

NARTH BULLETIN

Vol. 13, No. 3

National Association for Research and Therapy of Homosexuality (N.A.R.T.H.)

Winter 2005

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Psychology Losing Scientific Credibility, Say APA Insiders

*At NARTH Conference, APA Past-President
Charges His Association With Stifling Discourse And Distorting Research*

By Linda Ames Nicolosi

In a harsh critique of his own profession, a former American Psychological Association president told fellow clinicians at the NARTH Conference about recent destructive trends in mental health.

Speaking to a rapt audience of about 100 fellow professionals at the Marina Del Rey Marriott Hotel on November 12, 2005, psychologists Nicholas Cummings, Ph.D. and Rogers Wright, Ph.D. had much to say about the profession they had served throughout their long and distinguished careers—charging “intellectual arrogance and zealotry” within a profession that they say is now dominated by social-activist groups.

Dr. Cummings said he has had a career-long commitment to promoting diversity. Therefore he has been dismayed to see activists exploit the stature of the parent body to further their own social aims—pushing the APA to take positions in areas where they have no conclusive evidence.

When APA does conduct research, Dr. Cummings said, they only do so “when they know what the outcome is going to be...and only research with predictably favorable outcomes is permissible.”

When writing their newly released book *Destructive Trends in Mental Health*, Wright and Cummings invited fellow psychologists to contribute chapters. Some of them flatly turned them down—fearing loss of tenure, loss of promotion, and other forms of professional retaliation. “We were bombarded by horror stories,” Dr. Cummings said. “Their greatest fear was of the gay lobby, which is very strong in the APA.”

“‘Homophobia as intimidation’ is one of the most pervasive techniques used to silence anyone who would disagree with the gay activist agenda,” said Cummings. “Sadly, I



Psychologists Rogers Wright, Nicholas Cummings, Joseph Nicolosi, A. Dean Byrd, and psychiatrist Jeffrey Satinover are shown here.

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have seen militant gay men and lesbians—who I am certain do not represent all homosexuals, and who themselves have been the object of derision and oppression—once gaining freedom and power, then becoming oppressors themselves.”

He described his own experience of oppression and reverse bias: “This was aptly demonstrated,” he said, “during an interchange that took place in a large meeting assembled by the then-current president to address the future of the APA. I was just about to agree with one of the participants, when she stopped me before I could speak: ‘I don’t know what you are going to say, but there is nothing you and I can agree on, because you are a straight white male and I am a lesbian.’ Such blatant reverse discrimination was overlooked by everyone else in the room, but I was dumbfounded. This woman is prominent in APA affairs, is extensively published, and has received most of the APA’s highest awards. The APA continues to laud her, even though recently she had her license suspended for an improper dual relationship with a female patient! What would be the response had it been a straight white male in an improper dual relationship with a female patient?”

Regarding treatment for unwanted homosexuality, the American Psychological Association has come very close to ratifying a statement which would declare therapy to modify sexual orientation “unethical.” But “why does free choice go only one way?” Dr. Cummings asks.

Cummings then discussed a 2004 resolution by the APA in favor of gay marriage, which APA recommended because it “promotes mental health.” What was the evidence APA offered? (Such a bold statement from APA, of course, would be used in the courts to decide key social issues.) The references APA cited, it turned out, actually proved only one claim—that as a general matter, “loving relationships are healthy.” “That was one of the worst resolutions,” Cummings said.

“When we speak in the name of psychology we are to

speak only from facts and clinical expertise,” he explained. If psychology speaks out on every social issue, “very soon the public will see us as a discredited organization—just another opinionated voice shouting and shouting.”

Cummings’ co-author Dr. Rogers Wright (who like Cummings, describes himself as a lifelong liberal) notes that “psychology has been ultra-liberal” and not particularly welcoming to the views of people of religious faith.

Dr. Wright described the difficulties he has encountered with the American Psychological Association since the Association instituted a “strategic decision not to respond” to their book in an effort to avoid attracting attention to it. Initially, the APA prohibited its member-publications from reviewing *Destructive Trends*. “So much for diversity and open-mindedness,” Wright added wryly.

Judicial Malfeasance By Activists

Joining them in yet another stinging critique of the mental-health profession was psychiatrist Jeffrey Satinover, M.D. In his talk entitled “Judicial Abuse of Scientific Literature on Homosexuality by the American Mental Health Professional Organizations,” Satinover offered a long, elaborately referenced description of ethics breaches in the recent legal cases—cases that set the stage for groundbreaking changes in family-law policy.

Satinover said the mental-health associations had allowed themselves to be used by gay activists who distorted the research findings to serve their socio-political aims. This distortion of the science, he said, has been so great that it is “appalling beyond imagination.”

Dr. Satinover recently taught constitutional law at Princeton University, and is presently doing research at the University of Nice. He showed the legal briefs to his students and told them, “Whether you become a leftist or a rightist, don’t hold yourself to such a standard.”

THE NARTH BULLETIN

Editor: FRANK YORK

The *NARTH Bulletin* is published three times yearly by the National Association for Research & Therapy of Homosexuality, a non-profit educational association. For information contact NARTH, 16633 Ventura Blvd., Suite 1340, Encino, California 91436, (818) 789-4440.



“Victory on the Bow of a Ship”

Called as an expert witness in court cases and asked to assess briefs being submitted to state and the U.S. Supreme Courts, Satinover had the opportunity to pore over hundreds of research papers offered as evidence by the gay activists who had been invited to represent the views of the major mental-health associations. Given *carte blanche*, he said, the activists wrote briefs that were “sophisticated, nuanced” but in many cases, almost entirely untrue. To Dr. Satinover’s dismay, the brief-writers’ testimony rarely matched the references they provided as corroborating evidence.

He quoted Susan Cochran, Ph.D., a lesbian activist advising the *Lawrence v. Texas* brief, which claimed that “Research has ... found no inherent association between homosexuality and psychopathology.” The references she provided were largely self-references, referring not to corroborating sources, but directly back to her own published work. Paradoxically, in those same studies, Cochran had consistently found *more* mental-health problems in lesbians and gay men—and she did not find that “social homophobia” was a sufficient cause for these problems. In fact, Cochran had concluded in one of her own referenced papers that “further research is needed to explore the causal mechanisms underlying this association.” In a follow-up paper, she herself showed that the effects of social homophobia couldn’t account entirely for the association.

Satinover also offered evidence from the *Romer v. Evans* brief that evidently came from gay-activist psychologist Gregory Herek, Ph.D., who wrote the brief on behalf of the APA. Herek, he says, distorted the findings of the authors of the research he cited; omitted available contrary evidence; and failed to mention the evidence for spontaneous changes of sexual identity.

Herek also defined the term “homosexual” in an arguable manner that worked most effectively to meet the aims of his brief—a definition that was the outcome solely of his own work, and that deviated from widely-used, neutral scientific standards.

In support of the argument that same-sex attracted people are as well-adjusted as straights, Satinover said, Herek also referenced the “notoriously flawed and out-of-date Hooker study, its claims long-since and multiple times overturned.”

Pedophile Supporters Offering Family-Law Testimony?

In the *Romer v. Evans* case, psychologist John Money, Ph.D. was referenced (also by Herek, evidently) as an expert in sexual identity. In an interview published in the Dutch journal of pedophilia (*PAIDIKA*), Money once said, “If it [man-boy sexual contact] is consensual, it can

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NARTH Interview

Physician Promotes NARTH’s Work In Italy

Dr. Chiara Atzori is a medical doctor practicing in Italy who deals regularly with homosexually oriented men and women who are suffering from sexually transmitted diseases. When she began speaking out in support of the work of NARTH President Joseph Nicolosi, she soon incurred the ire of gay activists. In this Q&A, she explains how she got involved in supporting freedom of choice in therapy.

Q. How did you get involved in this work?

A. First of all, I have to specify that I am not directly involved in clinical psychology. I am a medical doctor, with a specialization in Infectious Diseases, working in a hospital where, as physician, I am focused on

HIV, sexually transmitted diseases, hepatitis, and tropical diseases. In addition, I run a clinical research laboratory dealing with an AIDS-related pathogen.

My interest in understanding homosexuality came about not from ideology, politics, or theoretical issues, but as a result of my listening repeatedly to the deep unhappiness experienced and verbalized by people attending the hospital for treatment of sexually transmitted diseases.

I love reading and discovering new things, especially on mind mechanisms and the relationship between the brain and behavior. I have been involved for several

years with a group of people that includes sexologists, psychologists and experts in education who share the view that for the successful prevention of HIV, it is not enough to propose condoms. Conveying the sense of beauty, the great value of emotional relationships in sexuality is a “must” as a way of motivating responsibility.

Counseling, and prevention of high-risk behaviors (such as unprotected anal intercourse and high rates of promiscuity, so frequent in the gay world) is a consistent part of the work of a clinician involved with HIV-infected patients. I always spend time listening to my patients when they come to my office, and I always leave them the maximum freedom to ask any kind of questions about “safer” sex.

My first reaction to homosexual patients when they expressed dissatisfaction towards their orientation reflected my university education and previous beliefs. Having only read the politically correct books proposing homosexuality as a “normal” part of one’s deepest being and not a “problem,” I encouraged gay-affirmative therapy (GAT) as the only one acceptable for undesired homosexual feelings. At that time, as most do, I was referring patients looking for help to gay-activist organizations.

I was surprised to gradually realize that there is a persistent, deepening dissatisfaction growing inside this supposed protective network of gay activists. Other external events were putting doubts in my mind about the belief that GAT was the only answer for those allegedly suffering from “internalized homophobia.” This internal homophobia supposedly causes unhappiness in gays. Many of my clients, however, referred to feeling trapped in a “cage” (their term, not mine). They were often involved in a homosexual relationship with their therapist, closed into a network of gay clubs, cinema, and associations, with the opportunity for frequent sexual encounters, but rarely experiencing durable relationships.

I was especially touched by a former aggressive gay activist, a bright and witty person, who left the most prominent Italian gay-activist association after several years of true dedication. He managed to show me the dark side of his moon, as we say in Italy; his beliefs about the meaning of homosexuality were

completely destroyed from the inside as he studied the criticisms of homosexuality.

Q. When did you begin supporting NARTH’s work?

A. While attending a scientific meeting in San Francisco, I discovered Dr. Joseph Nicolosi’s work in a local bookstore. After reading the two books at the time that were available in English (*Reparative Therapy* and *Case Stories of Reparative Therapy*) I was thinking that this approach was really effective, and I proposed helping get both books translated into Italian. The only book with a similar approach, but dealing more about the narcissistic block in homosexuality, was van den Aardweg’s *Homosexuality and Hope*. But the unique perspective of Nicolosi’s work focusing on the idea that homosexuality is a symptom of the search for the hidden true identity was really intriguing.

It rang true to me. Here was a fresh word of possible freedom for gays in Nicolosi’s way of approaching the phenomenon. The importance given to the father also fit my own clinical evidence: Many homosexual patients admitted the non-existence of an emotionally accessible father; in fact, some adult patients after years, still arrived at their visit accompanied by their mother.

The Mediterranean model of the family is probably a little different from that in the USA, but Joseph Nicolosi’s approach fit very well with the people I was honored to listen to in my clinical work during the collection of family memories.

Q. What difficulties have you encountered in your practice?

A. I have experienced numerous attacks against my character and my support of reparative therapy in Italy.

The efforts at intimidation began shortly after I had invited Dr. Nicolosi to come to Italy. In June 2003, he very generously accepted my invitation to speak to a group in Milan. At the time, I was very naive in my ideas about reparative therapy and was not fond of politics or of the mass media. Nevertheless, it was interesting to see the reactions of the psychotherapists attending the conference where Nicolosi spoke.

Several came from different parts of Italy; there was true interest in hearing him speak, but also a fear of publicly supporting his views. Most declared that the powerful “politically correct” pro-gay lobby in Italy would have silenced Dr. Nicolosi if they could have done so.

Later, I was speaking of Nicolosi’s work in a Catholic network I belong to and with two ex-gays with the ministry Living Waters. I was presenting a speech about his work in a parish and in a couple of cultural centers that were interested in reparative therapy.

I am Roman Catholic and in my church, homosexuality is considered to be a disorder; I think that reparative therapy is a most valuable tool for people fighting to overcome undesired homosexual feelings. With reorientation therapy, they can freely decide how to manage these feelings. It gives them a true choice, after knowing the possibilities available to them. They can work to remove “homophobia” and self-identify as gay, or work to find their true identity.

For my willingness to speak out in support of reparative therapy, I have been attacked in several ways during the last few years. The psychology association sent a letter addressed to the medical association claiming that I was not “authorized” to express my support for reparative therapy because it was considered “unscientific,” and because I was not a professional psychologist.

The medical association, after receiving my documented observations, completely rejected the accusations. When that failed, gay activists tried to intimidate me with letters addressed to my Chief and Director of the Hospital where I practice. According to these activists, a physician like me with “homophobic and racist ideas” could not work in a public hospital. I answered every single false accusation, even in the local newspaper.

In addition, last May a politician accused me in the Italian Parliament of professional misconduct, based on a dossier published by a gay activist who falsely presented himself to me as a person with undesired same-sex feelings seeking help. I was also accused of looking for success—to exploit people so I could become rich, and other absurd charges. A search of the

Internet will show that my name is associated with racism and homophobia because of these unethical attacks against me. However, my patients love me, and this is enough for me. When a homosexual brings to me his lover, companion, or simply insists that he visit me, I feel honored by this and ignore the unethical attacks against me.

Q. How has NARTH supported your efforts?

A. Often, when I have been attacked by “scientific” groups, I use the richness of NARTH’s website to find documents, published articles, or the opinions of eminent doctors to understand what I am facing here in Italy.

Dr. Nicolosi himself has been very available to explain to me how these kinds of problems arose in the U.S. He says these attacks are normal reactions from activists who try to silence any voice that is opposing the social and political normalization of homosexuality. What these activists are unwilling to admit is that the requests for help come from people who are genuinely looking for help. This is not political ideology.

The best reward for me is to occasionally meet former patients who are freely undergoing reparative therapy. Some are simply less depressed, sleeping at night without medication, or are free from compulsive sex. Others are experiencing happy relationships with heterosexual men or are dating girls.

My hope is that a true network of trained professionals will be available in Italy soon to assist people freely asking for reorientation. But I am also convinced that this approach cannot be usefully conducted by people who are unaware of the meaning of reparative symptoms of homosexuality.

I am deeply grateful for the help that Dr. Nicolosi and NARTH have given me over the past few years; and I look forward to helping reparative therapy grow in Italy.

Dr. Chiara Atzori, II Divisione Malattie Infettive, Ospedale L.Sacco, Azienda Ospedaliera-Polo Universitario, Via G.B.Grassi 74, 20157 Milano. Dr. Atzori is a member of “Chaire” (www.obiettivo-chaire.it), a small but growing Catholic group supporting the free choice of reparative therapy.

Gender Identity Disorder

Can A Person's Sex Be Changed?

By Richard P. Fitzgibbons, M.D.

How should the Catholic community respond to men and women who think that a sex change operation would solve their problem? Catholic teaching in this area is clear. It is impossible to “change” a person’s sex. Hormone treatments, cosmetic surgery and surgery to mutilate the sex organs do not change a person’s sex.

Confusion in this area has come about because people tend to defer to scientists, particularly in areas where their personal experience is limited. Therefore, when doctors, including those from the prestigious Johns Hopkins, have promoted “sex change” operations for physically normal men who believed they were really women trapped in men’s bodies or women who believed they were men trapped in women’s bodies, many have accepted the idea that it was indeed possible to change a person’s sex.

In an article in *First Things* titled “Surgical Sex,” Dr. Paul McHugh, of Johns Hopkins, laid out some of the history of the “sex change” phenomenon. [1] From the beginning, McHugh had doubts. He interviewed the men for whom the surgeons had created bodies that appeared female, and found the claim that they were now women unconvincing. He states:

None of these encounters were persuasive...The post-surgical subjects struck me as caricatures of women. They wore high heels, copious makeup, and flamboyant clothing; they spoke about how they found themselves able to give vent to their natural inclinations for peace, domesticity, and gentleness—but their large hands, prominent Adam’s apples, and thick facial features were incongruous (and would become more so as they aged). Women psychiatrists whom I sent to talk with them would intuitively see through the disguise and the exaggerated postures. “Gals know gals,” one said to me, “and that’s a guy.” [2]

When he became psychiatrist-in-chief at Johns Hopkins, McHugh decided to challenge what he considered to be a misdirection of psychiatry. He encour-

aged a study already begun on the outcomes of such surgeries. The study found that while most of the clients said they were happy with the outcome, the various psychological problems, which accompanied their feeling they were the other sex, remained unchanged. They still had the same difficulties with relationships, work and emotions.



Dr. Richard Fitzgibbons

McHugh concluded that “to provide a surgical alteration to the body of these unfortunate people was to collaborate with a mental disorder rather than to treat it.” [3] He ordered the practice halted at Johns Hopkins and tried to convince others that such interventions were a misuse of psychiatry and surgery. However, in spite of the evidence, the support for the idea of “sex change” operations has continued to grow. In fact, there have been several articles discussing whether it is advisable to begin the “sex change” process in adolescence or even before. [4]

McHugh was frustrated to find that those promoting the practice were not persuaded by empirical evidence:

One might expect that those who claim that sexual identity has no biological or physical basis would bring forth more evidence to persuade others. But as I’ve learned, there is a deep prejudice in favor of the idea that nature is totally malleable. Without any fixed position on what is given in human nature, any manipulation of it can be defended as legitimate. A practice that appears to give people what they want—and what some of them are prepared to clamor for—turns out to be difficult to combat with ordinary professional experience and wisdom. Even controlled trials or careful follow-up studies to ensure that the practice itself is not damaging are often resisted and the results rejected. [5]

Each cell of a person's body contains chromosomes which identify that individual as either male or female. It is not simply a question of different genitals. Before birth prenatal hormones shape the brains of boys to be different than those of girls. [6]

Mutilating surgery and hormone treatments can create the appearance of a male or female body, but it cannot change the underlying reality. **It is not possible to change a person's sex.**

In promoting the truth about the human person, the Church is on the side of science when it proclaims that it is not possible to change a person's sex. Therefore, persons who claim to have had their sex changed may not marry or be ordained. [7] A man who is surgically altered to resemble a woman may not marry a man and a woman with a male appearance may not be ordained a priest.

Unfortunately, the promotion of "sex change" operations has decreased investigation into prevention and therapy for those suffering from gender dysphoria. However, a number of mental health professionals work with and do help such individuals.

For example, in one case a Catholic, married man who had several children wanted to become female. He had completed electrolysis to remove facial hair and was on hormone treatment. As a child he had been unable to model after his angry father, aggressive older brothers, or hostile boys in the neighborhood. He viewed men as angry, violent, dark people with whom he could not identify. Instead, he had escaped from what he perceived as the unsafe world of men, into a fantasy female world where he felt safe. As he matured, these fantasies diminished and he married and had children. However, at a certain point in his career he found himself in an extremely stressful situation both at work and at home, and his original fantasy about being more safe as a female reemerged.

In his therapeutic treatment, he came to understand the origins of his inability identify with his masculinity. Then he worked on forgiving the men and boys who had hurt him in his childhood and in his adolescence, especially his father and his brothers. In working with a spiritual director, he slowly came to experience God as loving father who could protect him and

to develop a relationship with St. Joseph as a role model of male love. A major goal of treatment was to help him see his own masculinity as a positive gift from God.

In another case, a thirty-year-old man with excellent athletic abilities was seeking "sex change" surgery. The therapist he consulted was able to help him uncover serious emotional conflicts with his mother. She was a self-centered person and a substance abuser who had essentially abandoned him as a child. Unconsciously, he thought that if he were a woman, he finally might receive his mother's love and acceptance. Because he had not experienced a comforting, loving mother/son relationship, his ability to trust and feel safe in the world was badly damaged. He thought that if he were a female he might feel protected in the world. As a result of his regular participation in a "transgender support group" (which was biased toward encouraging "sex change" procedures), he came to believe that there was a biological basis for his belief that he was female. It was extremely difficult for the young man to admit his problems with his mother, or to acknowledge his feelings of disappointment, sadness, and resentment. Eventually, through therapy, he was able to recognize the effects of his mother's dysfunction on his self-image.

Dealing with clients who have a desire to become the other sex, it is important not to take the desire at face value, but to uncover the emotional conflicts which has led them to think they would be happier, safer and more confident as the other sex. The recognition of emotional pain with peers or with a parent leads to the awareness of significant anger which can be resolved through a process of forgiveness. At the same time it is necessary to treat low self-esteem, poor body image, sadness, and fears. [8] Many of those who seek surgical "sex change" suffered from untreated and undiagnosed Gender Identity Disorder (GID) as children. For example, a therapist was consulted by a member of the family of a young woman who had told her parents that she wanted "sex change" surgery after graduating from college. Since childhood, the young woman had shown all the classic symptoms of GID. [9] She had never had female friends, never wore a dress, never used make up, never wore jewelry or dated a boy. She also insisted that her Catholic parents address her with a boy's name, which they agreed to do.

GID in children is a treatable condition; however, according to Zucker and Bradley, who are experts in the treatment of this disorder in children, parental ambivalence is, in most cases part of the problem with parents ignoring or excusing obvious problems. [10] Zucker and Bradley encourage early intervention, not simply to avoid a later desire for a “sex change” but to prevent the suffering, unhappiness, and isolation that children with GID experience. In the case of this young woman, the therapist recommended treatment of GID to the family member who asked for consultation, but this recommendation was never communicated to the parents. The young woman recently had her breasts removed.

The other conflicts in those who seek “sex change” surgery experience are a failure to embrace the goodness and beauty of their masculinity or femininity, hatred of their bodies, deep resentment with a parent or peer, childhood loneliness and sadness, rejection by peers of the same gender, intense fears of being betrayed and hurt, and a deep desire to be protected in the world. A less common conflict is seen in some boys and men who have powerful artistic and creative gifts, which lead them to experience a strong attraction to the beauty in the female world and to an identification with femininity. This artistic response can begin early in childhood and can lead to a desire to be female. In rare cases, a parent wants a child to be of the opposite sex, dresses and treats the child as being of the opposite sex and may even take the child to a “transgender support group.”

Self-knowledge, forgiveness, skilled psychotherapy and good spiritual direction can all play a part in the healing process. Much more work needs to be done in this field. Parents, pediatricians and educators need to be able to recognize GID in children. Mental health professionals and priests should understand the origins of the condition,

and know that successful treatment can occur in persons who come to them with the desire for a “sex change.” Finally, professionals with positive experience in treating this problem need to share their expertise with others.

This article was first published in *Ethics & Medics*, October 2005, Volume 30, 10. It is reprinted by permission of The National Catholic Bioethics Center, which maintains the copyright. *Ethics & Medics* is edited by Edward J. Furton, M.A., Ph.D., Ethicist and Director of Publications. Web site: www.ncbecenter.org.

End Notes

1. Paul McHugh, “Surgical Sex,” *First Things* 147 (November, 2004): 34-38.
2. *Ibid.*, 34.
3. *Ibid.*, 35.
4. Robert Listernick, “A 13-Year-Old Boy Who Desires Gender Reassignment,” *Pediatric Annals*, 32.6 (June, 2003): 378-382; Yolanda Smith, “Adolescents With Gender Identity Disorder Who Were Accepted Or Rejected For Sex Reassignment Surgery: A Prospective Follow-up Study,” *Journal of the American Academy of Child and Adolescent Psychiatry*, 40.4 (April, 2001): 472-481.
5. McHugh, “Surgical Sex,” 37-38.
6. Gerianne Alexander, “An Evolutionary Perspective of Sex-Typed Toy Preferences: Pink, Blue, and the Brain,” *Archives of Sexual Behavior* 32.1 (February 2003): 7-14. The problems of various genetic and congenital abnormalities are not relevant to this discussion. This essay focuses on the majority of cases, in which those seeking “sex change” operations are physically normal.
7. John Norton, “Vatican Says ‘Sex-Change Operation’ Does Not Change A Person’s Gender,” Catholic News Service, Jan 14, 2003.
8. Robert Enright and Richard Fitzgibbons, *Helping Clients Forgive: An Empirical Guide for Resolving Anger and Restoring Hope* (Washington, DC: American Psychological Association, 2000).
9. Richard P. Fitzgibbons and Joseph Nicolosi, “Gender Identity Disorder in Children,” *Lay Witness* (June 2001); also available at <http://www.narth.com/docs/fitz.html>.
10. Kenneth Zucker and Susan Bradley, *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents* (New York: Guilford Publications, 1995), 73.

A Woman’s Mind Trapped In A Man’s Body?

Transsexualism may be the next mental disorder to be removed from the DSM.

By Neil E. Whitehead, Ph.D.

What would you feel like if you really believed you were born into the wrong body? About one in 30,000 men have become convinced they are really women, but born with the wrong genitalia. Some (far fewer)

women also feel as though they are men trapped in a woman’s body. It has no necessary connection to transvestite behavior and is variously called transgender, transsexualism, etc.

Is this really just another form of same-sex attraction? No, the situation is much more complex and variable—some admit same-sex attraction while some don't. But it is hard to get to the truth because an indeterminate number may not be truthful in reporting sexual orientation. In addition, the transgender community finds the “approved answers” that have achieved clinical approval of sex-change surgery for them, and passes them around to be reproduced in clinical interviews. Many actually claim very rapid sexual orientation change after their surgery. This article will argue that any biological basis for transgenderism is weak, and that, in principle, the best solution is therapy, not surgery.

“Twin studies” shine a powerful search-light on this subject. Transgendered people are much rarer than those with same-sex attraction, and it is quite hard to find identical twins in this category, but a survey of the scientific literature (see below in the reference list) in which twins were studied, gives nine cases of transgender concordance and 12 cases of discordance in identical twins. I mention this because if the condition were genetic, all identical twin pairs (who have identical genes) would both be transgendered. They aren't.

What's more, this sums up the effects of the identical home environment, and any unknown factors that will be discovered in the future. Genes plus early environment, plus any other common factors, all summed up only gives a moderate degree of concordance. Now, of course, there are not many identical twin pairs available for study in this area, and the collection could be quite biased. Milton Diamond, the well-known sex researcher from Hawaii, says that his independent collation gave rather similar results (personal communication). A really comprehensive collection of twins, at least one of whom is transgendered, would probably reinforce this finding, showing that identical twins usually differ in transgenderism. Therefore genetic effects are minor at best.

I begin with this observation because readers will be familiar with various announcements from time to time in the popular press about hormones, or brain structure or some other factor that indicates there are fundamental differences between transgendered people and heterosexuals. These papers would give the impression that differences are strong and innate. That

is quite misleading, but is mostly the fault of commentators rather than the original scientists, who are usually more circumspect. Any such effects are *weak*, and the identical twin statistics summarize this.

Brain Structure Changes With Use

We must remember that finding hormone or brain differences between transgendered people and heterosexuals (Dörner et al., 1991; Bonsinski et al. 1997; Gorman 1995; Zhou et al., 1995; Kruijver et al., 2000) plausibly results from the well known microstructural changes already known to take place in brains when a physical or mental activity is strong, and long-continued. The current neurological catch phrase is to say the “brain is plastic.” London taxi-cab drivers have an enlarged area of the brain concerned with navigation. There are numerous such known effects. What differences do you think there must be when someone obsesses for 10 years about gender issues? Yes, there will be physical changes in the brain, and probably slight changes in hormone levels, but the person was not born that way. It is the obligation of others with a view that such differences are innate to prove their theories, which do not have the support that our knowledge of brain plasticity does. Many research papers are appearing at the moment that discuss relative finger lengths in lesbian women—they are somewhat more like the ratios found in men, and since this is obviously not influenced by anything after birth, this is taken as an argument for innateness. But studies (Hall & Love, 2003) found no difference for female-to-male transsexuals.

If genes and home environment don't have an overwhelming effect, what does? Chance. Here is one theory: A small minority of those towards the feminine end of the masculine continuum perceive themselves as abnormally feminine, from small physical or mental clues, and begin to anxiously wonder if they are really fundamentally female. Other men who are just as “feminine” don't care at all and remain heterosexual. One might speculate that Napoleon, with a rather delicate, feminine body-form could have become transsexual if he had obsessed sufficiently and long enough about it. Instead, he became the archetypal male military strategist.

If chance and thought patterns have created a trans-

gendered person, therapy can potentially reverse that, but it might take a long time. However, time is on our side—even heterosexuals change their sexual orientation. According to the surveys, half of them are no longer interested in sex at age 60! They have entered the “asexual” sexual orientation class. Many with same-sex attraction ultimately lose much of their enthusiasm with age as well.

How successful is therapy? Anecdotally, individuals report they have been helped, but I am aware of no good statistics taken under controlled conditions. An internationally known case of one man who did not proceed with sex-change surgery and eventually married a woman is Sy Rogers, and information about him is readily available on the web.

The Problem Is In The Mind—Not The Body

The usual response these days from those persuaded they are really women in men’s bodies is not to ask for therapy, but sex-change surgery, and more than 10,000 such operations have been performed (Israel & Tarver, 1997) which is likely to be a large fraction of those eligible in the West. Surgeons are eager to have the opportunity to do this, because it is a rather virtuoso piece of work, and even more so if a woman requests surgery to create a penis. The results of sex-change surgery are moderately satisfactory to most of those who have enough post-operative support. However, there are often difficulties in general life adjustment that are not changed by surgery (Meyers & Reter 1979). A small fraction regret the surgery in spite of counseling. This was as high as 16% in one study (Bodlund & Kullgren 1996), which is really rather disastrous, since the surgery for males is not satisfactorily reversible whereas therapy is. The patients have assumed that the body form is the problem, whereas the problem has really been in the mind.

Two factors make it likely that the “positive outcomes” have been exaggerated—the patients will want to report success to boost the chances for their friends who still seek the surgery, and the medical teams are unlikely to publish reports of outcomes worse than average.

At present, the transsexual is said to suffer from a Gender Identity Disorder (GID) according to the *DSM*

official guidelines, thus making it a mental disorder. This is strenuously resisted by the activist community. This diagnosis is likely to be removed from the classification list, essentially on political grounds, even though it fits well the definition of a mental disorder as a mental pattern which prevents easy functioning in some area of life, causing distress to the patient.

Although a precondition of surgery is supposed to be the ability to pass as the opposite sex for two years successfully, more and more of these guidelines are being ignored in many countries. Medical control is further subverted by ready availability of hormones via the internet.

Asking For A “Race Change”

“Transgenderism” is a strange case of a mental disorder claimed to be correctable by surgery unrelated to brain surgery. It is reminiscent of a case covered by the BBC some years ago in a documentary. A white woman (with white parents) was convinced she was actually black inside and her outward appearance was the result of a genetic accident. If genetic surgery had been available she would have requested a race change.

The ultimate philosophical end point of this activist direction is to say that “I have a right to be whatever I think I am or would like to be, and the medical profession must bring it about.” We see this already in euthanasia, abortion, and there will be much more extreme cases in future.

One can imagine someone wanting the physique of an Olympic champion and demanding medical assistance – unfortunately those “rights” will clash with those of the Olympic rules! One can imagine someone under the illusion they are Tom Cruise and saying it is their right to have cosmetic surgery to look exactly like him. I am not sure Tom Cruise or his agent would agree – but do they have a “right” to copyright Tom Cruise’s face?

“Rights” language does not have mechanisms for balancing competing “rights” because in most cases the person claiming rights is simply saying “Gimme” without sound supporting reasons.

Should what a person thinks (mistakenly) be allowed

to prescribe surgery? Usually not. We need a new Hippocratic Oath to cover ethical limits of deconstructive and constructive surgery.

Perhaps the human body has some rights too—a right not to have mutilating surgery done on it.

Although someone may believe they were born a woman trapped in a man's body, I conclude that therapy is a preferable option to surgery on the body, or political surgery on the body of laws of the country. I think Sy Rogers would agree.

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Dr. Neil E. Whitehead, Lower Hutt, New Zealand, whiteh@paradise.net.nz, is author of *My Genes Made Me Do It* and hosts a "Homosexuality and Science" web site that provides science-based information on sexual orientation.

Canadian Transgender Activists Urge Legal Protection For Gender Fluidity

By Frank York

“Why be just one sex?” written by Gloria Kim for *Macleans.ca* describes the lives of Canadian men and women who believe they are the opposite sex and are working to change the Human Rights Act to protect “gender identity” or “gender expression” as a fundamental right. Kim describes Harry (not his real name) who does not identify as either male or female. Harry was once married and cross-dressed with his wife’s permission. However, one summer in California, he was shopping in a fetish store and the salesgirl gave him a complete make-over. He walked out of the store as “Sally.”

Sally considers himself a gender outlaw, playing outside the traditional definitions of man and woman. Sally runs his business as a man and has not had sex change surgery but considers himself a woman.

Kim quotes Rupert Raj, a counselor at the Toronto-based Sherbourne Health Centre, who was born female but thinks she’s a man. According to Raj, “[Transgenders] mean an openness to not being boxed in to either sexual orientation or gender identity. Sometimes they want hormones and no surgery. Sometimes they want surgery and no hormones. Sometimes they don’t want either.”

Kim claims that “current thinking on gender is coming around to the concept that sex, like sexual preferences, isn’t an either/or proposition but rather a con-

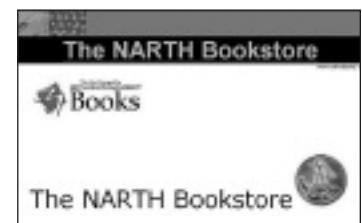
tinuum. Transgender studies have become a hot new area of scholarship as more transgendered academics come out and publish.” She describes York University Professor Michael Gilbert who began cross-dressing in 1996 after he’d received tenure. Gilbert claims there are numbers of people who aren’t comfortable with being categorized as either male or female. According to Gilbert, “I think of gender as analogous to eyesight—there are many different prescriptions.”

According to Stanford University biologist Joan Roughgarden, a transsexual, in half of the animal world and plants the most common body form is both male and female. Roughgarden says that many species have three or more genders. The traditional view that only male and female are normal is incorrect. Roughgarden believes that “diversity” is the norm.

The transgender movement has caught the attention of Vancouver Member of Parliament Bill Siksay who sees the need for protection for individuals who believe they are the opposite sex or are gender fluid. The MP introduced a bill in May, 2005 that would amend the Human Rights Act to include legal protections for “gender identity” or “gender expression.” According to Gilles Marchildon, executive director of the homosexual group Egale Canada, “Trans people are where the gay and lesbian rights movement was a couple decades ago.”

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NARTH’s online bookstore offers a wealth of reports and books to help individuals overcome unwanted same-sex attractions. The bookstore features NARTH’s Conference Papers. Selected back issues are available for \$5 each. The 2004 Conference Papers are available for \$10. The online credit card feature allows you to join NARTH or renew your membership online. Access the bookstore by going to the NARTH web site: www.narth.com.



Introducing The First Stage of Therapy with Women with Same-Sex Attraction: *Securing the Foundation*

Part 2 of a two-part series

By Janelle M. Hallman, MA, LPC

As a review, the first stage of therapy with women with same-sex attraction can be broken down into three separate therapeutic tasks:

Creating Safety - the Heart of the Helping Environment

Fundamental Therapeutic Processes:

Acceptance and Attunement

Client's Task: Rest

Building Trust - the Heart of the Helper

Fundamental Therapeutic Processes:

Caring and Commitment

Client's Task: Receive

Establishing and Maintaining a Secure Attachment - the Heart of the Relationship

Fundamental Therapeutic Processes:

Empathy and the Here-and-Now

Client's Task: "Become"

Part 1 in this series detailed the process of therapeutic acceptance and how it can further a woman's sense of safety in a therapeutic or helping setting. Following is a look at the process of attunement and its significance in creating a safe holding environment for the women with whom we work.

Safety in Attunement

One client told me:

You were silent a lot. I knew you were listening. Your silence said, "Keep talking, I'm engaged with you." You always looked at me, even when I had to say disgusting and shameful things. You even leaned forward. Those kinds of things comforted me. I knew you were with me, listening and you were not grossed out. -- *Ellen*

Attunement is the nonverbal communication such as eye contact, facial expression, voice modulation, gestures, and timing and touch, [1] common to the rela-

tionship between a young child and mother, "in which both are sharing affect and focused attention on each other in a way such that the child's enjoyable experiences are amplified and his/her stressful experiences are reduced and contained" [2] (emphasis mine).



*Janelle M. Hallman,
MA, LPC*

I recently watched a video illustrating the power of parental attunement. A mom of a six-month-old baby was first instructed to remain attuned and engaged with her baby by entering into the baby's emotional states. When baby laughed, mom laughed, affirming the baby's joy and pleasure. If baby became agitated, mom showed her care through her facial expression and reassuring touch. When baby practiced cooing out words and gurgles, mom reflected her pride and encouragement through her eyes and mirroring gurgles. The baby was engaged and energized.

But then mom was instructed to break attunement by retaining a blank expression or turning her face away from her baby. The baby initially continued in their playful joyfulness. But when mom only offered a deadpan response, the baby became noticeably agitated. But mom was not there to reassure him. Mom looked away. The baby became more and more overwhelmed with his distress and growing insecurity. He tried and tried to engage mom by flailing his limbs and releasing audible whimpers, but to no avail. The baby eventually slumped in his little infant seat, lowered his eyes and attempted to find comfort by sucking on one of his small hands. His inner self had literally shut down.

Parental attunement is considered by attachment specialists to be one of the most influential processes in developing a core self within a child and maintaining a secure attachment with the child even into the

child's adulthood. [3] Without it, a child lives within relational isolation. The formation of their basic sense of self will be severely altered if not altogether arrested.

Unfortunately, many women as young children, like this baby, lacked consistent moments of attunement. [4] They missed the significant ongoing experience of being the object of another's undivided, engaged, and regulating attention. They were, therefore, deprived of the environment in which to grow and develop their own feeling states and foundational core. Even now, they can be easily flooded with the shame of emptiness and fear of abandonment when they perceive they are being met with deaf ears or a disengaged heart. Therapeutic attunement is a powerfully healing and curative technique for these women. It can literally reestablish the environment in which a woman can continue her inner formation. A woman describes this experience:

I was shocked the first time I visited Beverly, my new counselor. She was so caring and compassionate. While she listened to me, tears came to her eyes. I knew she was right there with me. I knew I had someone who cared. This was huge for me! I cannot tell you the healing I experienced. I so needed somebody to just listen and care for me. It was a safe haven. -- *Joyce*

In order for me to offer my clients full attunement or emotional communication, I have to open myself and allow my "state of mind" to be influenced by them. My goal is to align my inner state so I can experience, as close as possible, what my client is experiencing within her subjective or inner world in any given moment. [6] I then communicate my attunement through my eye contact or gestures.

If my client lowers her chin as she speaks, I lower mine and form a slight frown, as I attune to her dejected affect. As she glances out the window, I follow her glance, shifting my position as I attune to her discomfort and anxiety; I then recenter my gaze on her face. When she smiles, I take a deep breath and slowly release it as I feel her relief and joy. When she frowns, I tilt my head, showing a look of consternation as I remain with her in her sadness. As a woman timidly attempts to articulate her thoughts, I soften my speech.

When she comes at me with force and anger, I place my feet on the floor, rise up in my chair and lean forward with strength and centeredness – and a slight smile. I am with her and I *can* handle her.

Attunement sends the nonverbal message that she is being understood in the deepest sense and is therefore not alone. You and she are in harmony, experiencing something together. And since you "with her," she feels safe.

I remember you looking at me after I had shared. You were hugging me with your eyes. I had goose bumps – the hug felt real. Light and warmth were coming from your eyes, totally engulfing me. It was truly incredible. I felt something touch me down to the depths of my soul. -- *Wendy*

The experience of attunement affords a woman the structure and support she needs to begin to connect with, regulate, and understand her own emotions, reactions, and behaviors. As she reflects on these experiences within herself, she may be able to acknowledge and therefore integrate previously ignored, denied or neglected aspects of her self. [7] "The job of psychotherapy then is not to de-emphasize, defuse, or discharge these moments of oneness, but to encourage, heighten, and embrace them instead. Only then will we be helping patients in their recovery from their detached, alienated core." [8] As another writer explains:

The affective experience of igniting an empathic connection between two separate beings is the magic of love, the holiness of spirituality, and the miracle of humanity. That two beings, separated by a lifetime of unique experiences, can "feel themselves into the other" is truly extraordinary. [9]

Containing and Regulating

Attunement is especially important in helping a woman to regulate and manage her anxiety. Just about every woman with whom I have worked, struggles with some form of anxiety. It may be familiar to her, something she has lived with for years, or it may be circumstantial, arising out of the newness or nature of the therapeutic work. It may serve as a "blanket" emo-

tion used to cover other powerful emotions she has never felt safe or strong enough to face. Regardless of its source, I have learned it is extremely important that I handle her anxiety with concern and respect. As I deal with it in this way, she learns by example how to welcome, regulate, and process not only her anxiety, but also all of her feelings.

In the beginning stages of our work, I carefully attune to my clients, noticing any indication of agitation or fear. She may halter in speech or twist on a Kleenex. She may tap a foot or continuously shift positions. My goal is to intervene long before she begins to verbalize her discomfort or inability to proceed. I gently stop our conversation, saying,

“Alaina, you just told me a lot about your family. I know it was hard for you so I really appreciate the effort you are making. But I’d like us to take a break.” Pausing and then speaking slowly, “Why don’t you relax back into the couch and take a deep breath in... and then slowly let it out.” (Notice, I do not *tell* her she is anxious.) “Let all of the tension you are holding just flow out of you as you slowly exhale.” (I coach her and do the exercise with her, exaggerating my intake and release of air. She can basically mimic me. We both relax.)

“Okay,” I say, smiling and leaning forward. “You are doing great work. We will continue your story next week. For now though, I would like to hear what it was like for you to share all of that information with me.”

We then reflect on her *experience* of sharing. This helps her to integrate or “take in” the experience as a warm positive moment of connection and acceptance (in contrast to all of her disappointing moments of rejection or neglect).

Go Where She Goes

Many women with same-sex attraction have spent a lifetime figuring out what other people want or like so they can please them. Pleasing others is often one of the only ways a woman knows how to gain a sense of connection, acceptance, and value. I learned fairly early on, thanks to the honesty of my clients, that

many of my clients tried to “read” me to determine what “I wanted or expected” so they could perform as good clients. I knew this could become extremely destructive to my client’s therapeutic process if I, for example, unconsciously *needed* her to cooperate with *my* treatment agenda for *my* ease or sense of security. I would be simply reinforcing a woman’s energy to please. Safety would be breached if she were to be used towards my end.

I have, therefore, made it an ongoing habit to continually check my hidden goals, agendas, or expectations I might have with respect to my clients. I also want to actively invite her to step out of this historic role of pleasing others by taking the initiative to discover what *she* wants or likes. Irving Yalom emphasizes “Above all, the therapist must be prepared to go wherever the patient goes, do all that is necessary to continue building trust and safety in the relationship” [10] (emphasis mine). Therapy, in this initial stage, must be thoroughly client centered.

I contemplated this concept at a recent baby shower. Many mothers and young children were present but one little girl caught my attention. Her eyes were as round as her face and her cheeks were even redder than her hair. She was about one and a half years old. She was dressed in a pink frilly dress with white lace anklets and patent leather shoes. She seemed oblivious to the “frill” as she walked, jumped and crawled in between the guests, up and down off of chairs and out into the garden. She delighted in exploring her world.

I wondered how her mom was handling being mom to a not so frilly active and adventurous little girl. At one point mom made a comment her daughter *loved* to play with cars and trucks. “Yep,” that didn’t surprise me. The little girl seemed developmentally healthy though, as she regularly ran back to mom throughout her explorations. But there was one dynamic I couldn’t help noticing.

As she returned to mom, the little girl tried to speak. In response to her unintelligible sharing, the mom scooped her child up and plopped her on her lap. The youngster immediately tensed into a stiff statue until mom put her down. She then whined out a few more words (maybe sentences) and finally returned to her wide-open spaces.

I was glad to see the mother was attentive to her little girl's need for affection and comfort. However, I couldn't help thinking mom was nevertheless "missing" her daughter, similar to how an arrow misses the round bulls eye. The archer no doubt wanted to hit the target, but was lacking something in terms of technique or aim. I think this little girl wanted her mother to come and explore the world *with* her. I suspect she would have been delighted if mom had left her chair and walked the garden or followed her into the house. I think the little girl wanted her mom as an exploring companion. Perhaps she would have felt safer, not to mention known and loved.

We have the same opportunity to *go where our clients go*. We can stick to *our* "cushy chair" or preferred styles of therapy, or metaphorically get up and follow our client's lead. Similar to our little redheaded friend above, the woman with same-sex attraction needs to know she is valuable and important enough to *be* followed. She longs to be pursued and known. She longs for connection that doesn't require her to do all the work.

"I worked so hard to keep you engaged. I did my homework. I intensely pursued my issues. I wanted to please you. And I figured if I ever stopped working so hard you would leave or terminate. What I realize now is that you were always engaged and it wasn't dependent on my performance or intensity. You always reflected back to me commitment and stability. When I finally realized you were committed to **me**, not just my process or work, I knew I was experiencing something completely new. It was absolutely pivotal! I can now say I shifted from a state of performance and intensity to warm and settled intimacy, for the first time in my life.

-- *A woman speaking to her counselor*

In the beginning stages of therapy, if a woman would rather tell me about an incident at work than continue talking about her childhood story, I will wholeheartedly engage as I follow her lead. I stay with her (fully attuned) while she shares yet another aspect of whom she is. I will not force her to reenter her past until she is ready. Truth be known, she probably doesn't care that much about addressing "past" issues, at least at this point in time. She is much more concerned about

my ongoing presence and ability to stay with her, *wherever she goes*.

She's Doing The Best She Can

To add to my client's sense of safety, I also allow a woman to experience and express her emotions and visceral feelings in the best way she knows how. Feelings of any sort are often difficult for most of these women to identify, experience, let alone articulate with another person. I have learned to be patient and calm as a woman sorts through her inner turmoil and displays certain behaviors related to her discomfort.

Danielle, a 45-year-old woman who had embraced a lesbian identity for over 11 years, told me about an experience with a previous therapist. In their second or third session, Danielle felt such agitation she got up out of her chair and began to pace as she and her therapist continued to talk. [11] Danielle's therapist eventually asked her to sit down because Danielle's walking was distracting her. This therapist was evidently uncomfortable with staying present to Danielle's agitation as manifested by her physical movement. As you might guess, Danielle never returned.

This therapist missed an incredible opportunity to enter into Danielle's "disordered" world and simply *be* with her. A group of therapists in the 70s discovered this very essential need:

A human being cannot suddenly give up all the images, roles and symbols of his existence, for he would have to face the unknown with extreme fear. *He needs someone who can take him into and through his disorderedness* to the reality of his impulses, thoughts, and expressions. He needs to make contact with another human being (emphasis mine). [12]

Hughes claims if a child's or client's disordered behaviors habitually annoy parents and therapists, those behaviors *will* resist change. However, "if we truly accept these behaviors, they are much more likely to change." [13] Following is an example of how I interacted with one of my clients after they had started pacing in my office:

"Are you feeling better, now that you have

walked a little?" I asked in a warm and caring tone.

"Yes, yes I am."

"Do you know what you were feeling when you first decided to get up and start walking?"

"I don't really know."

"Do you remember what we were talking about?"

"Nope."

"Well I think I do. You briefly mentioned your mom died when you were four years old. It must be very hard for you to talk about." I leaned forward and maintained eye contact with her as she continued to pace.

"I didn't think it was hard to talk about."

"What are you feeling right now?"

"I guess okay, but a bit bothered you're asking me all these questions."

Catching her increasing anxiety surrounding my probing questions, I decide to lighten up our interaction. "Would it still feel good to walk a little more?"

"Yeah, I'm all fidgety, I just can't sit down."

"That's fine, take as much time as you need." [14] I pause, relax and sit back in my chair. In a matter of fact manner, I continue with our original process, "So, you were giving me an overview of your life. I think we were at age five. Can you tell me what happened next?"

To relieve some of my client's anxiety, I chose to bypass the subject of her mother's death. There will be many more opportunities to explore this material. I also backed away from the intensity of our attunement, giving my client some needed "breathing room." I allowed my client to simply "be" who she is at this point in time. I did not expect something different or more from her. However, I did lightly challenge her to connect with her inner impulse or emotion that first prompted her to pace. I wanted to affirm her emotion and need to physically shake out some tension. I wanted her to feel safe. Another woman explains this phenomenon:

I was up and down, all over the map. But my counselor was always the same – consistent. My emotional roller coaster didn't change her and she

stayed with me. That was amazing to me. -- *Sandy*

I resonate with Mother Teresa's philosophy that it is not so important what we *do* for the poor and lonely, but that we simply *be* with them in the midst of their suffering. This tenet applies well to our work with these women. It is the essence of love.

When We "Miss" Her

Once attuned, my clients can be quite sensitive to an emotional shift on my part. Even with the best of intentions, I *do* fail in my attunement skills. Thankfully, the positive *and* negative impact of our personhood and behaviors on our client is an essential part of the "realness" they must experience, navigate, process, and integrate into their framework for healthy *human* intimacy.

For example, I have had many clients catch me as my mind has wandered to what I was going to eat for dinner or what I needed to pick up at the grocery store. They have not hesitated in asking,

"Hey Janelle, are you with me?"

I am honest and admit, "No I'm not. I'm sorry. I was drifting there for a minute. Thanks for calling me back. By the way, it's not your fault I was day-dreaming. It was rude for me to leave you. But I'm back. Thanks for being patient with me."

I might then pursue the feelings that emerged as they sensed me "leave the room," *or* simply proceed with our current content or process. It depends on my assessment of my client's anxiety as a result of my "abandonment" and their ability to proceed. Sometimes I simply "miss" my client. Once, during an obviously difficult moment for a client, I offered reassurance of my presence and care by sliding my chair a bit closer and leaning forward. She continued to speak. As I observed an increase in her anxiety, I assumed it was related to the content of her sharing. Assuming I was accurately attuned, I reflected her strained facial expression and offered empathy, commenting, "It's hard to talk about this. I can feel your nervousness and anxiety." My client abruptly reacted by sitting straight up and then pushing herself back into the couch. Her eyes were bright and large as she

announced, “Janelle, *you* are making me nervous. I’m fine with talking about *this*, but *you* are getting too close!” Thankfully, her articulation allowed us to quickly repair our attunement and reestablish safety by creating a bit more distance.

Dr. Daniel Siegel notes, “Unless repair of these disruptions in attunement is undertaken, toxic sense of shame and humiliation can become serious blocks to interpersonal communication.” [15, 16] This is painfully true with my clients. Because their core self is not yet developed and precariously unstable, a breach in attunement with me through *my* dissociation or misunderstanding, can catapult a woman back into her inner dark hole of despair and heart-wrenching shame of non-existence and worthlessness. A dread of annihilation may surface, overpowering her ability to articulate all that is taking place within her. The best she can do at the time may be to withdraw or shut down.

To repair this level of rupture, I must attune to her current state of emotion, rely on empathy, and be willing to own my failure if need be. To reengage in our original process, my client will have to be willing to “reconnect.” If she is unable or unwilling to remain open so that I can realign with her former inner feeling state, I affirm and respect her decision. I realize *her* safety has been breached and mistrust ignited. Hopefully, my ongoing patience and compassion will eventually reestablish safety and future attunement opportunities.

When She *Wants* To Be “Missed”

Many women might unknowingly resist against the warm feeling of safety and comfort often associated with attunement. She fears if she relaxes and simply enjoys the experience of togetherness and care, her guards or defenses may fall and it may still be too risky to drop her defenses. She is still not certain she can fully trust. She does not want to open her heart only to be hurt or disappointed “once again.” Additionally, she may not be ready to feel other emotions that could potentially surface if she relaxes and drops her defenses. It is not uncommon then, for some women to unconsciously attempt to sabotage the emotional connection with her therapist as soon as a *sense of safety* or trust begin to develop.

Many a time I have relaxed with a client, only to be abruptly startled by a sarcastic or mocking response to my last heart-felt remark. The sarcasm immediately breaks the felt warmth and closeness in the room. I have learned to never interpret these defensive maneuvers as personal or react with frustration or harsh confrontation. Indeed, my client’s defenses provide an excellent opportunity for me to readjust my attunement and empathy to her fear and insecurity. I go where she goes and allow her the freedom to relate and express herself in the best way she knows how. When a woman finally makes a choice to allow herself, perhaps for the first time in her life, to *feel* safe, to relax, and to begin to trust, you can be assured that you are both on holy ground.

End Notes

1. Hughes (2004) lists these constructs within the context of attachment therapy with children involving parents and a possible team of therapists. Touch can be executed safely and responsibly in this type of setting. Touch should *never* be a presumed part of therapy with women with same-sex attraction.
2. Hughes (2004, p. 1).
3. Ibid.
4. It is an infant’s experience of mother’s attunement and affectual regulation and the infant’s own inner feelings or feeling states that form the primitive core of the self. Masterson (1985, p. 24). In her work with women with same-sex attraction, Dr. Elaine Siegel (1988) notes, “because their mothers *appeared* not to love them and produced massive failures of empathy, my patients had no way to delineate a stable self” (p. 20, emphasis mine). This disruption or detachment from mother can lead to the overall personality development of what has been called “*the empty core*.” Walant (1995, p. 10).
5. Siegel (1999, p. 69).
6. Siegel (1999).
7. Hughes (1997); Walant (1995).
8. Walant (1995, p. 122).
9. Walant (1995, p. 103).
10. Yalom (2002, p. 34-35).
11. Often the body is used to relieve or process internal emotions and conflicts. This can be especially true of women with same-sex attraction. Siegel (1988) notes “Often this use of bodily communication made for tense, restless sessions. The analysts could find no comfort, or even a comforting and comfortable position on the couch” (p. 40-41). Many of my clients have paced, sat on the floor, laid on the couch, asked to sit in my chair, covered themselves with pillows, thrown pillows, abruptly stood to their feet, etc. When appropriate, the therapist can invite the woman to reflect or even exaggerate their actions to determine their meaning.
12. Karle, Woldenberg, & Hart (1976, p. 84-85).
13. Hughes (2004, p. 10).
14. Siegel asserts that attunement includes the “capacity to read

the signals (often nonverbal) that indicate the need for engagement or *disengagement*,” disengagement being defined as a person’s normal need to be alone and not in alignment with another (1999, p. 70).
15/16. Siegel (1999, p. 25)

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Homosexuality And Biological Factors: Real Evidence -- None; Misleading Interpretations: Plenty

Dr. van den Aardweg explains why he believes the claims for a biological basis for SSA have little merit.

By Gerard van den Aardweg Ph.D., Holland

In 1898, the Austrian empress Elizabeth was stabbed to death in Genova by 25-year-old Luigi Lucheni. The murderer was proud of his act, which he declared was “revenge for my life.” After turbulent years in prison, Lucheni hanged himself in 1910. A typical representative of the prevailing 19th century thinking on abnormal behavior, professor Mége-



Gerard van den Aardweg, Ph.D.

vant performed an autopsy, investigating the brain to uncover the anomalies that were supposed to underlie the murderer’s “psychopathic disposition.” However, nothing out of the ordinary could be found; even Lucheni’s brain weight was standard. Disappointed, the professor put the head in a jar with formaldehyde and stored it in the cellar of the Institute for Forensic Medicine. A neuroanatomically normal psychopath, what a scientific riddle!

less, and abnormally hostile personality was close at hand, provided one would pay attention to what he had to say himself about his *psychological history*. An illegitimate child, abandoned and cruelly abused and exploited by several foster “parents,” he was driven by frustration and embitterment. But psychogenesis had not been discovered by then, so to speak, and psychiatry was dominated by Kraepelin’s postulate: mental aberrations stem from abnormalities in the brain, which moreover are inherited. For criminal behavior, the variant was Lombroso’s theory of the *delinquente nato*, the born-that-way delinquent.

Perusing the research literature on homosexuality of the last 15-20 years, one recognizes the same 19th century mentality. The nonprofessional reader who is not able to read the rules will get the impression that there is no scientific doubt with respect to homosexuality’s biological causation; at least, that powerful constitutional predispositions have been ascertained. If you are not precisely born a homosexual, you will in any case possess some biological homosexual disposition, which in practice amounts to the same. And if science has not yet unearthed the definitive biolog-

ical causes, it is in the process of doing so, because the experimental indications are piling up. So science would seem to support the notion of the *omosessuale nato*. [1]

By and large, this is the message conveyed by the majority of the reports in the professional magazines. If developmental-psychological factors are given some attention they are played down as of secondary importance at most; often no mention is made of them at all. Now what is the truth? First, that not a single genetic, physiological, anatomical, or neuroanatomical correlate of homosexuality has been demonstrated. Secondly, that contrary to the impression they confer, precisely the studies of the last 15-20 years have made the existence of such correlates more unlikely than before. Thirdly, that these realities are either not perceived or purposely kept out of awareness because most academic publications on homosexuality are influenced or determined by the predominant gay ideology.

No Hormonal Correlates

The conclusion arrived at by Perloff in 1965 that no *hormonal* peculiarities had been demonstrated in homosexuals still holds today. In 1993, Byne and Parsons thus summarized their thorough expert analysis of the investigations on homosexuality and biologic factors, including hormones: "There is no evidence ... to substantiate a biologic theory." [2] And after 1993? Nothing remotely resembling proof of hormonal influences on homosexuality either. Yet a warmed-up version of the intersex (*Zwischenstufen*) theory of Magnus Hirschfeld, according to which male homosexuals have a hormone-induced feminized brain and lesbians a masculinized, continues being dished up as if founded in scientific fact. Prenatal androgen deficiency and excess (in homosexual men and women, respectively) are held responsible. [3] This view is however an undifferentiated programmatic sketch more than a testable theory. For what is meant, for instance, by a "feminized" male brain?

Does it mean that in some, as yet postulated, brain structure, the perceptual recognition center of "the feminine," the "image" of the female *Gestalt* has been substituted by the *Gestalt* of "the masculine"? That sounds rather fanciful (and what then caused the picture of the feminine in the homosexual pedophile to be

substituted by that of "the boyish"? And so on for the other sexual "orientations"). Or does a "feminized" male brain mean that the boy's behavior is becoming feminized; or rather, that the boy's aggression drive is reduced, because lack of daring and of physical fighting spirit is much more tied to homosexuality than "femininity"? [4] In the latter case, the supposed brain anomaly contains nothing that spontaneously generates or inherently predisposes to homosexual desires. Reduced male aggression (and its counterpart, enhanced female aggression/tomboyishness) as a temperamental trait (the current term is "gender nonconformity") might then be considered at most an "indirectly predisposing," better still, a "pseudo-predisposing" factor. In fact, it is the environment and the child's self-view which determine if such temperament plays a role in the genesis of homosexuality. In this variant of the sex-atypical brain theory, the origin of homosexuality itself is not accounted for; in principle it may be easily incorporated in a developmental-psychological view. It certainly does not justify the horrible notion of "gay children."

There would merely be temperamentally placid boys and "wild" girls, the vast majority of them growing up as normal heterosexuals.

The crucial question however is: What is the evidence for a link between this (or other) behavioral traits and prenatal, or whichever other, hormonal or brain irregularities? The alternative explanation, *habit formation* and *self-view* by rearing and other social influences, is certainly not less likely. Mama's boys and/or boys with "psychologically absent" fathers tend to be overdomesticated, so to speak, and it is precisely these parent-child factors that have incontestably been shown to be associated with male homosexuality. [5]

Fathers' girls and girls whose personality was not much shaped by their mother, and girls with other defeminizing childhood background factors may adopt more "masculine" or boy-like attitudes and habits. Anyhow, specific parent-child and peer group interactions have been amply demonstrated, while the hormonal-neuronal explanation has precious little to offer but speculations. There are no indications that homosexuals have suffered hormonal deviations before or after birth, their hormonal system is normal and in agreement with their biologic sex.

The evidence proposed by the proponents of the feminized/masculinized brain theory is limited to a few hardly relevant observations: the female lordosis reflex in male rats after testosterone deprivation (which reflex however is not indicative of their sexual drive); the possibly enhanced prevalence of lesbian tendencies in women suffering from congenital adrenal hyperplasia or CAH (who have been exposed to prenatal androgen hormones) [6]; and a few contradictory data regarding finger length ratios.

Regarding CAH, the majority of these women are heterosexual, so that their supposed brain masculinization would affect only a minority. If lesbianism would indeed be relatively frequent among these patients (the data are not conclusive [7]), it is hard to see why that would argue for a hormonal cause or even predisposition in healthy lesbians who are hormonally normal and whose genitals are not semi-masculinized like in these CAH patients. A psychological explanation of lesbianism in girls with “unfeminine” genitals and the various traumatic experiences associated with it is more realistic than a physiological explanation. For feelings of feminine inferiority are practically inevitable in girls who suffer from such a condition, and that is how a lesbian development often starts.

With respect to men with disturbances leading to prenatal androgen insensitivity or deficiency (and who are therefore believed to possess “feminized” brain centers), no connection with homosexuality has been found. [8] This has been the usual outcome of the older studies on homosexuality in persons who *really* have some aberration of the sex hormones or sex-chromosomes, too: they do not become psychosexually aberrant. According to some authors their sexuality may be somewhat rudimentary, “infantile,” underdeveloped, though, and this is understandable. [10]

Do homosexuals have a 2D:4D (index finger: ring finger) ratio like the one typical of the opposite sex? It has been declared this “suggests” sex-atypical prenatal hormones and brain formation. But the phenomenon is in all likelihood no more than a peculiar artifact, like others of that kind, [11] so we had better forget about it.

In all, the periodically launched “promising” leads of hormonal correlates of homosexuality have invariably proven dead ends; there is a history of nearly 90 years

to illustrate this point. It is at odds with scientific prudence to make the gigantic leap from (otherwise, not sufficiently studied) observations with rats to the complicated level of human sexuality. It is time the criticism of Byne (1995, p. 337) gets through to psychiatrists, psychologists and other professionals who sometimes tend to be overly impressed with reported biologic indications. Byne says there are too many “...hasty interpretations, based on limited sample sizes, shaky methodologies, and extremely limited knowledge about functions of particular brain structures and even less knowledge about the biological substrates of the mind.”

In other words, there is much amateur speculation instead of serious science. He explains:

“Attempts to prove that gay men have feminized gonatropin responses [12] were made decades after strong evidence suggested that the brain mechanism regulating the response does not differ between men and women” and “It required 25 studies to convince some that testosterone levels in adulthood do not reveal sexual orientation” (p. 336; see also Byne, 1997).

As long as a suspect’s guilt has not been proven, he must be treated as innocent. One may personally believe homosexual persons must have hormonal or neuroanatomical peculiarities, but scientifically there is no reason not to consider them physically normal and healthy (brain evidence: below).

No Genetic Proof

Despite numerous suggestions to the contrary, the last fifteen years of renewed research led even behavioral geneticists in favor of a genetic explanation of homosexuality to the conclusion that *genetic factors* for homosexual inclinations *as such* do not exist. This interesting fact hardly gets the attention it deserves. The other remarkable point is that in consequence, current genetic speculations focus on predisposing factors of a *non-sexual* nature. As a result, it is implicitly admitted that the prime and decisive causes lie in the person’s life history. The indirect evidence for these conclusions has come from twin studies, the direct from the exploration of genetic linkage.

Concordance percentages in *volunteer* studies vary

from 25-66 for monozygotic (MZ) twins, roughly two times the percentages for dizygotics (DZ). [13] This is quite dissimilar from the picture in the case of untested genetic factors like the color of the eyes, certain diseases, etc. Apart from the fact that volunteer studies do not adequately represent the total population of homosexuals with twins (see further on), these results are not proof of the genetic determination of homosexuality. *First*, because only half of the co-twins of the MZ homosexual index persons in these groups were also homosexual. *Secondly*, because the average concordance of DZ male homosexuals in volunteer studies is 20%, whereas the rate of homosexuality among non-twin brothers of male homosexuals “hovered closely around 9%.” [14] DZ twin brothers of homosexuals are genetically not more similar than other brothers, so the finding that DZ twins of male homosexuals are twice as often homosexual as the average brother of a homosexual man challenges a genetic explanation. Both the higher concordance in MZ than in DZ pairs and the higher incidence in DZ twins as compared with non-twin siblings point to a psychological (environmental) explanation. Very regrettably, the psychological dimension has been virtually neglected in all of these studies, except for an occasional observation like the footnote by Bailey and Pillard (1995, note 34):

We found in both our male and female studies that discordant MZ twins also reported quite different childhood experiences. ... the homosexual twins reported more sex-atypical behavior...

(“Sex-atypical behavior” is the concept of gender nonconformity we dealt with above).

Why did an observation like that did not lead to collecting detailed developmental-psychological data of these subjects of identical genetic make-up regarding their relationships with parents and peers and self-image in relation to their co-twin? Anyhow, the observation of Bailey and Pillard is satisfactorily explained by the psychology of twins. Their self-view is shaped by intense comparison with their co-twin (and by their being compared to each other by their environment); either they feel “identical” (want to be and act like their *alter ego*) or they overemphasize their differences, e.g., with respect to their virility or femininity. [15] *Thirdly*, 11% of *adoptive* brothers of homosexual

males are reported to be homosexual, too. [16] This finding, which neither genetic nor perinatal hormones can account for, casts more than a little doubt on the genetic explanation of the homosexuality of the biological sons, thus on the whole genetic hypothesis.

However, concordance rates in volunteer samples appear to be inflated, since homosexuality-concordant twins, especially MZ twins, are as a rule overrepresented. [17] Therefore, samples from twin registers are considered more representative. [18] Bailey et al. (2000) found 3 out of 27 MZ male homosexuals from the Australian twin register to be concordant (11%), versus 0 out of 16 same-sex dizygotics (0%) and 2 of 19 opposite-sex dizygotics (12%). Of 22 female MZ twins, 3 (14%) were concordant, versus 0 of 16 same-sex dizygotics (0%) and 2 of 19 opposite-sex dizygotics (12%). This was no “statistically significant support for the importance of genetic factors,” which the reader who inspects the simple numbers given above may readily see. Significantly, though, it has subsequently been attempted to squeeze as much “heredity” as possible out of these obvious data by applying more “flexible” (and thus more debatable) criteria for “homosexuality” and using a “hereditability” formula.

And, lo!, the magic formula turns the defeat for the genetic explanation into a victory so that henceforth what was evidently “no support for genetic factors” can be sold as modest “support” (Kirk et al., 2000)! Such handling of the raw numbers borders on what the French call “statistical massage”; it is at any rate no test of the power of a genetic versus a non-genetic model. [19] The same is true of the interpretation in a similar study that the “[homo] sexual orientation was substantially influenced by genetic factors.” [20]

In this case too, the simple numbers tell the tale better than sophisticated calculations based on a speculative model [21]: Two of 10 MZ homosexual men had a homosexual twin brother (20%) vs. 4 of a combined group of 28 male DZ twin pairs and pairs of non-twin brothers one of whom was a homosexual (14%). Four of 9 female MZ pairs were concordant (44%) vs. 8 of a combined group of 28 female DZ twins plus non-twin sisters one of whom was a lesbian (29%). This indicates a slight preponderance of MZ concordance, not significant statistically though. In a non-random

sample of never-married twins from the Minnesota Twin Registry, which seems to contain the majority of the twins of this State, Hershberger (1997) found heritability coefficients that were mildly consistent with genetic influences for lesbians, not for male homosexuals. [22]

In sum, MZ concordance becomes lower the more representative the samples; at the same time, the difference between MZ and DZ concordances becomes less convincing. [23] The more important conclusion, however, is that the genetic hypothesis has become increasingly less plausible and seems engaged in a rearguard action. For no theorists of genetic influences can be found any more who believe in the existence of a “gay gene” proper. The view of the role of genes underwent a silent, but very significant change: no longer the prime determinants, they now function at most as predisposing factors. In short, the decisive cause(s) of homosexuality are not hereditary. Even Hamer, the man who in 1993 caused the media stir with his “near-discovery” of the gay gene [24] admits:

We do not expect to find (in the future) a gene that is the same in every gay man ... just one that is correlated to sexual orientation. [25]

Unclearly as it is worded, he seems to hint at predisposing factors. Bailey theorizes in the same direction after finding that childhood *gender nonconformity* was (to a degree) compatible with a genetic statistical model while homosexual feelings were not. [26] But the case for the genetic origin of gender nonconformity is far from strong either. Wasn't it Bailey himself who previously had noticed that it was this very item of gender nonconformity which distinguished the homosexual from the heterosexual twin in MZ pairs discordant for homosexuality? [27]

Dramatically decreasing genetic evidence from modern twin research was on the one side, while on the other, the search for a *genetic linkage* came to a dead end. The well-known 1993 finding of Hamer, et al., did indeed not demonstrate the existence of a single gene, because it was not shown that the highly selective group of homosexual men showing a moderate correlation between DNA markers and a region of the X chromosome shared a particular molecular

sequence. [28] The supposed genetic factor thus might have been any physical or temperamental resemblance with the mother (from whom the X chromosome is inherited). The whole thing was, after all, a storm in a tea cup. Subsequent analysis and research vindicated the verdict by the famous French authority in the field, Jerome Lejeune, that the methodological defects of the investigation were so serious that “were it not for the fact that this study is about homosexuality, it would probably never have been accepted for publication.” [29]

A first replication by the same team with a small group reported a barely significant confirmation for homosexual men, not for lesbians [30]; the calculations of the team were, however, rejected by the statistician experts. [31] And an independent Canadian team failed to uncover a link between male homosexuality and the X chromosome in a larger sample. [32] So much for the direct exploration of the genes. Circumstantial evidence is sometimes deduced from *familial and pedigree* findings. It has long been known that homosexuality occurs relatively more frequently in certain families and pedigrees, but genetic explanations are implausible in view of the erratic way it is distributed within these families and pedigrees: “We never found a single family in which homosexuality was distributed in the obvious pattern that Mendel observed.” [33]

And this statement by Hamer is even an understatement. On the aforementioned higher correlation in lesbian propensities between lesbians and their mothers than between them and their sisters, [34] he comments: “The rate was a whopping 33 percent, meaning that the daughter of a lesbian had a one-in-three chance of also being a lesbian. Genetically speaking, this result was impossible.” [35] Psychologically not so, however. [36] Many specific personality-shaping habits are transmitted from one generation to the next by learning. This may explain varied familial phenomena a genetic hypothesis cannot. It is therefore arbitrary to present a possibly somewhat elevated occurrence of male homosexuality among maternal relatives as evidence for genetic influences, as has been done in a recent publication [37] (Fortunately the authors admit that it is “still possible” to attribute their data to “culturally, rather than genetically, inherited traits”). [38]

In an attempt to present the long known [39] and recently well-replicated [40] phenomenon that homosexual men (not women) have relatively more older brothers than heterosexual men as an indication of the biological cause of male homosexuality, a far-fetched theory has been invented. Mothers of male homosexuals might progressively produce an “antibody” to male fetuses every time they are pregnant with a boy, which in turn would eventually feminize the developing brain of the younger male embryos (The theory has only relevance for 15% of the male homosexuals, viz., those with more older brothers). [41] Physiological anti-boy mechanisms have never been demonstrated, however, and the fully speculative status of the feminized male brain has already been described. Why not try a psychological explanation? Already in 1937 psychiatry professor Schultz pointed to the impact of the position of the “nice little brother” (*liebe Brüderchen*) among his older brothers on his psychosexual development. [42]

No Neuroanatomical Correlates

Like professor Mégevant a century ago, present-time brain researchers have never really been awarded in their quest for unambiguous *brain anomalies* in homosexuals. E.g., an initial report of larger inter-hemispheric fiber bundles in homosexual men could not be replicated. [43] Nor was there a convincing reason to explain LeVay’s 1991 over-publicized observation of a smaller hypothalamic nucleus (INAH3) in some homosexual men who had died of AIDS in comparison with heterosexual intravenous drug users as evidence of a feminized brain center. Differences between the groups other than the homosexuality variable might have caused the effect: procedures of tissue preparation, length of the disease period, previous occurrence of other venereal diseases, or medication. A replication by Byne et al. (2001), hailed by some as “proof” of a “homosexual brain center” [44] has in fact made that explanation even more unlikely. In a small group of homosexual men who had died of AIDS they found a trend for the ratio of INAH3-volume to brain weight to be smaller than that ratio for deceased heterosexual men who were drug users. The trend was not significant statistically, hence strictly speaking, the difference is not uncontestable. Byne

suspects that since the brain weights of the heterosexual men with AIDS were much lower than both those of the HIV-negative heterosexual men and the homosexuals with AIDS, the trend,

“... may reflect the superior health care received by the homosexual male group compared to the heterosexual male group with AIDS, all of whom were intravenous drug users.” [45]

Nor does he exclude that histological preparation caused the relative shrinkage of INAH3 in the homosexuals:

“Since some New York hospitals have a preponderance of HIV+ patients who are gay men, while others have a preponderance of HIV+ patients who are drug users, the homosexual and heterosexual patients tended to come from different institutions, and therefore, there were likely variations in autopsy and fixation procedures that were confounded with sexual orientation.”

For these reasons, he believes his second finding is the more reliable and important one: the nuclei of the homosexuals contained as many neurons as those of the heterosexual men. That is, 60% more neurons than the female nucleus. This is the more interesting because INAH3 seems the only brain-anatomical structure which is sexually dimorphic. [46] In sum: no evidence for the “wrongly put on nerves” (like the strings of a guitar) the poet Dante ascribed to homosexuals! [47]

Conclusions

The main conclusion is obvious if we keep our eyes on the interesting factual observations in the reports of the last few decades and let our sight not be obscured by the biology-biased interpretations they are wrapped in. No bodily correlates of homosexuality have been demonstrated. Like with the monster of Loch Ness, there are periodic claims that a biologic factor has been spotted, but upon closer inspection, the claims evaporate. [48] This renders any discussion of whether a determinate correlate would be a cause, an effect, or an insignificant byproduct of another homosexuality-connected variable superfluous. But there is more. Whereas constitutional theories

seem increasingly speculative, they are only the psychological correlates of homosexuality that are well-established. The highest correlations have systematically been found for what is currently designated as childhood and adolescent *gender nonconformity*: lack of integration in the boyhood/girlhood world and feelings of not belonging to the same-sex world. [49]

This syndrome has been established in clinical as well as nonclinical samples, in various countries and over several generations. Significantly, it is also recognized by authors who prefer to believe in biological theories (Hamer, LeVay, Bailey). The second-highest correlations exist with the finding of defective relations with the same-sex parent; the third-highest with maternal dominance/overprotection for the homosexual man, and with varied father factors for the lesbian. [50] Empirically, then, a psychological explanation is the most realistic.

Furthermore, belief in a causal contribution of some (mostly unspecified) biologic variable, which is shared by many professionals who view homosexuality basically as a psychological phenomenon, is purely hypothetical. I think Schultz-Hencke, one of the coryphées of German psychiatry, was right when he wrote as far back as 1932: Homosexuality and every correlate of it is “psychologically explicable, without leaving a remainder.” [51] Even the unboyishness of many prehomosexual boys may rather be seen as an effect of intra-family factors, habit formation, and self-concept than as temperamental. [52] And certainly is all talk of “gay children” irresponsible, not only morally, but also scientifically. There is nothing intrinsically “gay” in either the biological or the psychological nature of children, nothing that spontaneously would push them to homoerotic feelings. The theoretical improbability of the existence of physiological correlates specific for homosexuality may appear more clearly if homosexual and heterosexual pedophilia, transvestism, exhibitionism etc. are taken into account (curiously, this is almost never done). For either specific hormonal, hormonal-brain or other factors are postulated for each of them, or they are regarded as “environmentally” caused. The first option is wild, the second challenges the biologic co-causation of homosexuality, because on what grounds should homosexuality be the exception, since the

desires of pedophiles, etc. have the same characteristics as those of homosexuals (exclusiveness, obsessiveness)?

Proven Psychological Variables Ignored

Methodologically, it is a pity that most of the reviewed studies did not include the psychological variables of proven validity as to their relation with homosexuality. The more so since their results are mostly used as arguments for a (biologic) theory. But what is the value of a theory based on research which left out some of the most important variables? Notably the various collections of MZ and DZ twins might have yielded rich data had thorough psychological examinations been conducted of the childhood/adolescence background, parental and peer factors, self-view, and neurotic emotionality. [53] That is equally true of studies on familial or pedigree clustering and the more-brothers phenomenon in a subgroup of male homosexuals. This missed opportunity points to either ignorance of the psychology of homosexuality or unwillingness to give it the credit it deserves (or both).

Gay Activists Dominate Research

Whence this 19th century step-motherly treatment of psychology by our present-day professors Mégevant? It is because with few exceptions they are gay persons wedded to the gay ideology. They are the Weinbergs, LeVays, Hamers, Baileys, Hershbergers etc., who openly admitted that biological roots of homosexuality favor social acceptance of the gay agenda (and right they are). It is in their interest to be single-mindedly biology-biased. And since the gay ideology has become the party line in the official establishment of the human sciences, inclusive of most professional journals, all findings “support” homosexuality’s biologic origin and mental normality or at least “suggest” it. Free research and free thinking is taboo as soon as it seems to threaten the gay cause. The ideologically distorted science thus produced and sponsored profoundly misleads the public. On a deeper level, it is often motivated not by thirst for the truth, but by the wish to *rationalize* or *justify* the normality sought by so many persons who are committed to a sexually abnormal lifestyle.

End Notes

1. This misrepresentation of the present state of research is imitated by not a few authors who apparently accept it without critical examination. A painful example is the contention of Serra (2004) that there would be “a coherent complex of observations indicating with sufficient strength that ... a (causal) biological component may not be excluded and which even suggest that this has an appreciable weight” (p. 232). That boils down to suggesting the existence of the *omosessuale nato*, though Serra’s formulation is vague. I mention this example because Father Serra is a retired professor of genetics of the Gregoriana University in Rome and a honorary member of the Papal Academy for Life. His misleading article in the Jesuit periodical *La Civiltà Cattolica* will probably make some impression in certain Catholic circles.

2. P. 228. Unlike the authors who blithely dream up physiological “explanations” without solid expertise in this area, Byne is an authority in the field of psychiatric neuroanatomy, Parsons in psychiatric genetics (both at the New York institute of Psychiatry).

3. E.g., Mustanski et al., 2002; Hershberger & Segal, 2004. They quote Meyer-Bahlburg (2001) although this author gives no evidence on hormonal or brain peculiarities of homosexuals, only on the psychosexual development of women with a chromosomal disturbance (classic CAH). According to some (not all) studies they manifest more lesbian inclinations than other women; yet their “prenatal hormonal milieu does not dictate a bisexual or lesbian outcome” and “few consider themselves lesbians” (p. 163).

4. Research data: van den Aardweg, 1986, chpt. 15; Freund & Blanchard, 1987; Hockenberry & Billingham, 1987.

5. As for the habit-formation explanation of boyish aggressiveness and daring or the lack of it, a comparison of the behavior of boys from families of working men with boys from academic families is instructive. Boys from the latter families are generally “softer,” more “feminine” if we prefer this psychological term, less physically aggressive. Also, compare boys from slums with boys from middle-class families.

6. Meyer-Bahlburg, 2001. Byne & Parsons (1993) make it clear how unconvincing the masculinized-brain hypothesis is to account for this otherwise not conclusively demonstrated phenomenon (p. 232).

7. See note 2, above.

8. Byne & Parsons, 1993, p. 232.

9. E.g., the older study of Raboch & Nedoma, 1958.

10. Züblin, 1957. Interestingly, Züblin remarked that the weak sexuality of these physically abnormal men seems strongly determined by their need to “behave like other men.” Meyer-Bahlburg (2001) points to the rudimentary sexual drive of women with CAH.

11. Mustanski et al., 2002.

12. Gonadotropins: hormones working on the sexual glands. Feminized gonadotropin responses: responses comparable to those of the female physiological cycle.

13. Of 56 American male MZ pairs, 59 (29%) were concordant, against 12 (22%) of 54 DZ pairs (Bailey & Pillard, 1991); of 20 British male and female MZ pairs, 5 (25%) were concordant, against 3 (12%) of 25 DZ pairs. The difference was not signifi-

cant (King & McDonald, 1992). Of 38 American male MZ pairs, 25 (66%) were concordant, against 7 (30%) of 23 DZ pairs (Whitam et al., 1993). Of 71 American female MZ pairs, 34 (48%) were concordant, against 6 (16%) of 37 DZ pairs (Bailey et al., 1993).

14. Bailey & Pillard, 1995, p. 136.

15. I know a few such cases. The homosexual twin of these MZ pairs had viewed himself (and was seen by his parents) as the weaker of the two or was mother’s boy (the other one, father’s boy). Farber (1981) described two MZ sisters reared apart, one of whom a lesbian, the other heterosexual. In contrast with her co-twin, the lesbian had a conflict-ridden relation with her foster mother and a strong attachment to her foster-father, whom she imitated. Psychology give the clues!

16. Bailey & Pillard, 1995, note 30. Homosexuality seems to be relatively frequent in adoptive children in general, which has to do with many of those children’s liability to feeling not belonging (less valuable) in comparison with their biological siblings.

17. The phenomenon of “concordance-dependent ascertainment bias,” which was responsible for the suspect 100% MZ concordance (against 11.5% DZ concordance; or, under a broader definition of homosexuality, 42.3% DZ concordance) in the male group of Kallmann (1952). The figure of Kallmann raises some questions, by the way. A favorite disciple of psychiatrist Ernst Rüdin, the highest Nazi authority on the medical aspects of “racial hygiene” and a zealous advocate of forced sterilization of the mentally disturbed and “psychopaths,” Kallmann, like Rüdin, saw twin research as a means to improve the diagnosis of family members of “racially inferior” persons. He called for the sterilization of schizophrenics and many of their seemingly healthy family members who allegedly carried the postulated sick recessive gene, estimating that this made necessary the sterilization of about 5% of the population (!). Probably not by coincidence, he found extremely high concordance rates for MZ schizophrenics. What did he originally, before his flight to the U.S., have in mind for homosexuals? (Müller-Hill, 1984; Blondet, 1995).

18. It is not clear, though, how representative because the volunteer effect cannot be ruled out. Only about half of the twins invited for the study eventually participated. In addition, the register itself is a *volunteer register* which may contain no more than 10-20% of the Australian MZ and DZ twins (Kirk et al., 2000, note 39).

19. Heritability formulas are statistics to estimate the part of score variance that *might* fit a proposed heredity model. Besides being based on assumptions which are susceptible of debate, heritability *coefficients* are not *measurements* of genetic influence, merely quantifications of the degree obtained observations are compatible with a postulated genetic model. It does not really enhance the plausibility of heritability coefficients for personality traits that according to their reckonings viewpoints on the death penalty, abortion on demand, and even a virtue like “humility” are “50%” genetically determined (Excellent analyses: Whitehead & Whitehead, 1999). *Another source of confusion flows from the use of *proband-wise* concordance percentages in stead of the usual *pair-wise* percentages. The proband formula overestimates “real” concordance, yielding genetically-biased results. Proband-wise formula: $2(++): [2(++)+-] \times 100\%$; pair-wise formula: $(++) : N \times 100\%$.

20. Kendler et al., 2000, p. 1843. The sample came from a U.S. national survey, but is not a representative of homosexuals with

twins, nor can the volunteer factor be excluded.

21. The authors use the proband-wise concordance formula, overestimating MZ twin resemblance; in this text, pair-wise percentages are given.

22. With reference to this “moderate consistency” with a genetic model, see the contradictory finding of Pattatucci and Hamer (1995) that the highest correlation concerning lesbian interests was not between the lesbians and her sisters, but between the lesbians and their mothers. See also the failure of Hu et al. (1995) to find markers for a gene for lesbianism.

23. We cannot rule out the hypothesis that MZ concordance for homosexuality (and for other features) in former days was indeed higher than at present. It may be that the MZ children of former generations were more than at present reared and viewed as being identical, whereas MZ children of recent generations are more treated as distinctive individuals, their differences being emphasized in stead of their similarities. Examination of the relative proportions of MZ and DZ twins in non-Western cultures might help clarifying this issue.

24. Hamer et al., 1993.

25. Hamer & Copeland, 1994, p. 198.

26. Bailey et al., 2000.

27. Bailey & Pillard, 1995, footnote 34.

28. Byne, 1994.

29. Lejeune wrote this to me (1993) in response to my question about his opinion on Hamer’s article in *Science*. Lejeune was a great and erudite scientist, the discoverer of the gene causing *Down syndrome*.

30. Hu et al., 1995.

31. Risch et al., 1993.

32. Rice et al., 1999.

33. Hamer & Copeland, 1994, note 47.

34. Pattatucci & Hamer, 1995.

35. Hamer & Copeland, 1994, p. 191.

36. The finding must be repeated before it can be generalized. It is certainly relevant in connection with the debate on parenting and adoption by lesbian couples.

37. Camperio-Ciani et al., 2004. This is a rather shoddy study. “Measurement” of the homosexual inclinations of the relatives consisted in the opinion of the interviewed homosexuals themselves (The tendency of self-defensive homosexuals to project homosexuality in others is a well-known phenomenon). Besides, the informants were volunteers, so that the results may be an artifact. Otherwise, the authors emphasize that only 20% of the variance of pedigree sexual orientation could be accounted for by the genetic hypothesis.

38. Ibidem, p. 2220. “Culturally inherited” sounds strange. Why not: “Transferred by habits of rearing and education”? For example, male-female role imbalances which clearly stem from habit can be observed in certain families; maternal overprotection can sometimes be traced back for several generations, not to speak of personality shaping world views or beliefs.

39. E.g., the study of Lang, 1936.

40. Bogaert, 2003. Statistically, the probability that a boy in certain families with more brothers becomes a homosexual increases 38% with each older brother. In view of the increasing rarity of families with a series of brothers, this familial factor will have affected few future homosexuals in Western society.

41. Bogaert, 2003. Bogaert’s 15% nicely accords with that of

Lang, 1936, who estimated 10-20%.

42. Homosexual men with more brothers not seldom felt inferior to them, were more overprotected, treated in a softer way.

43. Lasco et al., 2002.

44. In his book, Bailey (2003) misunderstood a communication of Byne to him as a confirmation of LeVay’s finding. He euphorically writes he would like to invest big money in Byne’s research (if he had it, of course), probably in the hope that this scientist will come up with the ardently desired biological proof. The scientific quality of Byne’s publications indicates that funding him is not a bad idea, indeed, but: will the outcome make Bailey cheerful?

45. Letter of July 20, 2005, to this author. The next quote is from this letter, too.

46. Byne et al., 2001, p. 90.

47. *Inferno*, XV, verse 114: *li mal proresi nervi*.

48. One of the recent one-day butterflies: the Swedish discovery of feminized body odor preferences of homosexual men. Evidence for a genetic cause of homosexuality, or for the sense of humor of the authors?

49. A survey of the studies until the eighties: van den Aardweg, 1986, Table 13.1; for later studies: e.g., Bem, 1996.

50. van den Aardweg, 1986, Table 15.1 and 27.5; Fisher & Greenberg, 1996, p. 137.

51. “restlos psychologisch erklärbar” (p. 300).

52. The analysis of the evidence concerning the specific “femininity” or nonaggressiveness in prehomosexual boys and “masculine” tendencies in some prelesbian girls is a chapter in itself. Here I can merely state my conclusion.

53. Earlier in the text I recalled Bailey’s observation that homosexuality-discordant MZ male twins differed in boyhood gender nonconformity.

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Recommended Reading On NARTH Web Site:

***The Innate-Immutable Argument Finds No Basis in Science—In Their Own Words: Gay Activists Speak About Science, Morality, Philosophy*, by A. Dean Byrd, Ph.D., MBA, MPH, Shirley E. Cox, DSW, Jeffrey W. Robinson, Ph.D.**

***The Treatment of Ego-Dystonic Homosexuality: The Development of a Masculine Self-Image*, by Steven A. Richfield, Psy.D.**

***Spitzer Study Published: Evidence Found for Effectiveness of Reorientation Therapy*, by Roy Waller and Linda A. Nicolosi**

Sexual Abuse In The Histories Of SSA Clients

By Christopher H. Rosik, Ph.D.

NARTH members have often observed what seems to be a disproportionate history of sexual abuse in the lives of many of their clients who present with same-sex attractions. Unfortunately, good research on this subject has been limited, and for too long we have had to rely substantially upon anecdotal accounts.

A recent study by Balsam, Rothblum & Beauchaine (2005) provides an important step forward in this regard. This research studied 557 lesbians and gay men, 163 bisexuals and 525 heterosexual adults. The heterosexual group was comprised of one or more siblings recruited by the LGB participants. The sample was 91.7% European American. The study assessed for several types of self-reported abuse in childhood and adulthood, including childhood sexual abuse, domestic violence from a partner, psychological maltreatment by a partner, physical assault and injury by a partner, and lifetime victimization risk.

Results

The authors report that hierarchical linear modeling analyses revealed that sexual orientation was a significant predictor of most of the victimization variables. Not surprisingly, women of all sexual orientations were more likely to report a history of sexual victimization, being injured by a partner and more types of lifetime victimization than their male counterparts.

In terms of the findings pertaining to sexual orientation, participants with LGB identification were significantly more likely to endorse all the variables related to childhood abuse than their heterosexual controls. For example, the experience of childhood injury inflicted by a parent or adult caretaker was reported by 11.1% of the heterosexual men, 31.6% of bisexual men, and 16.8% of gay men. Among women, these statistics were 11.4% for heterosexual women, 15.3% for bisexual women and 18% for lesbians. The experience of childhood sexual abuse was found to be 12.8% for heterosexual men, 44.1% for bisexual men, and 31.8% for gay men. Childhood sexual abuse was reported by 30.4 % of heterosexual women, 47.6% of bisexual women,



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and 43.6% of lesbians.

Victimization appeared to continue into adulthood for those with a sexual minority status. LGB respondents reported experiencing more domestic violence after age 18 and more frequently experienced at least one physical assault by a partner than their heterosexual counterparts. LGB participants were also more likely to report a history of non-intercourse coercion, coerced intercourse, and rape than heterosexual participants.

For example, only 1.6% of heterosexual men reported a history of rape in adulthood, compared to 13.2% of bisexual men and 11.6% of gay men. For women, these statistics were 7.5%, 16.9% and 15.5%, respectively. Coerced intercourse in adulthood was reported by 9.3% of heterosexual men, 39.5% of bisexual men and 20.6% of gay men. Among heterosexual, bisexual, and lesbian women, these figures were 26%, 34.1% and 30.9%, respectively. Consistent with these findings, LGB participants also reported higher levels of overall lifetime victimization than their heterosexual siblings. The study methodology allowed for examination of within-family influences in accounting for victimization history. Within-family influences were found to account for a considerable amount of variance in the majority of the victimization measures. In addition, significant effects were discovered for family size on several of the childhood abuse variables, with participants in larger families reporting more victimization.

Examining the gender of the perpetrators, gay men reported the highest percentage of male sexual-abuse perpetrators in childhood, and heterosexual men reported the least. Of the heterosexual men reporting CSA, 60.9% (N = 14) reported a male perpetrator and 47.8% (N = 11) reported a female perpetrator (percentages did not have to add up to 100% due to some

participants having more than one perpetrator and because of missing data). Among bisexual men, 80% (N=12) reported a male perpetrator and 60% (N = 9) recounted having a female perpetrator. For gay men, 95.7% (N = 66) reported a perpetrator who was male and 18.8% (N = 13) described a perpetrator who was female. Heterosexual, bisexual, and lesbian women did not differ significantly on the gender of the perpetrator for any of the childhood abuse variables. The adults responsible for CSA among women were overwhelmingly male, with 96% (N = 97) of heterosexual women reporting a male perpetrator, 96.6% (N = 57) of bisexual women and 93.6% (N = 131) of lesbians. The authors provide other intriguing findings regarding abuse history and perpetrator status, and the reader is encouraged to consult this article directly.

Discussion

In their discussion section, the authors seem to struggle somewhat with the potential implications of their findings. At times they seem to attribute causality when it is in keeping with a general gay-affirmative paradigm; however, at other times they go out of their way to underscore that their methodology can in no way allow for causal attribution. Examples of causal speculation include:

As hypothesized, sexual minority status was associated with higher levels of self-reported parental psychological abuse and physical abuse, suggesting that LGB youths may be singled out by their parents for maltreatment (p. 483).

The current study lends supports to the idea that the same-sex boys and girls who are bullied by classmates may be similarly targeted by the very people who are supposed to be protecting and caring for them (p. 484). For some LGB boys and girls, gender-atypical appearance and behavior may make them more visible and vulnerable to aggression by adults. (p. 484)

The prime example of eschewing causal thinking not surprisingly centered on childhood sexual abuse as a potential etiological factor in homosexuality:

It should be noted that the factors that might mediate the relationship between childhood sexual abuse and sexual orientation remain to be deter-

mined. This is a particularly important concern, given the possibility that the current results could be used politically to link childhood sexual abuse with homosexuality in the eyes of the public. The methodology and measures used in this research do not allow for questions of causality to be addressed (p. 484).

While unwilling to speculate regarding etiology, the authors at one point are willing to go so far as to concede CSA as a possible influence on the development of homosexuality.

Thus, it may be plausible to assume that for any individual, early sexual experiences, including experiences of abuse, are among the myriad of factors that might influence one's sexual attractions, behavior, and identity (p. 484).

The authors do not elaborate on the practical difference between cause and influence in the CSA-homosexuality link, though the latter may be a more politically palatable approach to the issue. In spite of the inconsistency, the authors for some reason in this instance appear confident enough in their methodology to rule out in advance any potential for an etiological connection. In discussing possible report bias among participants, the authors state:

This may be particularly true in the area of sexual abuse and sexual assault, as most LGB people have been exposed to the myths that these types of abuse cause people to become LGB (p. 485).

Finally, it was disturbing to find yet again credence being given to the work of Rind (2001) and the politically correct notion that girls are victimized by predatory men but "...boys may turn to older men as the only potential way to explore their sexuality" (p. 484). Surely, the contradiction inherent in such a stance is obvious to all but those who have been rendered ideologically unable to see it; namely, if girls are justifiably considered victims, why should boys not be depicted in the same manner? Such a portrayal seems to give credence to the kind of gender stereotyping (i.e., girls are passive and receptive, boys are active and take initiative) that would be anathema to liberal-leaning mental health professionals in any other context.

Conclusion

This study provides information on lifetime victimization statistics among heterosexuals, bisexuals, and gay men and lesbians that are likely to confirm the clinical experiences of many who work with clients experiencing same-sex attractions.

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New Zealand School Of Medicine Studies Mental Health Problems In People With SSA

By Frank York

In July, 2005, the Christchurch School of Medicine and Health Sciences, Christchurch, New Zealand, published the results of a study of the mental health of young homosexually oriented men and women.

The study, "Sexual orientation and mental health in a birth cohort of young adults," was published in *Psychological Medicine*, (2005, 35, 971-981) from Cambridge University Press. The researchers designed the study to discover the relationship between sexual orientation and mental health in a birth cohort of young men and women between the ages of 21-26.

The first aim of the study was to develop "an empirically based classification of sexual orientation" based upon sexual behavior, stated sexual preference, and sexual attraction. The second aim was to "extend and confirm previous research on this cohort showing that young people reporting gay, lesbian, and bisexual orientation were at increased risks of mental health problems." The study included a Composite International Diagnostic Interview to determine the following disorders in young gays: major depression, anxiety, panic disorder, agoraphobia, alcohol dependence, cannabis and other illicit drug dependence, and more.

The researchers also collected information about the childhood of each homosexually oriented person. One category was childhood sexual abuse. This included non-contact abuse to incidents of oral, anal, or vaginal

intercourse. Of those surveyed, 11.9% indicated they had experienced some form of sexual abuse.

In addition, 13.1% reported incidences of parental criminality; and 24.2% indicated a parental history of illicit drug abuse.

In comparing the mental health of "exclusively heterosexual" and "predominantly homosexual" young adults, researchers discovered that SSA males experienced major depression: 71.4% compared to 14.5% for heterosexual males; illicit drug dependence: heterosexual: 11.1%; homosexual: 42.9%; suicidal ideation: heterosexual: 10.9%; 71.4% for homosexual males; suicide attempts among heterosexuals: 1.6%; 28.6% among homosexual males.

Social Homophobia, Or Other Reasons?

The research team noted that their findings may "reflect the effects of social prejudices, homophobic attitudes, victimization and harassment in increasing the vulnerability of bisexual, gay and lesbian young people to mental health problems." They also noted, however, that there is a possibility that their conclusions are incorrect due to measurement errors; or that there is reverse causality involved. An individual prone to mental health problems may be more likely to engage in gay behaviors; or there is "the possibility that lifestyle choices made by young people of non-heterosexual orientation place them at greater risks of adverse life events, stresses and similar factors that

may increase risks of mental health problems.”

New Zealand NARTH Member Responds

Dr. Neil Whitehead, author of *My Genes Made Me Do It*, has reviewed this study and surveys the results of three previous papers on this subject. He observes:

This paper confirms that the mental health risk for men with same-sex attraction is about five times that of heterosexual norms and [homosexual] women’s risk is nearly twice as high.

This follows a cluster of three papers around the turn of the century which affirmed the same thing. One of those three was a New Zealand paper on the same group of 1,000 children followed from birth and by the same study group, but at age 21 rather than 26 for the present paper.

The authors of this current paper allowed for other social and family factors such as change of parents and childhood physical or sexual abuse, parental drug use and novelty seeking, but the effect remained. This means that the result was not chance – it has persisted in the study group from ages 21 to 26. The authors extended this finding to say that even a small amount of same-sex attraction (SSA) contributes to a significantly greater mental health risk.

Mental health factors studied were major depression, anxiety disorder, alcohol dependence, illicit drug dependence, and suicidal ideas and attempts.

This mental health effect exists in spite of the work of Dickson, et al. (“Same-sex attraction in a birth cohort: prevalence and persistence in early childhood,” *Social Science & Medicine*, 56:1607-1615, 2003) which (apart from a fascinating documented account of changes in type of sexual attraction between ages 21-26) found that same-sex contact between two men was regarded as always or mostly wrong by 36.3% of men and 22.2% of women, compared with 62.1% of men and 48.9% in the UK and 70.7% of men and 66.8% of women in the US.

This makes New Zealand extraordinarily liberal in its attitudes, but the health effect is very similar to that in the US, suggesting social prejudice has little to do with the poorer mental health. In spite of this, the authors suggest social prejudice may be to blame, but also wonder if young people with psychiatric disorders are somehow more prone to same-sex attraction, or alternatively that young people with same-sex attraction make lifestyle choices which “place them at greater risks of adverse life events, stresses and similar factors that may increase risks of mental health problems.” This is worth following up, although it cannot be a universal factor. If it were a universal factor, all those with major depression would also have SSA. It could be an important factor for a few. Some people exist with both SSA and heterosexual attraction. They find that when they are depressed that SSA predominates; when they are filled with well-being, opposite-sex attraction predominates.

New Study Describes Barebacking, Circuit Parties, And Spread of HIV

Researchers have surveyed the attitudes of males engaging in unprotected anal sex and the ideology behind extensive drug use and multiple sex partners at gay circuit parties.

A study published in the August, 2005 edition of the *Journal of Sex Research*, and one in the *Journal of the International Association of Physicians In AIDS Care [JIAPAC]* (Vol. 4. No. 2, 32-46, 2005) describe the

attitudes of individuals who engage in unprotected anal sex (barebacking) and those who use drugs and engage in multiple sex activities at gay circuit parties throughout the United States.

Northwestern University doctoral candidate Amin Ghaziani and Thomas D. Cook, Ph.D. wrote “Reducing HIV Infections at Circuit Parties: From Description to Explanation and Principles of

Intervention Design” for JIAPAC.

The authors describe circuit parties as weekend-long erotically charged “drug-prevalent dance events attended by up to 25,000 self-identified gay and bisexual men who socialize and dance nonstop, sometimes for 24 hours or longer.”

Ghaziani and Cook state that circuit parties originally began as AIDS awareness events in the mid-80s, but “Although it is unconfirmed, circuit parties may have ironically become potential sites for HIV serotransmission.” They maintain that the idea of a link between circuit parties and HIV transmission is “not unfounded, even if it remains speculative.”

They note that as many as 25% of the circuit party attendees admit they are HIV positive and use crystal meth as well as ecstasy in risky sexual behaviors. Most circuit party attendees (95%) admit using psychoactive drugs. Of these, 61% ingested three or more drugs in one night. In addition, 67% reported engaging in anal or oral sex. Only 21% reported engaging in “safe anal sex.” Twenty-nine percent had multiple sex partners during a weekend. Of these, 47% reported unprotected anal intercourse (UAI).

Reasons for attending circuit parties varied with 97% saying they wanted to attend to “celebrate and have fun”; 68% wanted “to be wild and uninhibited”; 43% said they wanted sex; and 14% wanted to “forget about HIV/AIDS.” The authors noted that the use of crystal meth at circuit parties is at epidemic proportions.

They propose a causal model that explains the process used by men at circuit parties who engage in unprotected sex. One part of this model includes elevated libido and the use of drugs that distort judgment. They say: “We posit three mediating mechanisms between party attendance and unsafe sex. One is pharmacological, because club drugs play a central role in risky sexual activity at parties.... Social psychologists have long known that large groups can reduce a person’s sense of self and that such de-individuation can loosen normative behavioral and moral constraints The final mediating mechanism has to do with feelings of social connectedness and the search for community, experienced at the individual level.”

Ghaziani and Cook observe that “Participants report becoming so immersed in the party atmosphere that they forget about the immediate threat of HIV/AIDS or no longer care about it.”

Review Of Study: ‘Sexual Behavior And Selected Health Measures’

By James E. Phelan, LCSW, BCD, Psy.D.

The National Center for Health Statistics released, on September 15, 2005, the results of the study, “Sexual behavior and selected health measures.” The data comes from the 2002 National Survey of Family Growth. The survey contractor was the University Of Michigan’s Institute For Social Research and the sample size included 12,517 men and women between the ages of 15-44.



James E. Phelan, LCSW,
BCD, Psy.D.

The survey was last used back in 1992, so some comparisons and additions were added, particularly sexu-

al activity among teens. *The New York Times* highlighted the findings in their September 16, 2005, “National Report” section, “Nationwide survey includes data on teenager sex habits: Surprising numbers for same-sex activity. (Pg. A12). The *Times* highlighted that: “Attitudes on sex are changing, especially among women.”

Among the study’s findings: About 4% of men and women describe themselves as homosexual or bisexual. Surprising to the researchers was that 14% of the women ages 18-29 reported having sexual experience with members of the same sex within the past year. The older group, ages 30-44, reported a lower figure of 10%. The lead researcher, Dr. William Mosher, said the difference was significant because questions about lifetime sexual experiences generally reveal

higher rates for the older subjects than the younger ones. Among the women, 86% said they were attracted “only to men” and 10% said they were attracted “mostly to men.” When they conducted this survey in 1992, only 3% categorized themselves as “attracted mostly to men.”

Over their lifetime, 6% of the men and 10% of the women reported having sexual experience with a member of the same sex. Nearly 4% of the subjects in the male study reported having anal sex with another man and 6% admitted to having oral sex with another man at some time in their lives.

The study underscores previous findings that sexual behavior is fluid and changeable. This is most clearly seen by the study’s results on female sexuality. While 14% of the women ages 18-29 reported having sexual experience with members of the same sex within the past year of the study, older women in their lifetime reported less such behavior.

The researchers commented that it is more common for women to engage in same-sex behavior in college (hence, the increased same-sex behavior in younger samples). After graduation from college, they report the behaviors are less frequent. Those that had sexual activity with members of the same sex, do not necessarily identify as “homosexual.”

Parenting/Family

Tips For Parents

By James E. Phelan, LCSW, BCD, Psy.D.

There is much testimonial data written by people with prior same-sex attraction (SSA) symptoms that tells about their family constellations and attributes their SSA to those factors. While the causal theme they offer usually traces back to family influences, people with SSA also link their symptoms to influences such as their own faulty perceptions and behaviors, and sexual abuse by peers, siblings, or others. Some have even gone on record to say that they had always sensed something missing or “void” inside themselves, for a variety of reasons, when they were children.

Some of their parents, they thought, had tried too hard to love them and it felt smothering; some of their parents retreated to their own preoccupations; others were unable to bond with their child due to their own health problems or other hardships such as divorce; some parents attempted to forge a strong sense of bonding with their child, but throughout the child’s growth years, the child somehow resisted or protested their bond.

It is not uncommon for parents of homosexuals to blame themselves for these outcomes, and though this is unproductive, they continue to badger and over-analyze themselves and their faults. Many have beat-

en themselves up. Others have given up and resolved to “disown” their child or to “forget” them. Some try to “pray it away,” while others resort to over-involvement in activities or engage in other distractions.

It is especially hard for a parent to understand a child when the child is active in the gay lifestyle. It is equally hard when the parents know that freedom from SSA is possible, but yet, their child will not seek that option. When people are “gay-identified,” meaning they have embraced the gay lifestyle, there is a sense of loss to their parents. It is very painful when the child ignores them, and retreats or rages against them. What advice is there for those parents whose child has SSA or is gay-identified? How can they put aside their dislike of the behavior and still have hope of a loving and productive relationship with their children? The following are tips parents can use to help them through their struggle with a child who has SSA or is gay-identified:

1. Do not get defensive or angry when your child says, “I’m gay.” This only fuels the fire. Realize that some children go through stages of self-doubt about their sexuality. Some go through experimental stages and sexual fluidity. While you may not condone your child’s behavior, getting in his face about it will only confuse him more and push you further away from him.

2. Do not blame yourself for your child's homosexuality. Some children struggle with same-sex attraction, which is not necessarily due to familial influence, per se, as in the case of someone who has been sexually abused and habituated into same-sex behavior. One SSA boy interviewed said, "Well, I must be gay. Why would that priest have picked me to [molest]?" A woman explained, "I vowed never to trust men after I was [molested]," and concluded that, "women [for sex], were much safer for me." If your same-sex attracted child tells you it's your fault, ask them why they feel that way. If they say you were over-intimidating and intrusive, give them some insight into why you may have been that way. If you had ever physically or emotionally abandoned them, explain to them your reasons. You are human, too. Tell them you wanted the best for them, despite your own shortcomings. Remember, it's not up to you to convince them of anything. Your healing can come from forgiving yourself for any misperceptions they may have about you. Your child's healing may come from confronting you or working through the past with a therapist. At any rate, do not take offense.

3. Take any criticism constructively. Learn from it. If you don't agree, agree to disagree, but don't let it continue to put a wedge between you. Ask for forgiveness, whether or not your actions were real or perceived.

4. Be prepared to listen to their feelings and thoughts. Be prepared if they don't want to talk. There are some good primers to help you in this area. NARTH has many good referral resources that can help.

5. Get professional advice prior to engaging your child about these issues. Many NARTH-based therapists can guide parents to learning more about what their child is facing and how they can respond.

6. Get peer support. Join or establish a support group for parents that are in the same boat. Support from others can bring listening, weeping, prayer – and most importantly, the acknowledgment that you are not alone. Groups such as JONAH and PFOX can be helpful (see resource listing below).

7. Be at peace with yourself. Forgive yourself and others for past mistakes. Take care of yourself through good diet, sleep, meditation, prayer or progressive

relaxation.

8. Focus your energy on loving the child, being there, and being sincere. Children can pick up on patronizing behavior. Keep your emotions in check. You might sense something's wrong, but don't know what to say.

Tell them that you sense some distance, that something may not be right between you, and that you want to know what's wrong and that you want to repair any brokenness that may be either real or perceived. Listen unconditionally.

9. Get involved, place a warm hand on their shoulders, or give them a hug. Tell them you love them. Remember, showing them love does not condone their behavior. Remember, they control their behavior – not you. This is one of the hardest lessons for parents to learn.

10. Don't let your conversations be all negative. Never lecture. Avoid legalism, by which I mean lecturing the child and telling him that he is wrong and you are right. Talk about their strengths; emphasize how we are all human.

11. Holidays can be difficult, especially if your child refuses to participate. If this happens, don't forsake the holidays, but spend them as they are intended. Do this for yourself and for your beliefs and peace.

12. Learn to let go of any guilt. Once you have done your part, allow them the opportunity to come through. Letting go means letting something that is greater and higher than you take control of the situation. The first step in recovery is to accept that we are "powerless." Another step is changing what we can change, and accepting what we can't.

A child who decides to be freed from homosexuality must be assured that help is available. A NARTH-based therapist can help. Some individuals benefit from self-help ex-gay groups which can be secular or of various religious denominations. Remember, they must want the change; you cannot superimpose change on them. Be patient, change takes a lot of time. Conjoint therapy may be helpful to assist with family reconstruction when the timing is right. Individual work for the parent and for the child is

important since the dynamics are different. Workshops, psychodrama, Gestalt-based therapies, experiential weekends dealing with deepening gender identity such as Journey into Manhood, New Warriors, Woman Within International can be helpful. Love, Sex & Intimacy Seminars given by the International Healing Foundation (IHF) offer deep inner child work (re-parenting) for healing the grief. And finally, never give up your belief that change and freedom is possible – It is!

Resources:

*In this paper, “gay” refers to human beings of either sex. I have chosen to do this for grammatical consistency. ** “He” “his” or “him” used in this article refers to human beings of either sex. I have chosen to do this for grammatical consistency.

For Parents:

PFOX: www.pfox.org

JONAH: www.jonahweb.org (for Jewish families)

For men:

Journey into Manhood: www.peoplecanchange.com

New Warriors: www.mkp.org

For Women:

Women Within International: www.womanwithin.org

Referrals for other resources or therapists in your local area, please contact NARTH.

Jim Phelan is a Licensed Clinical Social Worker as well as a Certified Addictions Counselor.

www.phelanconsultants.bravehost.com

Ethical/Theological

Jewish Man Finds Help For Unwanted SSA Through Jews Offering New Alternatives To Homosexuality

In a letter to the editor (9/21/2005) of *The Jewish Press*, a young man writes about his success in overcoming same-sex attractions with the help of a NARTH-associated organization known as JONAH. This letter is reprinted by permission of *The Jewish Press*.

Dear Rachel,

Every Friday I look forward to picking up a copy of *The Jewish Press* to see what you and others have written about SSA. I am a 24-year-old frum single male who has had somewhat of a different experience in regard to my struggle, and I hope that sharing it with your readers will help other strugglers in the larger Jewish community.

Having been raised in a frum kosher home, I attended mainstream yeshivas and graduated at the top of my class in both elementary and high school. I was known for having incredible middos and great hasmada. Everyone referred to me as the “great guy.” I still remember when a friend approached me to discuss a

problem he was facing and ended the conversation with, “I wish I could have your life.” I thought to myself, “Be careful of what you wish for. Having my life would be more of a curse than a blessing.” This friend was just one of many who did not know of my inner suffering.

Throughout my teens, I was attracted to males rather than females and theorized that I was driven in this direction due to excessive frumkeit. I finally built up the courage to confide in my rebbe and told him of my theory. He agreed with it and advised me not to worry, that I would eventually marry and things would be fine.

His response did not sit well with me and I took the matter up with a different rebbe who, to his credit, admitted to not knowing much about SSA. I was assured, though, that he would be supportive in any way he could. He did some research and familiarized me with JONAH — Jews Offering New Alternatives to Homosexuality, an organization that I found to be extremely helpful. They recommended some books

for reading, gave me contact information for therapists who deal with this issue and served as a support that I had thus far not had. For the first time in my life, I did not feel alone.

I started seeing a therapist to guide me through the reparative therapy process — long and difficult but well worth it. I learned that my attractions stemmed from insecurities — that I was attracted to other men who had the qualities I longed for, which I believed I was lacking. I worked on becoming more comfortable in my masculinity, and the more self-assured I became, the less attraction I had to other men — and the more I was attracted to women.

An experiential weekend I participated in, called “JIM” — Journey Into Manhood (geared for men with SSA), was one of the most incredible experiences of my life. I learned about the causes of SSA and did some powerful work around the specific issues that lead to it. It was certainly not a typical Shabbos, but it was for me a life-changing experience. I had spoken to my rebbe beforehand about whether to go, and he had said that my condition was like pikuach nefesh and to do whatever was necessary. He offered me guidelines in how to deal with some Shabbos issues, and off I went. I am most grateful to have a rebbe who is so supportive and encouraging.

Through therapy I learned how to make the attraction my ally as opposed to my enemy. When I feel attracted to another man, I am aware that there is something going on inside of me. Is it based on a physiological or psychological need? Am I hungry? Angry? Lonely? Tired? Do I consider him to be more of a man than I am? Once I determine the cause, I address it directly — and the attraction dissipates. My SSA is indicative of a physiological or emotional need unmet.

Books that I found helpful include: *Reparative Therapy: A New Clinical Approach*, by Joseph Nicolosi (among my favorites); and *Coming Out Straight*, by Richard Cohen (extremely informative.) Websites like <http://www.jonahweb.org/> and <http://www.peoplecanchange.com/> are filled with information and resources to help one along the journey.

I have come a long way, have learned much about myself

and am stronger than I have ever been. I am still in therapy and have recently started dating women. I know this is challenging for me and that I need a very special girl, but she is definitely out there somewhere. I still have some attraction to men, but it is less frequent, less severe, and I know how to deal with it in a healthy way.

Given the choice, I certainly would not have opted for this challenge. There are days when I wish I could be like my friends who are married, have children and are learning in kollel. Hashem, though, had a different plan for me. The process was and is lengthy and demanding, but the undertaking is a positive life-affirming one, and positive growth is gained along the way. For all those out there who struggle in silence, there is hope. -- *Growing and hopeful*

The Jewish Press responded:

Dear Growing,

If your letter helps alleviate the burden of but one struggling individual, the space your words have taken up in this column will be worth their weight in gold.

Your message is enlightening and logical, with a twist in perspective that should lead others who suffer in silence to reconsider their fatalistic thinking. Your approach is well worth exploring.

The larger picture that has emerged in this column in the last several weeks speaks of encouragement, hope, and light at the end of the tunnel — one that is well within reach for the sincerely motivated. Thank you for your part in lighting the way. I wish you a future bright with the light of a complete yeshua.

Another book that comes highly recommended by readers is Rabbi Chaim Rapoport's *Judaism and Homosexuality*. And <http://www.kedusho.com/> is an intriguing and informative website geared for the Jewish adult. May we all aspire to attain the level of kedusha (holiness) that is proper and fitting for our people — as G-d's children.

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be constructive."

Another expert offered by Herek was John de Cecco, Ph.D., who has also written affirmatively of man-boy "intergenerational intimacy" in the *Journal of Homosexuality*, and is an editor of *PAIDIKA*.

Yet one other frequent contributor to legal testimony, the *Lawrence* brief included, is lesbian activist-researcher Charlotte Patterson, Ph.D., who in a landmark case of same-sex adoption was cited for refusing to turn over her research notes, contributing to her side's defeat. "Her conduct was a clear violation of a court order," said Satinover, "yet she is still writing briefs in current court cases."

In discussing the overall "scope and type of malfeasance," Satinover concluded the following:

- "Briefs appear to be authored by a small circle of individuals who are called on repeatedly, with footnoted references that almost never properly substantiate their case."
- A common tactic is to reference studies "that are trivial or out-of-date, while ignoring more important, recent, larger, better, and superceding research."
- "A substantial portion of the authorities cited [through footnotes] will be themselves."
- "The most common pattern is by far the simplest: the overwhelming mountain of contrary evidence is simply never mentioned."
- "The malfeasance is relentless," Satinover concluded. "It is appalling beyond imagination."

Other Speakers

During the luncheon, Dr. Dean Byrd offered a rousing address. "As I reviewed the brief history of NARTH," he said, "it is nothing short of amazing what has been accomplished." To continue this forward momentum, he said, NARTH members should get more involved in the public sphere; work within the national associations, and remember to continually remind those who would silence them, that "diversity includes me."

Dr. Byrd then read from a letter he wrote to the American Psychological Association:

"In your addresses and written messages, you have repeatedly focused on the importance of diversity. Even in the recent *Monitor*, you noted that APA has demonstrated 'a lack of sensitivity or downright rudeness' toward marginalized groups. While it is not my intent to be offensive, it seems that your response to APA members who are members of NARTH reflects that insensitivity of which you are so critical.

"Client autonomy is central to NARTH's mission. NARTH's official position is that homosexuality is an adaptation. For some men and women, this adaptation is distressful and unsatisfying. NARTH supports an individual's right to either claim a homosexual identity or to pursue change in their adaptation in accordance with the ethical principle of client self-determination.

"Though not all of the patients that NARTH members treat are religious, many are. Is it not a blatant disregard for their religious values and an affront to real diversity to marginalize these individuals by failing to acknowledge their right to choose how they will adapt sexually?"

"The focus of NARTH's attention is a 'marginalized group within a marginalized group'—those who feel that homosexual attractions are not who they are and seek help in reconciling their unwanted sexual attractions with their value systems. Would you or APA not find a place at the table for such individuals or would you add to their distress by refusing to acknowledge that they exist? Would you deny the importance of client autonomy and client self-determination?"

"APA's continuous messages of 'respect for diversity' rings hollow if it does not represent different world-views....either you support client autonomy or you do not; either you support client self-determination or you do not; either your actions reflect diversity, or they do not.

"NARTH members and supporters have impressive publication records in respected journals such as *Professional Psychology*, *Archives of Sexual Behavior*, *Psychological Reports*, *Journal of Marriage and Family Therapy* and the *Journal of Law and Family Studies*.

"Listen to one NARTH supporter," Dr. Byrd concluded, "and tell me who you think he is. He said: 'I am here as the champion of one's right to choose....It is my fervent belief that freedom of choice should govern one's sexual orientation...If homosexuals choose to transform their sexuality into heterosexuality, that resolve and decision

is theirs and theirs alone, and should not be tampered with by any special interest group.' This statement was made by Dr. Robert Perloff – a former APA President.”

Other Speakers

Also during the luncheon, attorney Scott Lively noted that NARTH’s critics are supported by tens of millions of dollars from foundations on the left, which effectively permits them to “steer the culture through grants.” In an effort to begin reversing that trend, he recently created the Pro-Family Endowment, with one of its initial grants being made to NARTH.

On Sunday, Dr. Norman Goldwasser offered an address describing the use of EMDR (Eye Movement Desensitization Reprocessing) therapy to help clients overcome the effects of trauma and to actualize their heterosexual potential. Dr. Goldwasser says he had had considerable success using the technique with same-sex

attracted clients. Also offering an address was Nancy Heche, Ph.D., the mother of actress Anne Heche, a former lesbian. In a warm, inspirational and emotionally stirring speech, Dr. Heche offered support for families who have struggled to adjust to a loved one’s same-sex attractions.

On Friday, Dr. Joseph Nicolosi offered a Men’s Track workshop for in-depth training of psychotherapists, while a Women’s Track training workshop was offered by Mary Beth Patton, M.A., L.P.C., Janelle Hallman, M.A., L.P.C., and Cynthia Winn, M.A., M.F.T.

Other speeches and roundtable discussions were offered by Alan Chambers of Exodus, Dr. Julie Harren, Dr. Jerry Harris, Konstantin Mascher (from Germany), Dr. Christopher Rosik, attorney Arthur Goldberg, Dr. James Phelan, and Dr. Richard Potts.

NARTH President Challenges The APA To Correct Misinformation On Its Website

A NOTE FROM THE PRESIDENT

As part of NARTH’s ongoing public education efforts, I recently sent a letter of concern to the president of the American Psychological Association, Dr. Ronald Levant, to encourage him to correct factual errors on the APA’s web site.



Joseph Nicolosi, Ph.D.

One section of the APA web site includes a feature titled, “Being Gay Is Just As Healthy As Being Straight,” and cites the 1957 work of Dr. Evelyn Hooker, as proof of that assertion.

In my letter, which is reprinted below, I cite just a few examples of current research which contradict APA’s statements.

American Psychological Association
750 First Street, NE
Washington, DC 20002-4242

Dear Dr. Levant:

As the President of the National Association for

Research and Therapy of Homosexuality (NARTH), I am writing to you to ask that you reexamine some outdated and inaccurate statements made on the APA web site about gay men and women.

The APA article in question is titled, “Being Gay Is Just As Healthy As Being Straight,” and is posted in the “Psychology Matters” section of your web site. This article cites the work of Dr. Evelyn Hooker, who published a study in 1957 comparing the mental health of gays and heterosexual males.

The APA article’s subhead makes the following claim: “Evelyn Hooker’s pioneering research debunked the popular myth that homosexuals are less mentally healthy than heterosexuals, leading to significant changes in how psychology views and treats people who are gay.”

The fact is that for many years (if not decades) Dr. Hooker’s work has been rejected by researchers—including most gay-activist researchers—as too limited in scope to prove a mental-health equivalency between gays and straights. Dr. J. Michael Bailey, a researcher who specifically says he champions gay rights, has challenged Hooker’s work and the use of Rorschach tests to determine the mental health of an individual. Writing in his latest book, Bailey says of Hooker’s use of the Rorschach: “In recent times, the Rorschach has fallen

into increasing disfavor, and some of us think it is little better than reading tea leaves. So, the fact that psychologists couldn't tell gay men from straight men based on their Rorschach scores is not very meaningful." (*The Man Who Would Be Queen*, p. 81)

In addition, Richard Friedman and Jennifer Downey, in *Sexual Orientation and Psychoanalysis: Sexual Science and Clinical Practice* point out that Dr. Hooker used convenience samples in her studies of homosexual men: "Through word-of-mouth, Hooker recruited highly functional, socially well-integrated homosexual men." (p. 235). Hooker's study was never intended to reveal whether gays as a group were as healthy as straights; it only sought to indicate whether gross pathology was to be found in all homosexually-oriented men. In fact, a body of recently published studies in peer-reviewed journals indicate that homosexuals as a group have far more mental health problems than do heterosexuals.

Consider the following:

In July, 2005, the Christchurch School of Medicine and Health Sciences in Christchurch, New Zealand published a study titled, "Sexual orientation and mental health in a birth cohort of young adults." It was published in *Psychological Medicine*, 2005. The study surveyed the mental health of men and women between the ages of 21-26. The researchers found the following: 71.4% of gay males suffered from major depression compared to 14.5% for heterosexual males; illicit drug use: 42.9% for gays and 11.1% for heterosexual males; suicidal ideation: 71.4% for gays; 10.9% for heterosexuals; suicide attempts: 28.6% for gays; 1.6% for heterosexuals.

Two studies in the October, 1999 issue of *Archives of General Psychiatry* found that gays suffer from significantly more mental health problems than do heterosexuals. Researcher J. Michael Bailey noted: "Subjects whom they classified as gay, lesbian or bisexual were at an increased lifetime risk for suicidal ideation and behavior, major depression, generalized anxiety disorder,

conduct disorder, and nicotine dependence." Bailey questioned why these results are so stark and suggested that homosexuality "may represent developmental error." He also proposed the following possible explanation: "...that increased psychopathology among homosexual people is a consequence of lifestyle differences associated with sexual orientation."

A study published in the December, 2003 issue of the *British Journal of Psychiatry* found higher rates of illegal drug use, alcoholism and psychological problems among gays than among heterosexuals. The controlled study was conducted among gays in Britain and Wales. Gays were almost ten percentage points more apt to suffer mental problems than heterosexuals (44% to 35%). Gay males were also more likely to abuse drugs (52% to 45%).

These are just samplings of numerous studies conducted over the past few years that clearly demonstrate that the APA's statement "Being Gay Is Just As Healthy As Being Straight" cannot be justified by the latest body of research findings. NARTH can provide you with more information to back this recent finding that gay behavior is far more troublesome to individuals than is heterosexuality. We have not even dealt with the differences in physical health between gays and heterosexuals. Those differences are also stark and sobering.

We urge you to correct your web site based on the latest research findings comparing gay behavior and heterosexual behavior. The public relies on the APA to know the facts. Despite what your web site claims, same-sex sexual behavior is associated with a markedly lower quality of mental and physical health.

If you look into this matter yourself, rather than passing it on to a gay-activist member of the APA for a response, I am confident that you will agree that a change needs to be made in APA's web material.

Sincerely,

Joseph Nicolosi, Ph.D.

Call For Papers For April, 2006 NARTH Bulletin

If you are a NARTH professional, consider submitting a research paper for the next edition of the *NARTH Bulletin* to be published in April, 2006.

Contributions need to be submitted to the editorial director by February 1, 2006 for inclusion in the *Bulletin*.

Submissions should be no longer than 4,000 words and submitted in MS Word format. If footnotes are used, please avoid using Word's footnoting feature. Manually insert footnote numbers in document and include a footnote list at the end of the document. Submit paper by email to: Editorial Director, nationalarth@yahoo.com.