—forbidden sexuality—to arrive at unexpected heights and subtleties." The child partner in the novel became "a better, more engaged student after the affair gets under way."

The Washington Post story was joined by other reviews which have been noncommital and blasé in their portrayal of pedophile relationships. A writer for the *New York Times Book Review*, for example, said of another such novel: 'Lost in his new environment and shunned by the other boys, the 9-year-old James turns for comfort to a kindly, handsome teacher named Mr. Wolfe—comfort that very quickly (and on both sides, very willingly) turns to sex.'"

"Well, there it is," Ms. Eberstadt concludes. "The idea of an adult male having sex with a 9-year-old either horrifies you, or it doesn't. You either viscerally reject the idea that such a man is 'kindly,' or you don't."

Musing about the letters-to-the-editor that criticized her expose on the problem of pedophilia, Ms. Eberstadt observed that "the taboo against pedophilia is eroding....The meaning of it all is plain, and exceedingly sad."

"If the sexual abuse of minors isn't wrong," she concluded, "then nothing is."

Chinese Psychiatrists Remove Homosexuality From Their Diagnostic Manual

In a reversal of their previous policy, psychiatrists in China no longer classify homosexuality as a mental disorder.

This represents a major change for the country of 1.3 billion people. In 1994, the Chinese psychiatric association handbook opposed the World Health Organization, which urges the normalization of homosexuality.

The new policy is similar to the American Psychiatric Association's original, 1973 policy, which de-classified the

continued

condition as a disorder but did recognize ego-dystonic homosexuality as a problem for those who were dissatisfied with their homosexuality. Officials for the Chinese association explained that this exception was necessary in order to respect Chinese cultural traditions.

Chinese television has also begun to feature gays on talk shows discussing their lives and experiences.

New Guidelines from APA Division 44

The American Psychological Association's Div. 44 (Committee on Lesbian, Gay and Bisexual Concerns) recently issued new guidelines concerning treatment of gay and lesbian clients.

Guidelines are not mandatory, like the APA's "standards," which can be enforced against a therapist and accompanied by penalties. Nevertheless NARTH's President Joseph Nicolosi, Ph.D. expressed concern about their potential for influence.

"The uninformed psychologist will read, in these guidelines, that he is ethically required to make an accurate presentation of the current research to his clients—and that the only correct understanding of this research is as follows: gay parents are just as good for children as the child's natural family; change of sexual orientation is never possible; and there is no difference between gays and straights in terms of psychological health."

The Guidelines reiterated the APA's position that homosexuality should not be represented as a mental illness.

Ironically, the Guidelines also called for "respect for diversity" – while failing to recognize a diversity of value systems.

More Americans Experimenting with Gay Sex

A recent study in the prestigious *Journal of Sex Research* reveals a surprising upsurge in homosexual activity.

According to the study, the percentage of U.S. women who say they recently had gay sex has increased 15 times from 1988 to 1998, with rates among American men doubling over the same ten-year period.

Positive media images of gay life, like hit TV shows "Ellen" and "Will and Grace," may be helping to spur the increase, according to a March 14th press release from *Reuters Health.*

Researcher Amy C. Butler of the University of Iowa examined 1988-1998 data from the General Social Survey, a poll of adult Americans conducted every two years by the National Opinion Research Center. According to the survey, the number of men who said they had recently had gay sex rose from 2% in 1988 to 4% in 1998, while rates among women climbed from 0.2% in 1988 to nearly 3% ten years later.

Butler suggests that positive images of gay people in the media "may have made it easier for people to recognize their same-gender sexual interest and to act on it." She noted that some of the increase is likely due to heterosexuals who are experimenting with homosexuality.

Butler suggests another reason for the upsurge in lesbian sexuality: "Equalizing the earning potential of men and women may enable women to consider family structures and sexual partnerships that do not include men." More than 90% of women said their sexual relationships were exclusively heterosexual in 1988, Butler notes, compared with 86% of women ten years later.

Yet more than half of Americans believe that gay sex is "always wrong," according to another study quoted in the *Journal of Sex Research.*

SOURCES: Reuters Health (Mar. 14)
Journal of Sex Research 2001; 37:333-343. ■

HIV-Positive Former Therapy Clients Sought

Are you a former client of a therapist who told you that you were "born gay" - and that the change you sought was impossible?

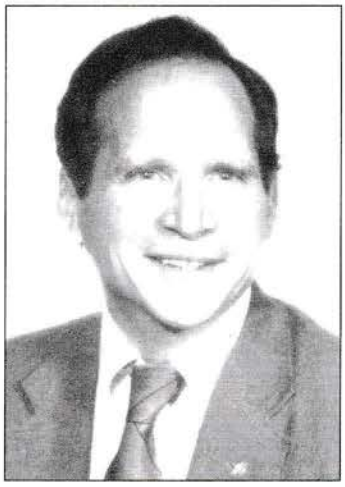
If you gave up any hope of change — and subsequently became HIV-positive — **NARTH would like to hear from you.**

Please contact Nikki at our administrative office.

Pastoral Counseling Association Initiative Calls for Blessing of Gay Relationships

A pastoral counselor recently received an internal petition from members of his professional group, the American Association of Pastoral Counselors. This initiative asks for a reversal of the longtime scriptural perspective on the design and purpose of human sexuality, calling for pastoral counselors to bless same-sex relationships.

Dr. Russell Waldrop wrote us to express his concern about the initiative, and at the same time, to join NARTH as a member. His letter is as follows:



Dr. Russell Waldrop

I recently learned about the existence of your website from a local newspaper column, which was highly critical of NARTH's views. But I decided to examine the website for myself, and found it to be highly professional and research-oriented about a wide variety of issues involving homosexuality and its impact upon society.

For three reasons, I then decided to join NARTH.

First, what I read on your website is a balance to the "gay is good" message which labels people as "homophobic" just because they express honest doubts about such a claim. Surely no open-minded person would fault others for including in their studies the contributions being made by the physicians, psychologists, psychiatrists, social workers and other professionals whose work is reported by NARTH.

Second, as a minister I find that Scripture is more often abused than appropriately used by several different sides in this debate about homosexuality. One extreme ridicules it; another ignores it; still another shoots from behind it. Too few study it for reasonable theological and practical solutions. I do find that NARTH contributors have enough respect for Scripture and tradition to engage my trust. So many others, from all sides, have failed to do that.

Third, one of my own professional groups, the American Association of Pastoral Counselors, is in the process of responding to attempts by its Eastern region to secure the signatures of two-thirds of its national members to a statement that says, among other things, "We have come to appreciate that sexuality in all forms comes to us as a gift of God."

When I read on--that this includes "Gay, Lesbian, Bisexual, and Transgender persons"--I knew that I had been caught off-guard and was unable to articulate much of a response to express my disagreement. I know that I cannot sign such a statement for theological and clinical reasons, but those reasons have long been abandoned, if not trashed, by the recent "gay liberation" movement.

I recognize my need for better understanding of these issues, and this includes both study of and prayer over a massive amount of literature. I certainly welcome NARTH into my library for this purpose. It won't be my only resource, but it will certainly be a well utilized one.

Rev. Dr. Russell G. Waldrop,
Chaplain/Pastoral Counselor,
Licensed Professional Counselor
Western State Hospital, Staunton, VA.

Announcement: Referral Therapists Needed

NARTH receives a high volume of calls from individuals seeking a therapist who will help them explore the possibility of overcoming unwanted same-sex attractions.

Our nationwide referral list is much too small to accommodate all these requests.

Please consider joining our list of independent practitioners if you are a licensed, experienced therapist with malpractice insurance who believes, as we do, that change is possible.

We need to expand our referral list so that *every major city in the country* is covered by NARTH's list of available practitioners.

Report: Annual NARTH Conference: Washington, D.C.

by Jim Lewis

On Saturday and Sunday, November 18 and 19, 2000 NARTH held its ninth annual conference at the Renaissance Mayflower Hotel in Washington, D.C. This was the best-attended conference in NARTH's history, with 110 participants from all parts of the nation.

One-and-a-half days of intense, educational workshops were provided for therapists, religious leaders, spouses, parents, and those struggling with same-sex attraction.

It was noted that although there is more research-based information about homosexuality in professional journals now than ever before, there is still a great need for more research that is unbiased by the values and political aims of the researchers, particularly in the area of gay parenting and adoption.

Dr. Benjamin Kaufman and Dr. Charles Socarides presented workshops on the early etiology of homosexuality in infancy and childhood. Psychologist Mark Yarhouse of Regent University suggested that professionals need to respect religious diversity with the same deference they grant to cultural diversity. Dr. Yarhouse was the organizer of the groundbreaking August 2000 symposium at the American Psychological Association Conference, which addressed the ethics and effectiveness of reorientation therapy.

Dr. Yarhouse is also the co-author of "The Use, Misuse and Abuse of Science in the Ecclesiastical Homosexuality Debates," co-written with Stanton Jones, which appeared in a book released last year, *Homosexuality, Science and the Plain Sense of Scripture.*

Dr. Richard Williams reported on his study of gay parenting. Some of his findings were that lesbian mothers had undergone more psychiatric counseling, children raised by lesbian mothers were more likely to be homosexual, and the range of difference in self-esteem of lesbian mothers' children was greater than that of children of heterosexual parents.

Counselor Richard Cohen, Director of International Healing Foundation, described the importance of mentoring and healing touch, and said that we are a touch-deprived culture. He also explained the etiology of what he terms "Same-Sex Attachment Disorder (SSAD)."

Dr. Harold Voth encouraged therapists to uncover the unconscious conflicts that lead to homosexuality, to allow themselves to feel compassion and love for their clients—becoming more than a therapist, but less than a friend—and to help clients distinguish between healthy and unhealthy behaviors.

Joseph Nicolosi described the Narcissistic Triadic Family model, a parenting style where the needs of the child are compromised by the parents' own narcissistic desires. This causes the sensitive, emotionally vulnerable child to surrender his authentic identity as a gendered, distinct individual and to develop a false self to please his parents. Because it is impossible to please them completely, he develops a defense against emotional attachment (known as defensive detachment) and a narcissistic pride (of which the reverse side is shame) to allow him to cope with his pervasive sense that he is unworthy of love. Thus some children's autonomy and gender identity come to be compromised.

Dr. Shirley Cox made a presentation about a guidebook she has co-authored for women struggling with same-sex attraction. The book is entitled, "Developing Genuine Friendships; A Guide For Women Struggling With Same-Sex Attraction."

Rabbi Sam Rosenberg of JONAH (an acronym for "Jews Offering New Alternatives to Homosexuality") spoke about Reparative Therapy and Judaic biblical and Talmudic insights into the homosexual condition.

At the luncheon, Keynote Speaker Robert Knight of the Family Research Council provided his insight into the gay liberation agenda and described his personal experiences in defense of the traditional family unit.

The NARTH Sigmund Freud Award was presented in absentia to George Rekers, Ph.D. of the South Carolina School of Medicine. Dr. Rekers is well-known as the author of several respected clinical works on childhood gender-identity disorder.

The NARTH Fellow Award was presented to Lynn D. Wardle, J.D., a nationally known family-law professor who has strongly urged clinicians who are writing from NARTH's perspective to contribute to the research now being used by legal experts in the same-sex marriage debate. Dr. Wardle made a compelling presentation at last year's NARTH conference, describing the "shunning" process that often accompanies the effort to speak up against same-sex marriage within the legal profession.

Joseph Nicolosi gave the following counsel in closing the meeting: we should study the literature, obtain good training, get to know the arguments (from both sides), and be aware that research indicates about one-third of those who persevere in therapy for unwanted homosexual attractions are successful in making a significant change in behavior and identity and developing heterosexual responsiveness. Even if the change is not complete, there is substantial improvement along with greater life satisfaction, better self-esteem and improved relationships with others. ■

More Balance Needed, continued from page 3

Walsh, Former Editor, JMFT and Robert-Jay Green, Editor, Special Section.

I discussed the matter further with the people at NARTH, and they sent additional published research—including a copy of a published analysis of the literature by Warren Throckmorton, Ph.D. past president of the National Association of Mental Health Counselors. Dr. Throckmorton's study of the literature concludes that change is possible.

NARTH also made the editor aware that both the American Psychiatric and Psychological Associations had scheduled symposiums on this issue.

Additional copies of that information were then sent to the AAMFT Board, requesting publication of a section on reorientation therapy.

I also sent my letter to the *Family Therapy News*. It was not published, but sent back to the journal editor, who stated that there was no place for letters-to-the-editor. It is clear that the AAMFT will print no opposing viewpoint at this time.

Please join me in taking the responsibility of promoting publication of research which clarifies that homosexuals can leave the lifestyle through change therapy.

Our culture depends on the sound judgment of those in positions of authority.

The AAMFT can be reached at:

Editor:

Board:

Problems for Psychologists in South America

Psychologist Esly Carvalho of Brazil recently contacted NARTH to inform us of a grave situation. Not long ago, Brazil's psychology licensing board passed a resolution forbidding psychologists from helping homosexual clients change orientation, even if the client specifically requests such treatment.

In spite of the resolution, Carvalho says, "We know of many who courageously continue to help their clients." Dr. Carvalho then asked NARTH to help a Brazilian psychologist who faces Ethics Board charges. NARTH has written a letter of support and sent corroborating literature.

As Dr. Carvalho explains:

"We have a serious situation in Brazil as a result of a recent visit by the Exodus International Ministry coordinator. Exodus's local coordinator, Dr. Rozangela Justino (who is a licensed psychologist in Brazil) has been asked to go before the licensing board to explain herself and her views on reparative therapy for homosexuals.

"Dr. Justino publicly affirmed that homosexual orientation can change, and that she perceives the orientation as a "kind of psychosexual immaturity." (She was speaking to a lay audience.) This particular meeting, in Bauru (in the interior of the state of Sao Paulo) was one of many held during the month of January and was publicized in the local newspaper.

"There are several gay militant people who are focused on stopping the Exodus message and movement in Brazil. Two years ago in March, they were able to ram through the Psychology Licensing Board a resolution that forbids psychologists from helping change homosexual orientation, even when the client requests it as a therapeutic goal. The resolution goes against human as well as constitutional rights, but it is still intact.

"There have been very many fruitful conversations with the Christian Psychology / Psychiatry Corps (CPPC) of Brazil - who defend the right for Exodus to proclaim its message of change – as well as the Licensing Board. But the resolution still stands.

"Rozangela needs our support. She cannot afford to go to court to defend herself. (There is no such thing as malpractice insurance in Brazil.) Exodus Brazil does not have the funds either.

"Rozangela will need words of wisdom and discernment when she goes before the Board, as well as someone who can accompany her to this meeting as a witness.

"This could well turn into a test case." ■

The Importance of Twin Studies

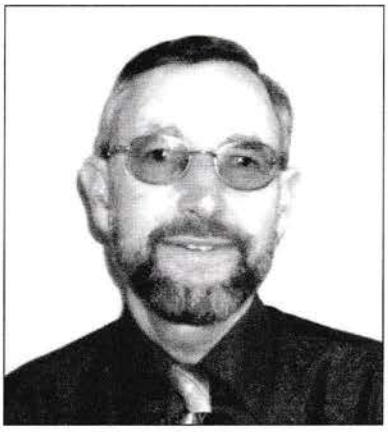
N. E. Whitehead, Ph.D.

A constant stream of media articles—several per year—assures us that there is a link between homosexuality and biological features. These articles mention genes, brain structure, hormone levels in the womb, ear characteristics, fingerprint styles, finger lengths, verbal skills..... and by the time you read this, some others may have appeared. The headlines imply that people are born with tendencies which infallibly will make them gay or lesbian, and that change of sexual orientation will be impossible.

Individually some of these pieces are not very convincing, but the sheer volume of them suggests that they must amount to an overwhelming influence—or if not, further research will add to them and make it so. This is not true either, and we see shortly that twin studies refute it.

Twin Studies

Twin studies in their modern form investigate both identical and fraternal twins, but this article emphasizes studies of identical twins, which are sufficient for our purposes. Studies of non-identical twins are detailed elsewhere (1).



N. E. Whitehead, Ph.D.

Earlier studies mostly used informal or "snowball" samples of twins recruited from gay and lesbian associations, and by advertisements (e.g. 2,3). Such studies are possibly biased by the nature of twins who volunteer, but even so, if one identical twin was homosexual, only about half the time was the co-twin concordant (i.e. also homosexual).

Better research, however, was based on twins who were recruited for other reasons, and only subsequently asked about their sexual orientation. These are known as "registry" studies, and they similarly gave a concordance rate between identical twins of less than 50%. There have been two major published registry studies (4,5), one based on the Minnesota Registry, the other on the Australian Registry. The larger of the two registry studies is the Australian one, done by Bailey, Martin and others at the University of Queensland. Using the 14,000+ Australian twin collection, they found that if one twin was homosexual, 38% of the time his identical brother was too. For lesbianism the concordance was 30%. Whether 30% or 50% concordance (snowball samples), all the studies agree it is clearly not 100%.

The critical factor is that if one identical twin is homosexual, only sometimes is the co-twin homosexual. There is no argument about this in the scientific community.

Interpretation

Identical twins have identical genes. If homosexuality was a biological condition produced inescapably by the genes (e.g. eye color), then if one identical twin was homosexual, in 100% of the cases his brother would be too. But we know that only about 38% of the time is the identical twin brother homosexual. Genes are responsible for an indirect influence, but on average, they do not force people into homosexuality. This conclusion has been well known in the scientific community for a few decades (e.g. 6) but has not reached the general public. Indeed, the public increasingly believes the opposite.

Identical twins had essentially the same upbringing. Suppose homosexuality resulted from some interaction with parents that infallibly made children homosexual. Then if one twin was homosexual, the other would also always be homosexual. But as we saw above, if one is homosexual, the other is usually not. Family factors may be an influence, but on average do not compel people to be homosexual.

Twin studies suggest that as a class, events unique to each twin—neither genetic nor family influences—are more frequent than genetic influences or family influences. But many individual family factors (such as the distant father) are commoner than the individual unique factors. Unique events would include seduction, sexual abuse, chance sexual encounters, or particular reactions to sensitive events, when young. Everyone has their own unique path which only partly follows that of the theoreticians!

A fascinating sidelight on all this comes from the work of Bailey (7). His team asked non-concordant identical twins (one was homosexual, one not) about their early family environment, and found that the same family environment was experienced or perceived by the twins in quite different ways. These differences led later to homosexuality in one twin, but not in the other.

Strength of Influences

At this point, some readers will be asking—what about the concordant identical twins who were both homosexual? Could their genes have "made them do it"?

It can be a strong influence for a few, but even for those few, it is never overwhelming. The record strengths for genetic influence on behaviors are 79% in a group of highly addicted women cocaine addicts (8) and about the same or somewhat higher, for ADHD (9). Because those figures

are not 100%, even among addicts or those strongly pushed towards some other behavior, there is room for outside intervention and change. Hence even if homosexuality is as addictive as cocaine for a few individuals, their genes didn't "make them do it."

For perspective, it is valuable to compare genetic contributions to homosexuality with the question—is a girl genetically compelled to become pregnant at 15? Her genes might give her physical characteristics that make her attractive to boys—but whether she gets pregnant will depend greatly on whether her community is Amish or urban, conservative or liberal, whether they use contraceptives, and whether the parents are away for the evening.

So the influence of the genes is very indirect. We can see this by thinking further—if she was in solitary confinement all her life, would her genes make her become pregnant? Of course not! Some influence from the environment (in this case a boy) is essential! The effects of genes on behaviors are very indirect because genes make proteins, not preferences.

So the results of identical-twin studies are critical in understanding the biological influences on homosexuality. Only for physical traits like skin color are identical twins 100% concordant.

Future Biological Research

Will continuing research eventually find some overwhelming biological influences to produce homosexuality, or find that added together, all the biological influences are overwhelming? The answer is no, because the twin studies prove that future research will never discover any overwhelming biological factors which compel homosexuality.

> "When one identical twin is homosexual, the other is usually not"

Future Psychological Research

The complementary finding is just as true. There are many influences from upbringing, and probably many we have not yet discovered—but however many we find, it will always remain true (because the twin studies tell us so) that family influences will never overwhelmingly compel children to be homosexual.

Childhood Gender Non-Conformity (essentially strong sissiness, rather than a diagnosis of GID) is the strongest single influence ever found associated with adult homosexuality, but even this factor is not overwhelmingly compelling. Indeed, 75% of a sample of extremely "sissy" boys became homosexual when followed through to adulthood (10). But we must remember they were so sissy that parents were extremely concerned and referred them to the research clinic for help. Only a small percentage of sissy boys from the general population become homosexual as adults (11). This leads to a another important rule of thumb: "Only a small minority of those exposed to any predisposing factor become homosexual."

This may be a surprise to some clinicians, who may have found high percentages of sissiness, tomboyishness or same-sex parent deficits in their clients. But that is a clinical sample. Out in the extra-clinical world, surveys show that only a small percentage of those with poor same-sex parent relationships become homosexual. For whatever reason those factors have often become extremely influential in those particular clients' lives and must be taken very seriously; but because they are minor factors in the whole population, clinicians must not force everyone into the same box, which may simply not fit.

The scientific truth is—our genes don't force us into anything. But we can support or suppress our genetic tendencies. We can foster them or foil them. If we reinforce our genetic tendencies thousands of times (even if only through homoerotic fantasy), is it surprising that it is hard to change? Similarly, we have a genetic tendency to eat, but it is possible to foster this tendency and overeat for the pleasure it brings. If we repeat that often enough, we will not only reinforce a genetic tendency to become overweight, but find that "starving" the habit takes a long time!

In summary:

1. No scientist believes genes by themselves infallibly make us behave in specified ways. Genes create a tendency, not a tyranny.

2. Identical twin studies show that neither genetic nor family factors are overwhelming.

3. Conclusion 2 will not be altered by any research in the future.

4. We can foster or foil genetic or family influences.

5. Change is possible.

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Psychiatric Disorders, continued from page 1

primarily due to social or internalized homophobia.

According to the report: "Homosexual men had a much larger chance of having had 12-month and lifetime bipolar disorders, and a higher chance of having had lifetime major depression. ... the greatest differences were found in obsessive-compulsive disorder and agoraphobia. The 12-month prevalences of agoraphobia, simple phobia, and obsessive-compulsive disorder were higher in homosexual men than in heterosexual men."

Homosexual women reported a substantially higher rate of substance abuse disorders during their lifetime than did heterosexual women, and "on a lifetime basis, homosexual women had a significantly higher prevalence of general mood disorders."

These three studies confirm what previous studies had found, which is that men and women who engage in same-sex behavior have significantly more psychiatric problems than heterosexuals.

The study categorized anyone who had recently had sex with a person of the same gender (exclusively or not) as homosexual. This distinction is significant, because the category of "homosexual" would, by these researchers' definition, include bisexuals and heterosexual people going through a phase of homosexual behavior.

If the study had been limited to individuals who were exclusively homosexual, the difference between homosexual and heterosexual populations might have been even more distinct.

The researchers note that when the American Psychiatric Association debated in 1973 about whether or not to delete homosexuality from the diagnostic manual, many psychiatrists supported deletion because of the supposed "equality in mental health status of homosexual and also heterosexual people." Yet there is now substantial disconfirming evidence of that equality in mental-health status, the authors say, and "recent studies applying a more rigorous methodology" show that there is "substantial support" for the idea that gay men and lesbians are, indeed, less psychologically healthy than heterosexuals.

Sandfort *et al.* list other studies which support their findings. In one study, "young people with a homosexual or bisexual orientation were found to be at increased risk of major depression, generalized anxiety disorder, conduct disorder, substance abuse/dependence, and suicidal behaviors."

In another study, "middle-aged men who reported ever having had male sex partners were at higher lifetime risk for various suicidal symptoms...even after controlling for substance abuse and depressive symptoms."

In yet another study, homosexually active men were found to be at greater risk of major depression and panic attack syndromes, while lesbians were more likely to be dependent on drugs or alcohol.

The authors of the Sandfort study suggest a number of possible reasons for the difference in mental-health status. They suggest loneliness, difficulty in finding and keeping longterm partners due to lesser stability of gay relationships, different social norms of the gay world (i.e., the acceptance of promiscuity), and the stress of social stigma—although the latter is, the authors admit, considerably less of a factor in the Netherlands (from which they drew the study population) than in other Western countries.

Sandfort *et al.* echo other recent researchers who suggest that to the extent that a homosexual orientation is biologically influenced in any particular individual, the condition may represent a "biological developmental error." Thus the differences observed in mental health, the Sandfort report suggests, may be due to "biological and genetic factors in the causes and development of homosexuality which predispose homosexual people to developing psychiatric disorders."

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Why Reveal the **Dark Side** of the Gay Movement?

by Joseph Nicolosi, Ph.D.

No one wants to be the bearer of bad news about a group that has suffered discrimination.

Statistics tell us that gay sex is often tied to substance abuse, promiscuity and unsafe sex practices. A significant minority of gay men also participate in sadomasochism, public sex in bathhouses, and group sex.

Many people, both gay and straight, become curious about this "dark side of life" and briefly dabble in it. Soon, however, they come to reject such things as degrading, destructive of their integrity as human beings, and "not who I am." Why, then, do such things maintain an enduring foothold in the gay community?

This phenomenon is not limited to the radical faction of gay life. Even Andrew Sullivan—a Catholic and well-known conservative in the gay movement—defends the "the beauty and mystery and spirituality of sex, even anonymous sex."

And in a speech to a gathering of college students, the Rev. Mel White was also reported to have said that he does not "struggle" with pornography, but uses it. Rev. White is the leader of Soulforce, a gay group that pickets Protestant denominational meetings to push for the blessing of same-sex unions.

Gay authors Gabriel Rotello (*Sexual Ecology*) and Michelangelo Signorile (*Life Outside*) are both conservatives in the sense that they have spoken out strongly about the dangers of irresponsible sex and sexually transmitted diseases, and have taken rancorous criticism from the gay community's more radical faction.

Yet when Signorile speaks of the "rauchy, impersonal atmosphere" of sex in public parks and bathrooms, he is careful to note that he, himself, would never judge it:

> "There's nothing morally wrong with this—and I say that as someone who has certainly had my share of hot public sex, beginning when I was a teenager and well into my adulthood." (1)

Similarly, Gabriel Rotello says he has been maligned for his role as a so-called "moralistic crusader" against unsafe sex. Yet he explains:

> "Let me simply say that I have no moral objection to promiscuity, provided it doesn't lead to massive epidemics of fatal diseases. I enjoyed the '70's, I didn't think there was anything morally wrong with the lifestyle of the baths. I believe that for many people, promiscuity can be meaningful, liberating and fun." (2)

Taking a Closer Look

When NARTH's literature describes the dark side of the gay movement, this is not done for the purpose of moralizing or gay bashing. Our primary purpose is to identify and understand a psychological pattern.

Little by little, the language of psychologists is being purged of evaluative judgment that would explain the meaning of a particular behavior. A 1975 Dictionary of Psychology states that "fetishism, homosexuality, exhibitionism, sadism and masochism are the most common types of perversion." Now, 25 years later, the word "perversion" is never used for any of those conditions; they are to be called deviations or variations.

Emotional Deficits Become Sexual Fixations

But because homosexuality is deficit-based, the dark side of gay life-—characterized by sexual addictions and fixations—keeps stubbornly emerging, in spite of public-relations efforts to submerge it.

Culture Facts, an online publication of Family Research Council, recently reported on a street fair that illustrates this paradox. The fair was sponsored in part by the Human Rights Campaign (HRC) and National Gay and Lesbian Task Force (NGLTF)—-two very prominent groups committed to mainstreaming and normalizing homosexuality.

Yet that event featured public whippings, body piercing, public sex, sadomasochism, and public nakedness by parade marchers. Fair booths sold bumper stickers that said, "God masturbates," and "I Worship Satan," and merchants peddled studded dog collars and leather whips (not for their dogs). On the sidelines of the public fair, a man dressed as a Catholic nun was strapped to a cross with his buttocks exposed, and onlookers were invited to whip him.

How long can psychologists be in denial about the significance of the dark side, and ignore what it implies about the homosexual condition?

And there's a matter of even greater concern. How long will psychologists eagerly throw open the door to gay life for every sexually confused teenager?

Endnotes

(1) "Nostalgia Trip," by Michaelangelo Signorile, *The Gay and Lesbian Review*, Spring 1998, Volume Five, No. 2, p. 27.

(2) "This is Sexual Ecology," by Gabriel Rotello, *The Gay and Lesbian Review*, Spring 1998, Volume Five, No. 2, p. 24.

A New Age Perspective on Masculine Potential

Book Review:

The Quest For Maleness,

by Theun Mares

(Lionhart Publishing/South Africa, 1999)

Reviewed by Thomas Phillips, M.B.A.

The reviewer is a "reparative-therapy graduate" who found The Quest for Maleness to be relevant in his own transition out of a gay lifestyle. He is a former financial and marketing consultant for IBM who now works as a real-estate investor in Sonoma County, California.

The author of this book, Theun Mares, is a New Age teacher whose philosophy evolved from the Toltec (native Mexican) perspective. Other Toltecs teachers include Carlos Castaneda, Don Miguel Ruiz, and Victor Sanchez. New Age Toltecs have adapted ideas from old Native Mexican tradition and updated them to offer guidance in today's world.

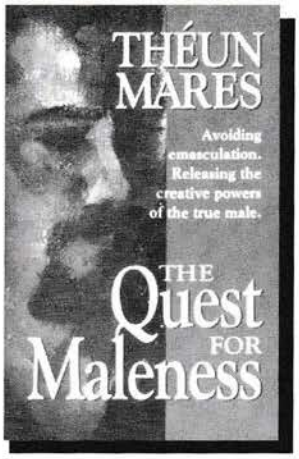
Mares' philosophy offers the model for male consciousness which I have found most relevant in my own life and transition out of homosexuality. Other prominent models of male consciousness include the Judeo-Christian, Mythic/Poetic (from Robert Bly, author of *Iron John: A Book About Men*), and the Gay-Affirmative/Feminist. Different models, of course, speak to different individuals.

The Quest for Maleness is an explanation of Mares' theory of masculinity. He investigates myths such as "Men Don't Cry...Men are Aggressive... Men are Strong ... Men Must Be Successful... Men are Sexual Studs," and develops a theory around his understanding of men's innate drives and also their potentialities. The goal of life for a man is to reach his true potential.

The author's philosophy of gender is that men are naturally active, while women, from the time they leave the womb, are inherently more passive. The male strives toward a greater awareness, while the female tends toward preservation. The male strives to grow toward his full potential, while the female already *is*. The two polarities of male and female create a whole.

Mares states that the male is the leader, in search of his full potential, and thus points the way to others, even to women. However the male must be constantly open to guidance from the female, whose natural ways of knowing make her more grounded.

The author believes that a natural aspect of maleness is to seek enjoyment and to be prone to succumb to excesses. Men indulge themselves in activities of every kind—alcohol, drugs, food, exercise, the radical pursuit of fitness. A



majority of men, he believes, have same-sex erotic experiences as they grow up even though most of them know they are heterosexual. But some men, he says, out of their sexual insecurity, succumb to homosexuality because "they abandon themselves to the experience," just as other men abandon themselves to sensual diversions and excesses of other kinds.

A small portion of the book—ten pages out of 228—deals with homosexuality. Mares sees homosexuality as contrary to "Male Truth," because men who do not include women will live unbalanced lives by elevating the masculine above the feminine. "This is a far cry from remaining true to our gender" (of union with the female), because "unless we remain true to our gender" (and unite with the female), "we cannot possibly unfold our true potential," he says.

Gay couples cannot evolve to their fullest potential because one male takes the female role, and the "femme"—who invariably feels the most inadequate about his masculinity—looks to another man to take the lead so he can be "fertilized." He'll always be "empty," however, no matter how much sex he has, because he cannot "conceive." He seeks out additional men, longing for fulfillment, "not realizing it is his own masculine potential he longs for."

Neither can the "top" find fulfillment, because although he's more masculine than the bottom, he knows his partner will never produce new life, and their relationship lacks the creative potential it would have if it had been endowed with natural male-female polarity.

Mares states that "I personally do not sit in judgment of homosexuality," and he admits that he himself has had homosexual experiences.

Are some men born homosexual? No, he says; "All men are born with a masculine potential which it is their duty to unfold."

His perspective reflects that of many native peoples from the developing world who believe that homosexual relationships can lay the groundwork for a boy's eventual manhood and marriage to a woman. But "the problem with most people [homosexuals] is that they like to indulge in the experience, rather than treating it as a learning curve which brings not only a gift of knowledge, but also the keys to liberation from that challenge." Then Mares strays to the New Age Left when he implies a belief in reincarnation, saying that some men consider themselves homosexual "because of many lifetimes of imbalance."

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Most men receive male modeling from their fathers, but it is commonly observed that gay men typically introject less male modeling from their fathers than do straight men. A model or mentor is essential for men coming out of homosexuality, providing guidance and direction during a confusing time when a struggler is changing lifestyles, beliefs, friends, sexual expression, and relationships. Growth outward toward women requires masculine strength and new relationship skills, and a mentor speaks to each man's dream of bonding with a woman. A mentor not only evokes a powerful heterosexual masculinity, but also is capable of offering an intelligent explanation of why the homosexual path is deviant.

Rather than being based on biblical revelation—to which only a particular faith community will be receptive—the mentor's advice can be based in an experiential point-of-view which calls on an intuitive awareness of nature and is grounded in the Force that created each one of us. For this purpose, Mares' book offers helpful guidance. ■

Clinical Issues:

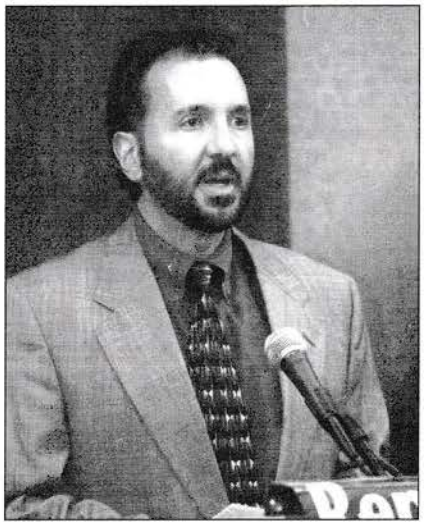
Grief Work

Discussion with Joseph Nicolosi, Ph.D.

Dr. Nicolosi (JN): In our continuing investigation of the clinical material, some recent work on the Narcissistic Family has added a deeper dimension to our understanding of the prehomosexual boy's experience. And so during the last three years, we've developed a new dimension of Reparative Therapy.

This expanded model gives us a better understanding of male homosexual development and leads us to a more effective treatment.

A good way of understanding this dimension is to envision lifting the reparative-therapy model up, and then putting a subfloor beneath it.



Joseph Nicolosi, Ph.D.

Linda Nicolosi (LN): A subfloor?

JN: Yes. The "house" of Reparative Therapy was built with the concepts of gender-identity deficit, defensive detachment and reparative drive. Now we are underlaying the structure of the house with our understanding of a deeper trauma experienced by a significant group of clients—the narcissistic family, along with the necessary treatment of that trauma, which is the grief work.

I've developed these ideas by integrating the concept of the narcissistic family with the work of psychoanalyst Martha Stark. Her books are *A Primer on Working With Resistance,* and *Working With Resistance* (both 1994). Dr. Stark's therapy requires getting the patient to look back on the experiences of his early family life to resolve grief around what is known in psychoanalytic terms as "abandonment."

LN: How does this fit the Reparative Therapy model?

JN: Reparative Therapy has long recognized the Classic Triadic Family model to understand the most common pathway to male homosexuality. But when we combine that model with the Narcissistic Family and grief work, we gain a fuller understanding of our clients' childhood experiences. Our expanded model is the Triadic Narcissistic family.

This model will not fit all clients, of course, but it resonates with many.

We've always known that homosexuality is not a sexual problem, but a symptom of an underlying problem of gender identity. But the deficit typically goes deeper than that; there's also a damaged sense of self. This damage to the self is the integral part of the gender problem.

LN: Can you describe the Classic Triadic Family?

JN: Irving Bieber's 1962 study established this family type empirically. It has been repeatedly shown to be the foundational model in male homosexuality, although there is more consistency in findings about fathers than about mothers.

In the classic triadic family we have a sensitive boy who did not get the close, affirming relationship with his father that would have confirmed him in his gender identity, and a mother who is likely to be over-close and standing in the way between father and son. The father was not supportive enough in affirming, recognizing and reinforcing the boy's maleness. If there is an older brother, he usually had a fearful-hostile relationship with him.

LN: How would temperament play a role in this model?

JN: Some boys—particularly those with a resilient, extroverted temperament—were not so vulnerable to being emotionally hurt by a distant, rejecting father or molded by an over-involved mother, so the classic triadic family caused no gender-identity injury.

But the sensitive, compliant son was not so fortunate. He couldn't move beyond the comfort and security of the mother-son relationship to establish his own masculine autonomy. He experiences a narcissistic hurt and eventually surrenders his natural masculine strivings. I say "natural," because gender strivings are grounded in the biology of human design.

LN: How does the triadic model work together with the narcissistic family model?

JN: The two models can be seen as fitting together in a compatible overlay. In the narcissistic family, the boy grows up with a parental dynamic in which the son is perceived as a self-object. Now, both parents, it should be said, are often good people who were consciously very loving, self-sacrificing and well-meaning. There is no conscious intent to hurt the child. But on some level, such parents have a need for the child to be "for" them, meeting their needs and expectations that he be a certain kind of child.

In the psychoanalytic literature on the narcissistic family, the child (either a boy or a girl) was not seen for his True Self. He was seen or not seen, responded to or not responded to, depending on whether particular aspects of his True Self gratified or did not gratify the parental team's narcissistic needs.

When the boy's spontaneous expression of self conflicts with the parents' needs, he finds himself in a no-win, double-bind situation. If he holds onto and expresses his True Self, he is overtly or covertly punished by being ignored by his parents—which at his young age means he simply ceases to exist. The expression of his true self, which must involve his gendered self, is met with what is called the abandonment-annihilation trauma. In other words, "When my parents cease to reflect me, I cease to exist." And so as a survival tactic, he develops the False Self as a way of complying with his parents' vision of who he must be. That False Self is typically "The Good Little Boy."

LN: How common is the narcissistic family?

JN: As parents, we probably all exhibit some narcissism in our parental expectations. So the narcissistic family, then, exists on a broad continuum. But when the parents' narcissistic expectations combine with the Classic Triadic Family pattern, the family produces a genderless, non-masculine, "Good Little Boy." For some reason, this parental team had a vested—-if, in fact, quite unconscious—interest in this particular boy not developing his masculine identity.

Perhaps this was the son who was born sensitive, introspective and unathletic, so he became his mother's confidante. And perhaps the mother's needs meshed with the boy's own fears—that he could not compete with his male peers on their own level. Staying close to his mother would feel very natural and comfortable to him.

And so this particular son abandoned the natural striving to achieve masculine autonomy, which is to say, he gave up developing the side of himself that would have been rambunctious, mischievous, active, independent, and aggressive. He becomes his mother's best friend...sitting in the kitchen and watching her cook, hearing her stories and hopes and dreams and maybe even her complaints and disappointments about his father.

LN: Does the narcissistic family model also involve both parents?

JN: Yes, because the father—at least unconsciously—went along with the arrangement with this particular son by allowing his wife to interact with the child as a husband-substitute. It may have fit the father's needs because it allowed him to escape some of the emotional responsibilities of marriage that he considered burdensome. And maybe there was another son he could be close to, with whom he had more in common. So both mother and father would have participated in producing the non-masculine son.

Of course, the Narcissistic Family syndrome by itself, *without* the Classic Triadic relationship, will have a damaging effect on the child's sense of self, but not likely affect the child's gender identity.

But any time a parent's love is mediated through narcissistic expectations, the child will be left with a feeling of weakness, vulnerability, sadness, emptiness, a deep suspicion of never having been truly "seen" for who he was, and loved. These feelings are common complaints of the homosexual client that go beyond the feeling of gender deficit, and in many cases, they can be explained by the narcissistic family.

LN: How common is this combined family model?

JN: Most of my clients report experiencing it to some extent, but it would be inaccurate to lay the blame solely on the parents for the child's homosexuality. However, we can say that when we see this model in its fullest expression—when the child knows that his existence needs to be gratifying to his parents—he experiences what object-relations theorists call "abandonment," and that brings up a flood of sorrow and grief about not having been seen or known for who he really was. Such a client will need to understand and mourn that loss.

> Grief work can heal the distortion that "I am defective."

LN: Does this also happen in the same way with lesbianism?

JN: We may see a scenario in which the girl's authentic expression of self, including her femininity, was met with disapproval. Sometimes the narcissistic need of her parents required her to renounce her feminity, to "be strong" and take care of her mother.

In some family histories I am aware of, the girl was expected to be feminine in a stylized way that did not suit her. These young women describe themselves as having been tomboyish, spontaneous, assertive girls whose mothers' narcissistic need required them to adopt a caricatured "girlish" femininity which meant expressing no opinions and conforming to a very narrow vision of gender. This feminine straitjacket of their mothers' envisioning did not match their own internal sense of who they really were.

But there are other pathways to lesbianism which don't

continued

involve the narcissistic family system. Maternal inadequacy is one common finding. When the mother is inadequate as an emotional resource or a feminine model (she was depressed, unavailable, abused by the father, alcoholic), the girl is left with a maternal nurturance deficit which later leads to a craving for love and intimacy with women.

LN: Returning to the boy, how does he protect himself from a narcissistic parent's expectations?

JN: The child is made to feel shame regarding his true, gendered self. The "Shamed-Damaged" self will defend itself through two mechanisms. One is narcissistic pride, which we see so commonly in the homosexual condition, and in the service of which the homosexual condition develops. The other defense is the False Self which originated from the "Good Little Boy." The homosexual condition is characterized by these two defenses.

One client said to me recently, "I always tried to make my mother happy but I could never keep her happy for very long. So she was very disappointed in me." This is what many of our men are grieving. They are grieving the fact that so much of their life was spent trying to live up to an expectation that was never really verbalized, yet clearly understood. Much of their life was spent trying to gratify and please, to seek the approval of others.

The grief work penetrates the two defenses of narcissism and the False Self and focuses the client on fully feeling and expressing the Shamed-Defective Self. He discovers that, as an adult, he need not fear the primal threat of abandonment-annihilation, and he can begin to surrender the defenses of homosexuality, narcissism and the False Self.

The Narcissistic Triadic model explains other clinical features we see besides the narcissism and the False Self. It also explains the pervasive sense of not belonging, of never having felt understood or connected, and of experiencing an inner void and emptiness.

Homosexuality is more than a "pull" toward connection with the masculine (through the pursuit of male attention, affection and approval). Homosexuality is also a "push" from the gut sense that "I am defective."

I recall years ago a client whose wife had just discovered his many anonymous sexual encounters. She tearfully asked him, "How could you have done such a thing?" The client said to me, "From the depth of me came an answer that surprised even me; I said, 'Because it hurt too much not to.'" This man was looking for much more than male attention, affection and approval. He was seeking relief from the deep void in his heart which he knew on some level, had existed since early boyhood.

And so we see that this Shamed-Defective Self goes much deeper than a deficit in gender. We gain a fuller understanding of it through the established literature on self psychology and object-relations theory.

Gay theorists also recognize this "Shamed-Defective Self," and many gay men admit that no matter how liberated they are, they always struggle, on some deeper level, with a sense of inferiority. They point to this as evidence of homophobia that's been internalized from society. But I attribute this feeling to an internal process, unrelated to social stigma, which precedes same-sex attractions. The awareness of social stigma is later layered on top of the Shamed-Defective Self.

LN: How does this "deep grief" fit with the sadness described by other clinicians who deemphasize family dynamics and focus on peer rejection?

JN: When you begin the grief work, the peer memories usually arise as the first source of pain. But as you keep the client focused, we find the sadness often goes deeper to memories of the mother and father. As much as the parents tried to love their son in their own way, the clients harbors the felt memory of not having been understood, not having been "seen," not having been loved for who he really was.

LN: How does the client get in touch with this grief?

JN: We start out by focusing on his emotional state in the here-and-now. He will periodically express the feeling of being "stuck"—weak, hurt, hopeless, blah, depressed, lonely, not belonging, and feeling forlorn and self-pitying.

These feelings are what we call the Black Hole, which is a cluster of thoughts and feelings that permeate his consciousness. Our earlier strategy was to bounce the client out of the Black Hole through a change in self-talk. We applied van den Ardweg's concept that these men were caught up in a state of self-pity. We "called them on it," challenging them to move onward.

But now we are realizing that the Black Hole can offer a doorway into a deeper grief that lies beneath it.

LN: A doorway?

JN: It's a feeling-level opening through which the client confronts dreaded memories which may include rejection and even victimization.

LN: How do most clients deal with "The Black Hole"?

JN: When our men fall into it, their first impulse is to run away and to connect with a man sexually. We always ask the client—and this is a very important factor in the therapy—"What was the feeling that preceded your homosexual enactment?" They report the complex of the Black Hole: "I felt alienated, disconnected, empty...I felt inferior, not good enough." These are the common feelings that precede homosexual acting out.

So every time they go to those feelings, any time something in their lives stimulates those feelings of not belonging and not being good enough, having been slighted or rejected...this stimulates the defense of

homosexual enactment. But what they are actually doing there, is unconsciously avoiding the deep grief. Experiences of hurt, failure, feeling let down and disappointed stimulate an affective memory of that early trauma. As soon as they get the slightest hint of that old feeling, they move away from it into homosexual behavior.

But instead you take them by the hand and walk them into the deep grief, let them stay there, let them experience it, let them realize the anguish is not going to annihilate them. They need to feel it more deeply, and not to be afraid of it. They now have enough ego strength, enough insight, enough emotional resources to transcend it.

Grief work inevitably includes feeling the anger, often even rage at having lived a lie to please others. It includes the pain of surrendering the illusion of homosexuality. Same-sex relationships—as this client already knows, because this is why he has sought out Reparative Therapy—never worked for him. But now he faces this realization squarely, powerfully, without defenses. So much of the appeal of a gay relationship has been the illusion that someday when that certain best friend and lover comes along, this new man will alleviate that sadness, but then each relationship disappoints him.

Once he "goes there" into the grief and acknowledges what he sees...with enough of an observing ego to allow him to integrate it...he can finally start to come out on the other side. The hurt no longer has such compelling power; he's faced that reality down and survived.

When I first read Martha Stark's grief work, it struck me that this was a dimension to which we had not been paying enough attention. For many of her patients, she finds this to be a core element for a complete therapy. I have come to a point where I believe that a comprehensive Reparative Therapy must include grieving.

Maybe for my own reasons I hadn't gone into it, because these feelings—sometimes murderous rage and deep, agonizing grief-—are so uncomfortable and so primitive that many therapists, including myself, might shy away from it.

But as I've had more experience with grief work, I've come to see its often fundamental importance to the healing of homosexuality. ■

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The duration of treatment is generally of a long-term nature, and many benefit from two to three sessions per week, depending on the level of functioning of the client. Therapists who travel frequently, who know in advance they will not be able to continue the therapeutic relationship (i.e., they plan to relocate or leave practice), or are experiencing their own personal crises, should consider carefully before accepting such a client. Therapist reliability and consistency are important elements in treating the female homosexual.

Prognosis

As in treatment of any kind, success is dependent upon many factors. Some of the factors are within the client's control—such as her motivation and determination to change, her regular attendance at sessions, and her cooperation with treatment. Other important factors determining rate of success involve characteristics of the therapist. The therapist should be capable of attachment, be well-differentiated, and have adequate skills and experience, or at least qualified supervision. Other considerations for prognosis include the client's age, history, personality organization and overall level of functioning.

In my work with women, I have found change to be a slow and arduous process. However, the work contains its own rewards. It is always a privilege to assist a client on her journey to becoming a healthier person and I often find myself inspired by the determination of my clients.

Because the lesbian struggle is a symptom of a woman's inner pain and conflicts, attaining the capacity for healthy same-sex relationships and opposite-sex relating is a manifestation of inner healing and growth. Many lesbian women who desire change will fully realize their goals. And even those who are elsewhere on the "success continuum" will grow and change through therapy, experiencing greater self-understanding and sense of personal wholeness. ■

Wanted: Articles for the NARTH Bulletin and Website

If you have a story of interest to our readers, please write the Bulletin editor or send e-mail to xiranicolo@aol.com.

Help us keep our membership informed on the news—professional issues, ethics concerns, new books of interest, alternative families, same-sex partnership legislation, school programs, and legal issues.
We are also seeking clinicians interested in contributing to our "Questions and Answers" column.