

*Homosexuality and Hope (Second Edition)*¹

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Introduction

No issue has raised more concern in the past decade than that of homosexuality and therefore the CMA offers the following updated version of its booklet *Homosexuality and Hope (H & H)*. The research referenced in this report² counters the myth that same-sex attraction is genetically predetermined and unchangeable and offers hope for prevention and treatment. It is hoped that this review will serve also as an educational and reference tool for all concerned with this issue.

“Same-sex attraction” or “SSA” is used “Same-sex attraction” (SSA) is used instead of words like “gay,” “lesbian,” or “bisexual.” Using the latter words, or even “homosexual” and “heterosexual” as nouns, implies a fixed state or identity and suggests an equivalence between the natural state of man and woman as created by God and persons who experience (SSA). Persons should not be identified with their emotions, stage of development, or particular accomplishments, difficulties, joys or conflicts, as though such were the essence of their identity or most important aspect of their existence. As the Congregation for the Doctrine of the Faith wrote in 1986):

The human person, made in the image and likeness of God, can hardly be adequately described by a reductionist reference to his or her sexual orientation. Every one living on the face of the earth has personal problems and difficulties, but challenges to growth, strengths, talents, and gifts as well. Today, the Church provides a badly needed context for the care of the human person when she refuses to consider the person as a “heterosexual” or

¹ The first edition of *Homosexuality and Hope (H & H)*, was written by the present authors at the request of the Catholic Medical Association (CMA, which published it as a booklet in 1999. Subsequently, CMA published a shorter version, *H & H: Questions and Answers about Same-Sex Attraction*, as a pamphlet in 2003, which was updated in 2008 and 2010. ¹ The present edition is our attempt to update the longer booklet itself. While it is our intent that the second edition of *H & H*, also is published as a CMA document, the present document is being released in advance of formal CMA acceptance. With the CMA, the present authors are dedicated to upholding the principles of the Catholic Faith as related to the practice of health-care and to promoting Catholic medical ethics to the medical profession, including mental health professionals, the clergy, and the general public.

² It should be noted that H&H contains results of studies from many authors who do not agree with CMA’s ethical stance.

a "homosexual" and insists that every person has a fundamental Identity: the creature of God, and by grace, his child and heir to eternal life. (n. 16)

Both revisions of *H & H* were written by Catholics for Catholics and also by a medical and a mental health professional for our colleagues in the medical and mental health arts and sciences, whether of Catholic or other religious faith or none. With the exception of guidelines for meeting specific pastoral needs of Catholic patients or clients, "Catholic" healthcare ethics apply to *all* healthcare professionals.³ While the Church does not claim to be expert herself in the medical and mental health arts and sciences, she proposes that her "authoritative teaching (speaks) with love and mercy not only to believers but to all people of good will.: For, "as an 'expert in humanity',⁴ she places herself at the service of every individual and of the whole world."^{5,6} Concerning the topic of homosexuality – indeed, all moral issues – the Church proposes that she understands what it means to be a human being and how human dignity and wellbeing may be authentically understood, lived and fostered.

When considering the pastoral care of persons with SSA in light of the proper role of scientific and professional truth, the Church makes three observations. 1) She observes that: "[T]he Catholic moral perspective...finds support in the more secure findings of the natural sciences, which have their own legitimate and proper methodology and field of inquiry." 2) But, the findings of modern science – when conducted and reported responsibly – properly need to be augmented by "the Catholic moral viewpoint (which) is founded on human reason illumined by faith and is consciously motivated by the desire to do the will of God our Father." 3) Her moral viewpoint and motivation allow her:

to learn from scientific discovery but also to transcend the horizons of science and to be confident that her more global vision does greater justice to the rich reality of the human person in his spiritual and physical dimensions, created by God and heir, by grace, to eternal life.⁷

³ Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* (Boston, MA: Pauline Books and Media, 1995).

⁴ Paul VI, *Address to the General Assembly of the United Nation* (October 4, 1965), 1: *AAS* 57 (1965), 878; cf. Encyclical Letter *Populorum Progressio* (March 26, 1967), 13: *AAS* 59 (1967), 263-264.

⁵ Cf. Second Vatican Ecumenical Council, Pastoral Constitution on the Church in the Modern World *Gaudium et Spes*, 16.

⁶ John Paul II, (1993). Encyclical Letter, *Veritatis Splendor*, n. 3. (http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor_en.html)

⁷ Congregation for the Doctrine of the Faith (1986), *Letter to the Bishops of the Catholic Church on the Pastoral Care of Homosexual Persons*, n. 2.

Part I Understanding Same-sex Attraction

By the end of the first decade of the 21st Century, the general public has repeatedly heard and has largely come to believe that homosexuality is inborn (innate) and unchangeable (immutable). As documented in the *Journal Human Sexuality*:⁸

(O)ver the past few decades there has been a clear trend toward the belief that homosexuals are born that way—a belief that is increasing among the general public as well as the homosexual community. This trend indicates a growing belief in all communities that those with same-sex attraction are acting out an attraction that is normal and natural for them and that they cannot change.⁹

Public opinion polls have documented “the increase of positive attitudes toward those with same-sex attraction, as measured by the belief that they should have equal access under the law—a belief that generally indicates at least some degree of acceptance of homosexuality.”¹⁰ This acceptance is the consequence of intentional efforts by some homosexual activists to influence the general public – as well as educators, religious leaders and persons involved with public policy, including local, state and federal lawmakers, and the courts – to come to tolerate, accept and ultimately approve of homosexuality.¹¹

Born that way?

Those promoting the normalization of SSA have argued in public that people are “born that way” and cannot change; therefore SSA is not a psychological disorder. The decade of the 1990’s saw a handful of studies by scientists investigating possible genetic or other biological influences on the development of SSA. The public media declared that there now was proof that persons with homosexual feelings were “born that way,” although none of the researchers made such claims. In 1999, the American Psychological Association (APA) formally concluded in response to these studies, “*There is considerable recent evidence to suggest that*

⁸ National Association for Research and Therapy of Homosexuality (NARTH) Scientific Advisory Committee (2009). What Research Shows: NARTH’s Response to the American Psychological Association’s (APA) Claims on Homosexuality. *Journal of Human Sexuality*, 1, 1-128. Retrieve from:

<http://www.scribd.com/doc/115507777/Journal-of-Human-Sexuality-Vol-1>

⁹ Ibid., p. 44.

¹⁰ Ibid.

¹¹ Marshall Kirk & Hunter Madsen, *After the Ball: How: How American will Conquer Its Fear and Hated of Gays in the 90’s* (Plume Books, 1990); Charles Socarides, *Homosexuality: A Freedom Too Far* (Adam Margrave Books, 1995); Jeffrey Satinover, MD, *Homosexuality and the Politics of Truth* (Baker Books, 1996); Michael Brown, *A Queer Thing Happened to America* (EqualTime Books, 2011).

biology, including genetic or inborn hormonal factors, play a significant role in a person's sexuality."¹² Within the gay/lesbian community, there was – and still is – an ongoing debate over the born-that-way argument, with many taking the view that this claim is demeaning.¹³

If it were one would expect that identical twins would virtually always have the same pattern of sexual attraction. Numerous studies have found discordant identical twin pairs.¹⁴ Using the Australian twins' registry, a team of researchers located 27 pairs of identical male twins in which one was identified as having SSA. In only three pairs were both so identified (11%).¹⁵ These results point to non-shared experience, internal and/or external, as a major etiological factor. Neil Whitehead summarizes the research on identical twins as follows:

*From six studies (2000-2011): if an identical twin has same-sex attraction, the chances that the co-twin has it too are only about 11% for men and 14% for women. This means that factors the twins have in common, such as genes and upbringing are mostly not responsible – individual and idiosyncratic responses to random events and to common factors predominate.*¹⁶

¹² American Psychological Association, *Answers to Your Questions about Sexual Orientation and Homosexuality*.(1998), as quoted in Dean Byrd, *APA's New Pamphlet on Homosexuality De-emphasizes the Biological Argument, Supports a Client's Right to Self-Determination*, (2009). Retrieve from: <http://www.narh.com/docs/deemphasizes.html>.

¹³ Gareth Kirkby, "No need to lie," *Xtra West*, (August 20, 1998); John McKellar, "There is HOPE for the world," Toronto, CA: Homosexuals Opposed to Pride Extremism, Feb, 2003.

¹⁴ J. Michael Bailey, Richard Pillard, "A genetic study of male sexual orientation," *Archives of General Psychiatry*. 48 (1991): 1089-1096; E. Eckert, *et al.*, "Homosexuality in monozygotic twins reared apart," *British Journal of Psychiatry*, 148 (1986): 421-425; Richard Friedman, F. Wollesen, R. Tandler, "Psychological development and blood levels of sex steroids in male identical twins of divergent sexual orientation," *The Journal of Nervous and Mental Disease*. 163, 4 (1976): 282 – 288; Richard Green, *Sexual Identity Conflict in Children and Adults*, Baltimore: Penguin, (1974); L. Heston, J. Shield, "Homosexuality in twins," *Archives of General Psychiatry*. 18 (1968): 149-160; McConaghy, "A pair of monozygotic twins discordant for homosexuality: Sex-dimorphic behavior and penile volume responses," *Archives of Sexual Behavior*, 9 (1980): 123-131; J. Rainer, *et al.*, "Homosexuality and heterosexuality in identical twins," *Psychosomatic Medicine*. 22 (1960): 251-259; B. Zuger, "Monozygotic twins discordant for homosexuality: Report of a pair and significance of the phenomenon," *Comprehensive Psychiatry*, 17 (1976): 661-669; N. Parker, "Homosexuality in twins: A report on three discordant pairs," *British Journal of Psychiatry*. 110 (1964): 489-492.

¹⁵ J. Michael Bailey, M. Dunne, N. Martin, "Genetic and Environmental Influences on Sexual Orientation and its Correlates in an Australian Twin Sample," *Journal of Personality and Social Psychology*, 78, 3 (2000): 524-536. Also see, Niklas Langstrom *et al.*, "Genetic and Environmental Effects on Same-sex Sexual Behavior: A Population Study of Twins in Sweden," *Archives of Sexual Behavior*, 2008,

¹⁶ Neil Whitehead, *Common Misconceptions About Homosexuality*. Retrieved 2013-06-04 from: (<http://mygenes.co.nz/myths.pdf>). Cf. Neil Whitehead & Briar Whitehead (2010), *My Genes Made Me Do It! - A Scientific Look at Sexual Orientation.*, Chapter 10. Self Published: Retrieve from: <http://www.mygenes.co.nz/MGMMDIInfo.htm>.; Cf. Neil E. Whitehead (2011). Neither Genes nor Choice: Same-Sex Attraction Is Mostly a Unique Reaction to Environmental Factors. *Journal of Human Sexuality*, 3, 81-114. Retrieve from: <http://www.scribd.com/doc/115507954/Journal-of-Human-Sexuality-Vol-3>.

Claims that SSA has a biological cause are like fireworks; they go up with a great flash and come down as cinders. Each study was – and still is - announced with great fanfare, but there is little or no publicity when the study is discredited.¹⁷ For example, in 1995 the *Journal of Homosexuality* published double issues¹⁸ in which a number of authors reviewed various theories suggesting a biological causation for SSA – genetic, hormonal, brain structure, socio-biological. The conclusion of the editors: “Current research into possible biological bases of sexual preference has failed to produce any conclusive evidence.”¹⁹

Supporters of the “born-that-way” theory frequently cite a 1993 study by Dean Hamer and associates who claimed to have found a “gay gene.”²⁰ However, other scientists have failed to duplicate their results.²¹ And a genome wide study of 465 individuals by Mustanski and associates found no genetic basis for homosexuality.²²

Some researchers have tried to cloud the issue by speaking about *heritability* – the way in which inherited traits may affect behavior. It is undeniable that inherited traits such as temperament, appearance, talents, and physical coordination do affect the way individuals interact with their environment, the way they are treated by others, and the way they respond to stress. There is no evidence that such inherited traits predestine a particular individual to SSA. Dr. Francis Collins, head of the Human Genome Project, explained, “There is an inescapable component of heritability to many human behavioral traits. For virtually none of them is heredity ever close to predictive.” Concerning SSA in particular, “Whatever genes are involved represent predispositions, not predeterminations.”²³

¹⁷ Chandler Burr, “Suppose there is a gay gene...What then? Why conservatives should embrace the gay gene,” *The Weekly Standard* (Dec. 16, 1996) 22-26. Cf. Whitehead & Whitehead, (2010).

¹⁸ David Parker, John DeCecco, “Sexual Expression: A Global Perspective,” (in *Sex, Cells, and Same-Sex Desire*, 1995, simultaneously issued as Vol. 28 *Journal of Homosexuality*): 427.

¹⁹ Ibid. Cf. NARTH website: <http://narth.com/main-issues/born-that-way-theory/>.

²⁰ Dean Hamer *et al.*, “A linkage between DNA markers on the X chromosome and male sexual orientation,” *Science*, 261 (1993): 321 -327; Byne, “Science and belief.” 309.

²¹ George Rice, *et al.*, “Male homosexuality: Absence of linkage to microsatellite markers at Xq28,” *Science*, (April 1999) 665-667.

²² B.S. Mustanski, *et al.*, “A genome wide scan of male sexual orientation,” *Human Genetics*, 116, 4 (2005): 272-278.

²³ A. Dean Byrd, “Homosexuality Is Not Hardwired,” *Concludes Dr. Francis S. Collins, Head Of The Human Genome Project*, (2007). Retrieved from: <http://narth.com/docs/nothardwired.html>.

It has been suggested that SSA is caused by hormones. Tests on adults revealed no hormonal differences.²⁴ A review of the literature on hormone levels in persons with SSA found no evidence of abnormalities: “The current consensus opinion is that no causal relationship exists between adult hormonal status and sexual orientation”²⁵

In 1991 Simon LeVay claimed to have found differences in brain structure of men and women with and without SSA.²⁶ His oft-referenced study was based on a small unrepresentative sample of men who died of AIDS. It also reveals a limited understanding of brain development. Even if differences were found that would not validate the born-that-way theory. According to Jeffrey Schwartz, author of *The Mind and the Brain*, “Key brain structure can change in response to your experience as an adult.”²⁷ Since the actions, experiences, and sexual behavior of a person with SSA may be substantially different from that of persons without homosexual experience, one would expect that differences in brain structure and response to various stimuli might be detected.

Sociobiologists have offered theories of how SSA could be genetically determined given that persons with SSA have fewer children. One theory suggests that having an uncle with SSA might increase the survival offspring of nieces and nephews. An article analyzing these theories concluded that they “were derived primarily from current stereotypes about homosexuals” and were “misconceived and without scientific merit.”²⁸

Although each biological causation theory has been discredited, the media continues to announce that a biological cause for SSA has been or is just about to be discovered. For example, a study by Ivanka Savic, et al entitled “Brain

²⁴ Louis Gooren, “Biomedical concepts of Homosexuality: Folk belief in a white coat,” (in *Sex, Cells, and Same-Sex Desire*, 1995) 237.

²⁵ H. Meyer-Bahlburg, “Psychoendocrine research on sexual orientation: Current status and future options,” *Progress in Brain Research*, 61 (1984) 375-399; William Byne, B. Parsons, “Human sexual orientation: The biologic theories reappraisal,” *Archives of General Psychiatry*, 50 (1993): 229-239; Louis Gooren, *op. cite*.

²⁶ Simon LeVay, “A difference in hypothalamic structure between heterosexual and homosexual men,” *Science*. 258 (1991): 1034-1037; LeVay later admitted: “It’s important to stress what I didn’t find. I did not prove that homosexuality is genetic, or find a genetic cause for being gay. I didn’t show that gay men are ‘born that way ... Since I look at adult brains, we don’t know if the differences I found were there at birth or if they appeared later.” (David Nimmons, “Sex and the Brain,” *Discover* (March 1, 1994) 64-71).

²⁷ Jeffrey Schwartz, Sharon Begley, *The Mind and the Brain: Neuroplasticity and the Power of Mental Force*, (NY: Regan Books, 2002) 252.

²⁸ Mildred Dickerman, “Wilson’s Panchreston: The Inclusive Fitness Hypothesis of Sociobiology Re-Examined,” (in *Sex Cells and Same-Sex Desire*, 1995): 147.

responses to putative pheromones in homosexual men”²⁹ reported on the difference between the ways in which persons with and without SSA reacted to particular smells. The study was misreported by the Associated Press which stated that it added “weight to the idea that SSA has a physical basis and is not learned behavior.” There is nothing in the study to suggest that these differences were present at birth and not the result of experience. Dr. Savic informed the AP that their interpretation of her work was “incorrect and not stated in the paper.”³⁰ AP was forced to correct its report.³¹

William Byne in an article entitled “Science and belief: Psychobiological research on sexual orientation” discusses the problem of flawed research. According to the abstract, the article:

Analyzes the assumptions and evidence that support biologically deterministic theories of sexual orientation. It is concluded that support for these theories derives as much from their appeal to prevailing cultural ideology as from their scientific merit. This appeal may explain why seriously flawed studies pass readily through the peer review process and become incorporated rapidly into the biologically deterministic canon where they remain viable even when replication attempts repeatedly fail.³²

Gerard van den Aardweg in an article entitled “Homosexuality and Biological Factors: Real Evidence None, Misleading Interpretations Plenty,”³³ carefully analyzed the current claims for a biological cause and explains why each is flawed. The Whiteheads similarly have critically examined and refuted such claims and continue to evaluate each new report claiming evidence of genetic and/or biological factors associated with homosexuality.³⁴

After a decade of failures by researchers either to replicate the findings of the ‘90’s studies, which the media at least claimed showed genetic and/or biological

²⁹ Ivanka Savic, et al, “Brain responses to putative pheromones in homosexual men,” *Proceedings of the National Academies of Science*, 102, 20 (2005): 7356-7361.

³⁰ Robert Knight, “AP reports ‘gay brain’ study incorrectly www.worldnetdaily.com/news/article.asp?Article_ID-50136

³¹ Hilary White, “AP Issues Incomplete Correction on Lesbian Study,” *LifeSiteNews.com*, (May 15, 2006) <http://www.lifesite.net/ldn/2006/may/06051505.html>

³² William Byne, “Science and Belief: Psychobiological Research on Sexual Orientation.” (in *Sex, Cells, and Same-Sex Desire*, 1995) 304.

³³ Gerard van den Aardweg “Homosexuality and Biological Factors: Real Evidence none, misleading interpretations plenty,” *NARTH Bulletin*, www.narth.com/docs/aardweg.pdf.

³⁴ Whitehead (2010).

causation, or to offer any new, persuasive evidence, the APA backed away from its 1998 emphasis on “genetic or inborn hormonal factors.” In 2009, APA concluded:

*There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles. ...*³⁵

Ironically, this change by the APA was – and continues to be – overlooked by the popular media, which gave – and continues to give – so much publicity to studies which have suggested only a possible, partial influence of genetics and/or biology. Unfortunately, the APA and other secular mental and medical health organizations are engaged more in political correctness and ideological activism than the conduct of responsible profession and science.³⁶

If the genesis isn’t biological, what is it?

The Catechism of the Catholic Church in speaking of homosexuality states that “its psychological genesis remains largely unexplained.”³⁷ This does not mean that the Church’s Magisterium is unaware of possible causes. The 1975 Congregation for the Doctrine of the Faith (CDF) document *Persona Humana* explains that the tendency for homosexual behavior may come “from a false education, from a lack of normal sexual development, from habit, from bad example, or from other similar causes.”³⁸ When so caused, the CDF refers to such tendencies as “transitory or at least not incurable,” while speculating that some persons with homosexual tendencies may be “definitively such because of some kind of innate instinct or a pathological constitution judged to be incurable.”³⁹

³⁵American Psychological Association. (2008). *Answers to your questions: For a better understanding of sexual orientation and homosexuality*. Washington, DC: Author. Retrieved from <http://www.apa.org/topics/sexuality/orientation.aspx>, p. 4: cf., Byrd (2009).

³⁶A. Dean Byrd (2004). *When Activism Masquerades as Science: Potential Consequences of Recent APA Resolutions*. Retrieve from: <http://narth.com/docs/masquerades.html>; Rogers H. Wright and Nicolas A. Cummings, Editors (2005). *Destructive Trends in Mental Health: The Well-Intentioned Path to Harm*. New York: Routledge. Jeffrey B. Satinover *The "Trojan Couch": How the Mental Health Associations Misrepresent Science*. Retrieve from: <http://narth.com/docs/TheTrojanCouchSatinover.pdf>.

³⁷ *Catechism of the Catholic Church (CCC)*, n. 2357.

³⁸ Congregation for the Doctrine of the Faith (1975). *Persona Humana: Declaration on Certain Questions Concerning Sexual Ethics*, n. 8. Retrieve from: http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19751229_persona-humana_en.html.

³⁹ *Ibid.*

In 1983, the Church's Congregation for Catholic Education first restated the possible causes of homosexual tendencies listed in the CDF's *Persona Humana*, and then listed additional possibilities. Some factors are psycho-social: "lack of affection, immaturity, obsessive impulses, seduction, social isolation and other types of frustration, depravation in dress, license in shows and publications."⁴⁰ Other factors may be spiritual: "the innate frailty of man and woman, the consequence of original sin; ...the loss of the sense of God and of man and woman (which may) have its repercussions in the sphere of sexuality (Cf. *Rom.* 1, 26-28; cf., *per analogia*, *Humana Persona*, n. 9)."⁴¹

Finally, in 2005, the CDF released its *Instruction Concerning the Criteria for the Discernment of Vocations with regard to Persons with Homosexual Tendencies in view of their Admission to the Seminary and to Holy Orders*.⁴² In this *Instruction*, the CDF clarifies that while the homosexual tendencies of some persons may be "deep-seated," the tendencies of others may be only "transitory."⁴³ Transitory homosexual tendencies may result from affective immaturity or "an adolescence not yet superseded," which may be overcome.⁴⁴ The Church declares that for men who discern a call to priesthood and who experience transitory homosexual tendencies, "affective maturity" is not only necessary, but also possible for them to achieve, through a proper participation in the *human* and other dimensions of seminary formation.⁴⁵

Given the state of science, the Church wisely leaves the question of causation open, challenging those in the field to study the issue, conduct research, and propose theories. There is no reason to suppose that there is a single cause for all SSA.⁴⁶ Rather each person with SSA has his or her unique history in which many factors play a part.

⁴⁰ Congregation for Catholic Education (1983). *Educational Guidance in Human Love*, n. 102. Retrieve from: http://www.vatican.va/roman_curia/congregations/ccatheduc/documents/rc_con_ccatheduc_doc_19831101_sexual-education_en.html.

⁴¹ Ibid.

⁴² Congregation for Catholic Education (2005), *Instruction Concerning the Criteria for the Discernment of Vocations with regard to Persons with Homosexual Tendencies in view of their Admission to the Seminary and to Holy Orders*. Retrieve from:

http://www.vatican.va/roman_curia/congregations/ccatheduc/documents/rc_con_ccatheduc_doc_20051104_istruzio_en.html.

⁴³ Ibid., n. 2.

⁴⁴ Ibid., n 1, 3.

⁴⁵ Ibid., n. 3.

⁴⁶ Evelyn Schlatter, Robert Steinback, "10 Anti-Gay Myths Debunked," *Intelligence Report*, Winter 2010, No. 140, <http://www.splcenter.org/get-informed/intelligence-report/browse-all-issues/2010/winter>

The search to understand the origins of SSA is not merely an academic exercise. Given the problems faced by persons with SSA, understanding the genesis of SSA could lead to advances in its prevention and treatment. According to the consistent Catholic teaching homosexual acts “are contrary to natural law” and the desire for such is “intrinsically disordered”⁴⁷ therefore any advances in prevention and treatment should be pursued.

While there clearly is no evidence that SSA is genetically and unchangeably predetermined, even SSA or any condition *were* genetically determined, it does not follow that the condition is normal, healthy, or moral. Unfortunately, many secular mental and medical health organizations insist that SSA is a normal variant of human sexuality and that prevention and treatment are unnecessary. For example, in 2009, the APA asserted that it is a “scientific fact” that “same-sex attractions, behavior, and orientations per se are normal and positive variants of human sexuality— in other words, they do not indicate either mental or developmental disorders.”⁴⁸ In a recent *amiciae* brief to the Supreme Court in support of “homosexual marriage,” APA was joined by the American Medical Association, the American Psychiatric Association, the American Academy of Pediatricians, and other national and California medical and mental health organizations, in the assertion, “Homosexuality is a normal expression of human sexuality.”⁴⁹

While researchers looking for a sole or primary biological cause have failed to find one, research into environmental influences has yielded some interesting results. A study of 2 million Danes found that:

Children who experience parental divorce are less likely to marry heterosexually than those growing up in intact families... persons born in the capital area were significantly less likely to marry heterosexually, but more likely to marry homosexually, than their rural-born peers. ...For men, homosexual marriage was associated with having older mothers, divorced parents, absent fathers, and being the youngest child. For women, maternal death during adolescence and being the only or youngest child or the only girl in the family increased the likelihood of homosexual marriage. Our

⁴⁷ CCC, n. 2357.

⁴⁸ APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Washington, DC: American Psychological Association, p. 2, cf. pg. 54. Retrieve from: www.apa.org/pi/lgbcc/publications/.

⁴⁹ Brief of the American Psychological Association, et al., in the Supreme Court of the United States, no. 12 – 144, (Feb. 28, 2013), p. 7. Retrieve from: http://www.americanbar.org/content/dam/aba/publications/supreme_court_preview/briefs-v2/12-144_merits_affirmance_apa-et-al.authcheckdam.pdf.

study provides population-based, prospective evidence that childhood family experiences are important determinants of heterosexual and homosexual marriage decisions in adulthood.⁵⁰

A study of twins found that a boy with a twin sister was more likely to have SSA, unless the boy had an older brother:

We show that male but not female opposite-sex twins disproportionately report same-sex attraction; and that the pattern of concordance of same-sex preference among siblings is inconsistent with a simple genetic influence model. Our results provide substantial support for the role of social influences, reject the hormone transfer model, reject a speculative evolutionary theory...⁵¹

Those who conceptualize SSA as a disorder have long recognized the part poor identification with the father plays in the development of SSA in men. Irving Bieber who conducted a comprehensive study of men with SSA in therapy wrote

“We have come to the conclusion that a constructive, supportive, warmly related father *precludes* the possibility of a homosexual son; he acts as a neutralizing, protective agent should the mother make seductive or close binding attempts.⁵²

Joseph Nicolosi has observed that men with SSA rarely reported rough-and-tumble play with their fathers or periods of “shared delight.” This leaves them “delight-deprived.” According to Nicolosi:

Physical interaction between father and son appears essential in making the father feel familiar, non-mysterious, and approachable in the boy’s eyes. So much of what lies behind adult same-sex attraction is that deep, lingering unsatisfied desire for physical closeness with a man.⁵³

⁵⁰ Morton Frisch, Anders Hviid, “Childhood family correlates of heterosexual and homosexual marriages: A national cohort study of two million Danes,” *Archives of Sexual Behavior*, 35, 5 (Oct. 2006): 533-547.

⁵¹ Peter Bearman, Hannah Bruchner, “Opposite-sex Twins and Adolescent Same-Sex Attraction,” *Institute for Social and Economic Research and Policy, Columbia University, Working Papers 01-04*, (2001).

⁵² Irving Bieber, *et al.*, *Homosexuality: A Psychoanalytic Study of Male Homosexuals* (NY: Basic Books, 1962): 311.

⁵³ Joseph Nicolosi, “A Shared Delight... What is it that my clients missed in their memories of their fathers?” *NARTH Bulletin* (April 2004): 29; cf., Joseph Nicolosi, *Shame and Attachment Loss: The Practical Work of Reparative Therapy* (Downers Grove, IL: IVP Academic, 2009).

It is important to note that therapists who insist that SSA is not a disorder still report a failure of their clients to identify with their same-sex parent.⁵⁴ Those who wish to understand the factors that influence the development of SSA may find Joseph Nicolosi's book *Shame and Attachment Loss: The Practical Work of Reparative Therapy* helpful.⁵⁵ Nicolosi describes SSA in males as a "shame-based" symptom:

First the boy suffers an insecure attachment with the mother due to her narcissistic parenting style, which confuses the child's needs and identity with her own needs. Then when confronted with the second developmental challenge of bonding with a hostile/critical or distant/uninvolved father, the boy lacks the secure maternal attachment that he needs to successfully negotiate the phase of gender individuation."⁵⁶

Gender Identity Disorder

It is widely accepted that a significant percentage of adults with SSA evidenced the symptoms of Gender Identity Disorder (GID) as children. Because the symptoms of GID emerge early in life – often before age 2 -- many people assume that the problem is biological and that these children are just naturally girlish boys and boyish girls. Kenneth Zucker and Susan Bradley have treated children with GID and have found that many of these children to be suffering from anxiety caused by stress within the child's early environment.⁵⁷ When their analysis was challenged,⁵⁸ Zucker and Bradley responded with a review of the mental health of the parents of their last 10 boys with GID assessed in their clinic. In each case one or both of the parents was found to have psychological or substance abuse problems.

"Of the 10 mothers, 8 had been or were currently receiving some form of psychotherapy. Six of the mothers had been or were currently receiving pharmacotherapy. Four of the mothers reported a severe history of sexual abuse (e.g., incest or rape). Of the two mothers, who had no DIS diagnosis, one was in long-term psychotherapy to deal with complex interpersonal

⁵⁴ Richard Isay, Richard Friedman, "Toward a further understanding of homosexual men," *Journal of the American Psychoanalytic Association: Scientific Proceedings* (1989): 193-206.

⁵⁵ Joseph Nicolosi, (2009)

⁵⁶ *Ibid.* p. 57.

⁵⁷ Kenneth Zucker, Susan Bradley, *Gender Identity Disorder and Psychosexual problems in Children and Adolescents*, (NY: Guilford Press, 1995);

⁵⁸ Miriam Rosenberg, "Children with gender identity issues and their parents in individual and group treatment," *Journal of American Academy of Child and Adolescent Psychiatry*, 41 (2002): 619-621; E. Menvielle, "Gender identity disorder," (Letter to the editor in response to Bradley and Zucker article). *Journal of the American Academy of Child and Adolescent Psychiatry*. 37, 3 (1998): 243-244.

issues related to her own family background and the other was often disabled by severe migraine headaches.”⁵⁹

In a sample of 26 girls with GID, 20 (76.9%) of the mothers were depressed when their daughters were infants or toddlers. Eleven mothers showed character pathology. In 12 of the families the daughter was exposed to aggression directed at the mother or at them. Six of the mothers were victims of incestuous sexual abuse.⁶⁰

It has been suggested that the roots of SSA for some may lie in a failure to achieve secure attachment to the mother in the first year of life. According to Alan Schore, an expert on attachment,⁶¹

“A securely attached child can express both positive and negative emotions, and perceives the caregiver as responding to his or her happiness and distress. The child in an avoidant attachment relationship avoids expression of negative feelings, sensing that the caregiver will not attend to or be interested in his or her distress...”⁶²

Other insecure attachment patterns are resistant/ambivalent and disorganized:

“Each of these attachment patterns is accompanied by an internal working model that sets up expectancies of caregiver behavior and that presumably, with time and development, creates neural networks to guide the child’s behavior.”⁶³

The interactions between mother and baby literally build the child’s brain.

Susan Bradley in her book, *Affect Regulation and the Development of Psychopathology*, applies her understanding of secure and insecure attachment to the issue of GID:

⁵⁹ Kenneth Zucker, *et al*, “Psychopathology in the parents of Boys with Gender Identity Disorder,” *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 1 (2003): 2-3.

⁶⁰ Zucker (1995) 252-253.

⁶¹ Allan Schore, *Affect Regulation and the Origin of the Self*, (Hillsdale NJ: Lawrence Erlbaum, 1994), *Affect Regulation and the Repair of the Self* (NY: Norton, 2003), *Affect Regulation and Disorders of the Self*, (NY: Norton, 2003).

⁶² Susan Bradley, *Affect Regulation and the Development of Psychopathology*, (NY: Guilford Press, 2003) 105.

⁶³ *Ibid*

In the area of gender identity disorder (GID), with which I am very familiar, the same basic formulation applies. ...what makes GID different from anxiety disorders is that there are factors in the family making gender more salient. Specifically, boys with GID appear to believe that they will be more valued by their families or that they will get in less trouble as girls than as boys. These beliefs are related to parents' experiences within their families of origin, especially tendencies on the part of mothers to be frightened by male aggression or to be in need of nurturing, which they perceive as a female characteristic. Girls with GID have a perception of themselves as "protectors," specifically of their mothers but also of other women. They appear to be identifying with the aggressors (often their father, but sometimes with other aggressive males). Beyond these specific dynamics, both boys and girls with GID display the temperament and attachment difficulties I have described above. Their interactions with parents are conflicted, and these children become highly distressed and anxious, with perceptions of themselves as bad and their parents as angry. I conceptualize the symptoms of GID as a child's solution to intolerable affects. This is confirmed by the fact that GID typically has its onset at a time in the child's life when the family has been particularly stressed and the parents are either more angry or less available or both. The GID symptoms, particularly the assumption of the role and behaviors of the opposite sex, act to quench the child's anxiety and to make him or her feel more valued, stronger, or safer.⁶⁴

For the child with GID, coping mechanisms, self-comforting behaviors, and fears may interfere with the sexual identification process. The boy feels very insecure, different from or rejected by his father and male peers, and becomes fearful of rough-and-tumble play. The girl does not see her mother as an object of identification. This theory would explain some of the common features found in the early childhood histories of many persons with SSA.

It should be noted that a significant percentage of persons with SSA did not have obvious symptoms of GID as children. Friedman and Stein compared 17 men with SSA who reported no feminine identification or clinical symptoms of GID with a matched group heterosexual men:

Thirteen of the 17 homosexual subjects (76%) reported chronic, persistent terror of fighting with other boys during the juvenile and early adolescent period. The intensity of this fear approximated a panic reaction. To the best

⁶⁴ Ibid: 202.

of their recall, these boys never responded to challenge from a male peer with counter-challenge, threat, or attack. The pervasive dread of male-male peer aggression was a powerful organizing force in their minds. Anticipatory anxiety resulted in phobic responses to social activities; the fantasy that fighting might occur led to avoidance of wide variety of social interactions, especially rough-and-tumble activities (defined in our investigation as body-contact sports such as football and soccer). ..These subjects reported that painful loss of self-esteem and loneliness resulted from their extreme aversion to juvenile peer aggressive interactions. All but one (12 of 13) were chronically hungry for closeness with other boys. Unable to overcome their dread of potential aggression in order to win respect and acceptance, these boys were labeled "sissies" by peers. These 12 subjects related that they had the lowest possible peer status during juvenile and early adolescent years. Alternately ostracized and scapegoated, they were the targets of continual humiliation. All of these boys denied effeminacy..."⁶⁵ No pre-homosexual youngster had any degree of experience with fighting or rough-and-tumble during the juvenile years. None engaged in even the modest juvenile sex-typed interactions described by the least aggressive heterosexual youngster.⁶⁶

These men appear to have suffered from chronic feelings of profound insecurity without any female identification. This left them isolated and longing for masculine companionship.

Insecure attachment to the mother and to father has been shown to affect the emotional development of the individual, and has been linked to internalizing disorders such as anxiety and mood disorders, eating disorders and gender identity disorder, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, alcoholism and depression.⁶⁷ If SSA is linked to attachment, this might explain the high rate of depression, other anxiety and mood disorders, substance abuse, and sexual addiction among persons with SSA.

According to this theory a particularly sensitive child may need special nurturing by both parents in order to achieve secure attachment, but precisely because this child is more needy and because the child may have inherited this sensitivity from a parent, the parents may be less able to provide the secure attachment the child

⁶⁵ Richard Friedman, L. Stern, "Juvenile aggressivity and sissiness in homosexual and heterosexual males," *Journal of the American Academy of Psychoanalysis* 8, 3(1980): 432-433.

⁶⁶ Ibid: 434.

⁶⁷ Bradley, (2003)

needs. When this happens the child may develop dysfunctional ways of meeting his own needs. These will lead in turn to other interpersonal difficulties and set the child on the path to various psychological problems, including gender identity disorder and later SSA.

A person with a psychological disorder rooted in an insecure attachment will feel that they were “born that way” – because they can only remember always feeling alienated or different. Because the attachment process occurs on the right side of the brain and is not the result of intellectual choice, they will sincerely believe that their various coping mechanism are “the real me.”⁶⁸

If SSA is in some cases a particular kind of attachment disorder, then, as our knowledge of how to prevent and treat attachment disorders expands, we may be able to apply that knowledge to the prevention and treatment of certain issues in SSA.⁶⁹ It should be pointed out that while SSA is relatively uncommon (less than 3% of the population), attachment disorders are common.⁷⁰

Attachment theory is a comprehensive concept, which treats the individual as a whole. It considers brain development, brain chemistry, inherited temperament, the effect of family environment, the part played by physical and emotional trauma, along with observation of mother/child interaction, and the way in which various therapies can actually change the brain. Nothing is predestined; positive experiences or therapeutic interventions can change the trajectory for a particular child. This theory may explain the various demographic differences between persons with and without SSA – factors which might produce disruption in attachment to parents (separation, divorce, depression) would be more common among persons with SSA, but family structure alone would not predestine a child to GID or adult to SSA. It would also explain differences in later childhood experiences since a child with an attachment disorder would be more likely to experience certain difficulties than a child without.

Each person with SSA has his or her unique history. It is probable that no single explanation will ever account for every instance of SSA⁷¹; it is very possible that there are forms of SSA not related to early attachment disorders. We can

⁶⁸ John Bowlby, *A Secure Base: Parent-Child Attachment and Healthy Human Development* (London: Routledge, 1988).

⁶⁹ Joseph Nicolosi, Linda Nicolosi, *A Parent's Guide to Preventing Homosexuality*, (Downers Grove, IL: INP, 2002)

⁷⁰ Bradley, (2003)

⁷¹ Neil Whitehead, “Neither God, Parents, nor Choice; Same Sex Attraction is Mostly Chance,” *Journal of Human Sexuality*, 3, accepted for publication. .

conceptualize this as a puzzle. We have many pieces, but they may be parts of several puzzles. It is also important to explore the part childhood sexual abuse, plays in the development of SSA in adults.

The authors and the Catholic Medical Association encourage professionals in every discipline to apply their expertise to this problem and encourage open debate and continued research into the genesis of GID and its relation to SSA. A related issue which warrants further responsible research, open discussion and medical and mental healthcare intervention is adult gender identity disorder or what now is commonly called “transgenderism,” which is beyond the scope of this monograph.⁷²

Co-morbidity

Contrary to the claims made by activists that persons with SSA are on average as psychological healthy as those without SSA,⁷³ several recent large well-designed studies have found that persons with are far more likely to suffer from psychological disorders,⁷⁴ depression, substance abuse problems, and suicidal

⁷² As it does with homosexuality, the APA responds toward “transgenderism with an ideological and political activists. That said, APA distinctions are useful for defining terms. The 2011 edition of the *APA Answers to Your Questions About Transgender People, Gender Identity, and Gender Expression* explains: “Transgender is an umbrella term for persons whose *gender identity*, *gender expression*, or behavior does not conform to that typically associated with the sex to which they were assigned at birth. *Gender identity* refers to a person’s internal sense of being male, female, or something else; *gender expression* refers to the way a person communicates gender identity to others through behavior, clothing, hairstyles, voice, or body characteristics. “Trans” is sometimes used as shorthand for “transgender” (p. 1). Retrieve from: <http://www.apa.org/topics/sexuality/transgender.aspx>.

APA also explains why some people are transgender: “There is no single explanation for why some people are transgender. The diversity of transgender expression and experiences argues against any simple or unitary explanation. Many experts believe that biological factors such as genetic influences and prenatal hormone levels, early experiences, and experiences later in adolescence or adulthood may all contribute to the development of transgender identities” (p. 2).

Similar to the changed 2008 APA position on what causes homosexuality, APA appears to be saying that anything *could* cause transgenderism (adult GID), but avoids endorsing any one influence as more significant than others. Questions of etiology are associated with diagnostic labels given to this condition. While members of the trans community – like members of the openly homosexual community – typically do not want to be considered as having a “disorder,” the need to justify the expensive medical treatment (commonly hormone replacement and plastic surgery) sought by some persons with adult GID remains an issue. Further information on trans issues may be found at: <http://parakaleo.co.uk/> and <http://help4families.com/>.

⁷³ Evelyn Hooker, “The adjustment of the male overt homosexual,” *Journal of Projective Techniques*, 21 (1957): 18-31.

⁷⁴ Richard Herrell *et al.*, “A co-twin control study in adult Men: Sexual orientation and suicidality,” *Archives of General Psychiatry*, 56, 10 (1999): 867-874; David Fergusson, John Horwood, Annette Beautrais, “Is sexual orientation related to mental health problems and suicidality in young people?,” *Archives of General Psychiatry*, 56, 10 (1999): 876-888;

Theo Sandfort *et al.*, “Same-sex sexual behavior and psychiatric disorders: Findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS),” *Archives of General Psychiatry*, 58 (2001) 85-91: “The findings support the assumption that people with same-sex sexual behavior are at greater risk for psychiatric disorders.”:

ideation, than persons without SSA. For example, the study by Fergusson and associates on a birth cohort of over 1,000 children born in Christchurch New Zealand reported on data collected over a 25 year period. At age 21 the rate of major depression for persons with SSA were in this group was almost double that of persons with no SSA (71.4% to 38.2 %).

The rate of SSA among persons with borderline personality disorder is significantly higher than in the general population.⁷⁵ Persons with schizophrenia also may present with SSA, and in some cases the SSA may be resolved when the schizophrenia is treated.⁷⁶ Two reviews of the literature published in the *Journal of Human Sexuality* (JHS) provide a comprehensive analysis of what the research

;Theo Sandfort *et al.*, Sexual orientation and mental and physical health status: Findings from a Dutch population survey,” *American Journal of Public Health*, 96, 6 (2006): 1119-1126 “Gay/lesbian participants reported more acute mental health symptoms than heterosexual people and their general mental health also was poorer.” ;

R. deGraff, Theo Sandfort, M. ten Have, “Suicidality and sexual orientation: differences between men and women in a general population-based sample from the Netherlands,” *Archives of Sexual Behavior*, 35, 3(2006): 253-262;

Stephen Gilman *et al.*, “Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey,” *American Journal of Public Health*, 91, 6 (2001): 933-939: “Homosexual orientation, defined as having same-sex sexual partners, is associated with a general elevation of risk for anxiety, mood, and substance use disorders and for suicidal thoughts and plans.” ;

Susan Cochran, Greer Sullivan, Vickie Mays, “Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States, *Journal of Consulting and Clinical Psychology*, 71, 1 (2003): 53-61: “Results indicate that gay-bisexual men evidence higher prevalence of depression, panic attacks, and psychological distress than heterosexual men. Lesbian-bisexual women showed greater prevalence of generalized anxiety disorder than heterosexual women.” ;

James Warner *et al.*, “Rates and predictors of mental illness in gay men, lesbians, and bisexual men and women,” *British Journal of Psychiatry*, 185 (2004); 479-485 : “Gay, lesbian and bisexual men and women have high levels of mental disorder.”

It should be noted that the rate of SSA among persons borderline personality disorder is significantly higher than in the general population. See: J. Parris, H. Zweig-Frank, J. Guzder, “Psychological factors associated with homosexuality in males with borderline personality disorders,” *Journal of Personality Disorders*, 9, 11 (1995): 56; G. Zubenko *et al.*, “Sexual practices among patients with borderline personality disorder,” *American Journal Psychiatry*, 144, 6 (1987): 748-752.

In some cases persons with schizophrenia present with SSA, but the SSA is resolved when the schizophrenia is treated. See: J. Gonsiorek, “The use of diagnostic concepts in working with gay and lesbian populations,” (in J. Gonsiorek, *Homosexuality and Psychotherapy*, NY: Haworth, 1982) 9-20.

29, (1992): 501 – 523; S. Sleek, Concerns about conversion therapy. *APA Monitor*, (October, 281997): 16; J. Smith, “Psychopathology, homosexuality, and homophobia,” *Journal of Homosexuality*, 15, 1/2(1988): 59-74.

Warner: “Gay, lesbian and bisexual men and women have high levels of mental disorder.”

⁷⁵ J. Parris, H. Zweig-Frank, & J. Guzder, “Psychological factors associated with homosexuality in males with borderline personality disorders,” *Journal of Personality Disorders*, 9, 11 (1995): 56; G. Zubenko *et al.*, “Sexual practices among patients with borderline personality disorder,” *American Journal Psychiatry*, 144, 6 (1987): 748-752.

⁷⁶ J. Gonsiorek, The use of diagnostic concepts in working with gay and lesbian populations. In J. Gonsiorek, *Homosexuality and Psychotherapy*, (NY: Haworth, 1982) , 9-20.

shows about psychological disorders which are co-morbid – co-occur – with SSA.⁷⁷ As the JHS summarizes,

It would be difficult to find another group of people in society of comparable size to those with same-sex attraction that have such a high level of psychopathology that expresses itself in such varied forms... In summary, there are now so many relevant studies that have been so carefully controlled methodologically and that have used such adequate sample sizes, the evidence is clear: *compared with the heterosexual population, significantly higher levels of psychological adjustment problems do exist within the homosexual population.*⁷⁸

No longer able to deny the extent of the problem, activists argue that these problems are caused by societal oppression.⁷⁹ Were this true one would expect to find the co-morbidity to be lower in countries where acceptance and tolerance are higher, but this is not the case. Studies in Netherlands⁸⁰ and New Zealand – both noted for tolerance – have found high levels of various psychological disorders similar to those found in countries considered less tolerant.⁸¹ Overall, research has failed to show that societal discrimination is responsible for the increased psychological difficulties experienced by persons with SSA. This does not mean that perceived – or even actual – discrimination is not a factor for some persons. But discrimination clearly is not the sole or primary factor behind the development of these difficulties.⁸²

It should be noted that these studies do not include sexual disorders such as sexual addiction, promiscuity, compulsive masturbation, pornography addiction, gender identity disorders, paraphilias, all of which are more common among people with

⁷⁷ NARTH (2009A), p. 53-87; Neil Whitehead (2010). Homosexuality and Co-Morbidities: Research and Therapeutic Implications. *Journal of Human Sexuality*, 2, 125-176. Retrieve from: <http://www.scribd.com/doc/115506183/Journal-of-Human-Sexuality-Vol-2>.

It should be noted that the rate of SSA among persons borderline personality disorder is significantly higher than in the general population. See: J. Parris, H. Zweig-Frank, J. Guzder, "Psychological factors associated with homosexuality in males with borderline personality disorders," *Journal of Personality Disorders*, 9, 11 (1995): 56; G. Zubenko *et al.*, "Sexual practices among patients with borderline personality disorder," *American Journal Psychiatry*, 144, 6 (1987): 748-752. In some cases persons with schizophrenia present with SSA, but the SSA is resolved when the schizophrenia is treated. See: J. Gonsiorek, "The use of diagnostic concepts in working with gay and lesbian populations," (in J. Gonsiorek, *Homosexuality and Psychotherapy*, NY: Haworth, 1982) 9-20.

⁷⁸ NARTH (2010), 79-80.

⁷⁹ Cochran, (2003)

⁸⁰ Sandfort, (2001)

⁸¹ Fergusson, (1999)

⁸² NARTH (2009A), 68-72; Whitehead (2010).

SSA than among the general public.⁸³ Were these also considered, the burden of co-morbidity would be even higher for persons with SSA. The defenders of homosexual behavior argue that these behaviors are considered disorders merely because they violate a “repressive” religious sexual moral code and therapists should work to free clients from their guilt not from SSA.⁸⁴

Can persons with SSA change?

The Church’s views

The Church’s magisterium assumes that some people with SSA may change and that professional as well as pastoral assistance may be helpful and necessary for this to happen. For example, in 1983, the Holy See’s Congregation for Catholic Education encouraged families and teachers to seek to understand the causes of a young person’s SSA, and then to:

offer an efficacious help in the process of integral growth: welcoming with understanding, creating a climate of hope, encouraging the emancipation of the individual and his or her growth in self control, promoting an authentic moral force towards conversion to the love of God and neighbor, **suggesting - if necessary - medical-psychological assistance from persons attentive to and respectful of the teaching of the Church** (emphasis added).⁸⁵

Similarly, in 1986, the CDF asked “the Bishops to support, with the means at their disposal, the development of appropriate forms of pastoral care for homosexual persons.” Such care “would include **the assistance of the psychological, sociological and medical sciences, in full accord with the teaching of the Church**” (n. 17 – emphasis added).⁸⁶

Also, in 1995 the Pontifical Council on the Family advised parents that if their adolescent children experience homosexual tendencies, “especially when the practice of homosexual acts has not become a habit, **many cases can benefit from appropriate therapy.**” The PCF further advised parents in particular that if “

⁸³ Alan Bell, M. Weinberg, Hammersmith, *Sexual Preference: Its Development in Men and Women*. (Bloomington IN: Indiana University Press, 1981); Alan Bell, M. Weinberg, *Homosexualities: A Study of Diversity Among Men and Women*. (NY: Simon and Schuster, 1978).; NARTH (2009A).

⁸⁴ Barry Schreier, “Of shoes, and ships and sealing wax”; Schreier suggests that: “Perhaps instead of sexual reorientation individuals could seek religious reorientation to any number of major U.S. religions that are affirming of people with same-sex orientation.”

⁸⁵ Congregation for Catholic Education (1983),

⁸⁶ Congregation for the Doctrine of the Faith (1986),

parents notice the appearance of this tendency or of related behavior in their children, during childhood or adolescence, they should **seek help from expert qualified persons in order to obtain all possible assistance**” (n. 104 – emphasis added.)⁸⁷

Finally, as mentioned above, the 2005 CDF *Instruction* accepts that at least “transitory” homosexuality is changeable, assuming that the man with SSA takes appropriate responsibility for his “human formation.”⁸⁸ In 1997, a consortium of Vatican dicasteries led by the Congregation for Catholic Education clarified the inner process, ideally helped by the “human formation” dimension of seminary life, by which a man who experiences weaknesses, problems, or “inconsistencies in the affective-sexual area” – including homosexual tendencies - may come to develop “basic affective-sexual maturity” and freedom.⁸⁹

⁸⁷ Pontifical Council for the Family (1995). *The Truth and Meaning of Human Sexuality: Guidelines for Education within the Family*.

⁸⁸ Congregation for Catholic Education (2005), *Instruction Concerning the Criteria for the Discernment of Vocations with regard to Persons with Homosexual Tendencies in view of their Admission to the Seminary and to Holy Orders.*, n. 1-3.

⁸⁹ Pontifical Work for Ecclesiastical Vocations (1998), *New Vocations for a New Europe*, n. 37. Retrieve from: http://www.vatican.va/roman_curia/congregations/ccatheduc/documents/rc_con_ccatheduc_doc_13021998_new-vocations_en.html. According to *New Vocations*, affective maturity involves, and develops, as a young man is-or becomes- “substantially reconciled with his past”. For the young man who has experienced “more or less serious traumas from his past, ...re-taking possession of the life that (he) plan(s) to give” to God, “in all its aspects”, is important. Taking or retaking possession of one’s life means “to integrate the less positive aspects, recognising them with realism and assuming a responsible attitude, and not simply feeling sorry for oneself in their regard.

The ‘responsible’ young person” will dedicate himself “to assuming an *active and creative attitude* when faced with a negative event” in his life, and will seek “to benefit in an intelligent way from a personal negative experience.” Along with being reconciled “with the inevitable negative aspects” of his life, the affectively mature young man “should be able to recognize (them) ...with gratitude.” He should be(come) “reconciled also with the significant figures of his past, with *their richness and weakness.*” And he should be(come) able to interpret his life history, *especially if it was difficult-* and even if *traumatic-* “as a grace” not a “lament”, thereby be(com)ing open to giving what he has received. A man’s maturity requires “*docibilitas*” which is : “the interior freedom to let himself be guided by a bigger brother”, especially: *when re-elaborating and re-appropriating “the most problematic” elements of his own past.* This docility also involves “the subsequent *liberty to learn and to know how to change*”, particularly in “the *affective-sexual area.*”

In order to develop “basic affective-sexual maturity,” Several conditions are necessary. First, “the young person (must) be conscious of the *root of his problem*, which often is (emotional and) not sexual in origin.” Second, he must “feel (perceive) his weakness as something extraneous to his own personality, something that he does not want and that jars with his ideal, and against which he will struggle with his whole being.” And third, the young man must be “able to *control* these weaknesses, with a view to overcoming them, either: so that in fact it happens less and less, or so that these inclinations will less and less disturb his life (also his psychological state), *and* allow him to carry out his normal duties without creating excessive tension nor unduly occupying his attention.”

What Scientific Research and Clinical Experience Show

In 2009, the National Association for Research and Therapy of Homosexuality (NARTH) published *What Research Shows*.⁹⁰ This inaugural volume of the *Journal of Human Sexuality* was “a landscape review of more than one hundred years of experiential evidence, clinical reports, and research studies.” This review documents “that it is possible for men and women to diminish their unwanted homosexual attractions (and behaviors) and develop their heterosexual potential” through professional help.⁹¹ As a summary of *What Research Shows* concludes,

Various paradigms and approaches have been used to treat homosexuality, including psychoanalysis, other psychodynamic approaches, hypnosis, behavior therapies, cognitive therapies, sex therapies, group therapies, religiously-mediated interventions, pharmacology, and others. In many cases, combinations of therapies have been used. There also have also been reports of spontaneous change, i.e. of persons experiencing various degrees of sexual reorientation without professional or pastoral guidance.⁹²

A review of a few noteworthy studies, which offer evidence of the changes reported above, follow. In 2003 Dr. Robert Spitzer, who had thirty years before been instrumental in the decision of the American Psychiatric Association to remove homosexuality from the *Diagnostic and Statistical Manual of the APA*, published a study of 200 men and women who had undergone therapy for SSA and reported change in their pattern of sexual attraction. At the time a major initiative had been launched by pro-SSA mental health professionals to ban therapy directed to changing SSA. Spitzer conducted phone interviews with 200 persons who had been in treatment for SSA. He concluded that although not all successfully became functioning heterosexuals, some did and the rest felt the therapy had benefited them.⁹³ The study was not designed to discover the percentage of those who through therapeutic, pastoral or other assistance experienced a “real change,” only to clarify the plausibility and nature of any reported change.⁹⁴

⁹⁰ NARTH (2009a).

⁹¹ National Association for Research and Therapy of Homosexuality (2009b). *Summary of What Research Shows: NARTH's Response to the APA Claims on Homosexuality* (*Journal of Human Sexuality*, Volume 1), p. 1. Retrieve from: <http://www.scribd.com/doc/125145105/Summary-of-Journal-of-Human-Sexuality-Volume-1>.

⁹² *Ibid*, p. 2.

⁹³ Robert Spitzer, “Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation,” *Archives of Sexual Behavior*, 35, 5 (2003): 403-417.

⁹⁴ The authors are aware of the controversy in the last year following the report that a decade after his study was published, Dr. Spitzer no longer was certain that the 200 men and women whom he interviewed had changed as much as they had claimed. Spitzer’s findings are included here, because while he has changed his interpretation of the participants’ reports, those reports remain as documented evidence gained through a rigorous interview protocol.

Because of the controversial nature of the study the editors of *Archives of Sexual Behavior* and the *Journal of Gay and Lesbian Psychotherapy* solicited comments on the study which were published together with the original study. There were several repeated themes in the critiques: 1) the people who claimed change were either lying or deceiving themselves; 2) they weren't really gay to begin with but bisexual⁹⁵; 3) any effort to change sexual orientation is oppressive to those who try and fail and because it increases discrimination against entire gay and lesbian community⁹⁶; 4) such studies will negatively affect the gay political agenda; 5) the interviewee may have had high levels of internalized homophobia, their motivation was religious and rather than changing their sexual orientation they should have changed their religion.⁹⁷

In response it should be noted that:

1) Reports from clients and from therapists using a wide variety of treatment protocols spanning the various schools of therapy go back over 125 years and it is difficult to believe that all these people are lying.⁹⁸ The *Journal of Human Sexuality* provides a comprehensive review of the literature on therapy for unwanted SSA, which shows that almost every form of therapy had some success.⁹⁹ There are also reports of spontaneous change¹⁰⁰ and of change during

⁹⁵ Craig Hill, Jeannie DiClementi, "Methodological limitations do not justify the claim that same-sex attraction changed through 'Reparative therapy,'" (in *Ex-Gay Research*): 143; Helena Carlson, "A methodological critique of Spitzer's research on reparative therapy," (in *Ex-Gay Research*): 92.

⁹⁶ Milton Wainberg *et al.*, "Science and the Nuremberg Code: A Question of Ethics and Harm," (in *Ex-Gay Research*): 197.

⁹⁷ Richard Friedman, "Sexual Orientation Change: A study of Atypical Cases," in *Ex-Gay Research*): 116; Craig Hill, Jeannie DiClementi, "Methodological limitations," (in *Ex-Gay Research*): 142.

⁹⁸ In addition to several reviews of the literature (R. Goetze, *Homosexuality and the Possibility of Change: A Review of 17 Published Studies*, (Toronto Canada: New Directions for Life, 1997); W. Throckmorton, "Efforts to modify sexual orientation: A review of outcome literature and ethical issues," *Journal of Mental Health and Counseling*, 20, 4 (1996): 283-305), there are numerous reports from therapists of success in treatment: Ruth Barnhouse, *Homosexuality: A Symbolic Confusion* (NY: Seabury Press, 1977); E. Bergler, *Homosexuality: Disease or Way of Life*, (NY: Collier Books, 1962). Bieber, *Homosexuality*; D. Cappon, *Toward an Understanding of Homosexuality*, (Englewood Cliffs NJ: Prentice-Hall, 1965); F. Caprio, *Female Homosexuality: A Psychodynamic Study of Lesbianism*, (NY: Citadel, (1954); S. Hadden, "Male homosexuality," *Pennsylvania Medicine* (February 1967): 78; J. Hadfield, "The cure of homosexuality," *British Medical Journal*, 1 (1958): 1323-1326; L. Hatterer, "Changing Homosexuality in the Male," (NY: McGraw-Hill, 1970); H. Kaye *et al.*, "Homosexuality in Women," *Archives of General Psychiatry*, 17 (1967): 626-634; R. Kronemeyer, *Overcoming Homosexuality*, (NY: Macmillian, 1980); J. Nicolosi, Dean Byrd, R. Potts, *Towards the Ethical and Effective Treatment of Homosexuality*, (Encino CA: NARTH, 1998); Carl Rogers *et al.*, "Group psychotherapy with homosexuals: A review," *International Journal of Group Psychotherapy*, 31, 3(1976): 3; Jeffrey Satinover, *Homosexuality and the Politics of Truth*, Grand Rapids MI: Baker, (1996). Mention of Stanton Jones. Mark Yarhouse book, *Ex-Gays: A longitudinal study of religiously mediated change in sexual orientation*, (Downers Grove, IL: IVP Academic, 2007): :

<http://www.narth.com/docs/APA2009SymposiumReport.pdf>

⁹⁹ NARTH (2009a).

treatment for other disorders.¹⁰¹ It should be noted that some persons presenting themselves for treatment of SSA may actually have another disorder. For example, a significant minority of clients with “unwanted SSA” actually has “unwanted OCD”- they are more distressed by obsessive thoughts/ urges/images/etc. than attracted by/to them.

A number of studies have found that the percentage of persons with SSA is not stable overtime.¹⁰² Many young men who believed they were “gay” as teenagers become heterosexual in their twenties.¹⁰³ Women who thought they were lesbian in college go on to marry.¹⁰⁴ Married women with children decide in their 30’s that they are lesbians.¹⁰⁵ Lesbians who enter into relationships and acquire babies decide they are really heterosexual.¹⁰⁶ A ten-year study of women with same-sex sexual experience found that the majority changed their sexual identity self-identification at least once during that period, some more than once.¹⁰⁷ Even those who deny the possibility of total change admit that change of behavior is possible.¹⁰⁸

2) It does appear that men and women with some heterosexual experience have a better prognosis.¹⁰⁹ However, since a high percentage of persons with SSA have had some heterosexual experience this should be encouraging to those considering therapy. Change also appears to be more common among women than men.

3) It is true that failing to achieve one’s goals in therapy is disheartening, but no one suggests that it is unethical to offer a therapy unless one can a guaranteed

¹⁰⁰ Elaine Siegle, *Female Homosexuality: Choice without Volition*, (Hillsdale, NJ: Analytic Press, 1988):

¹⁰¹ Dean Byrd “The malleability of homosexuality: A debate long overdue,” (in *Ex-Gay Research*): 83 -87.

¹⁰² Edward Lauman *et al.*, *The Social Organization of Sexuality: Sexual Practices in the United States*, (Chicago: University of Chicago, 1994): Lisa Diamond “Sexual identity, attractions, and behavior among young sexual-minority women over a two-year period,” *Developmental Psychology*, 36, 2 (2000): 241-250

¹⁰³ Warren Throckmorton, “Hiding truth from school Kids: *It's Elementary* Revisited,” June 16, 2004, www.drthrockmorton.com/article.asp?id=78.

¹⁰⁴ “Lesbian until graduation,” Wikipedia, July 2007.; [Lisa M. Diamond, *Sexual Fluidity: Understanding Women's Love and Desire*](http://www.narth.com/docs/diamond.html) (Boston, MA: Harvard UP, 2009) <http://www.narth.com/docs/diamond.html>:

¹⁰⁵ “Feminism Turned Happy Hetero Woman Toward Homosexuality,” *WorldNetDaily.com* (July 1, 2007).

¹⁰⁶ Dale O’Leary, *One Man, One Woman*, (Manchester NY: Sophia Institute Press, 2007)

¹⁰⁷ Lisa Diamond, *Sexual Fluidity*, Harvard U.P.: Cambridge, 2008/

¹⁰⁸ The APA Task Force *Report* declares that sexual behavior, attraction, and orientation identity are fluid -- i.e., changeable. “Recent research on sexual orientation identity diversity illustrates that sexual behavior, sexual attraction, and sexual orientation *identity are labeled and expressed in many different ways, some of which are fluid*” (p. 14; cf. p. 2, 63, 77); Eli Coleman, “Toward a new model of treatment of homosexuality: A review,” *Journal of Homosexuality*. 3, 4(1978): 345 – 357; W. Herron *et al.*, “Psychoanalytic psychotherapy for homosexual clients: New concepts,” (in J. Gonsiorek, ed., *Homosexuality and Psychotherapy*, NY: Haworth, 1982).

¹⁰⁹ F. Acosta, “Etiology and treatment of homosexuality: A review,” *Archives of Sexual Behavior*, 4 (1975): 9-29.

100% total cure. Therapists treating depression don't promise clients they will never have a relapse.¹¹⁰

4) A careful reading of the articles opposing therapy for change reveals that the authors who see therapy for change as unethical¹¹¹ do so because they view such therapy as oppressive to those who do not want to change¹¹² and view those persons with same-sex attraction who express a desire to change as victims of societal or religious oppression.¹¹³ Therapy should be guided by the best interests of clients not the political goals of a special interest group.¹¹⁴

5) Forced to choose between sexual inclinations and religious faith, it is not surprising that some people should choose faith. They should certainly have that right and have the right to therapy that helps them live according to their conscience.¹¹⁵

those who are highly pessimistic regarding change in sexual orientation appear to have assumed a categorical view of change, which is neither in keeping with how sexual orientation has been defined in the literature nor with how change is conceptualized for nearly all other psychological challenges. NARTH believes that viewing change as occurring on a continuum is a preferable therapeutic approach and more likely to create realistic expectancies among consumers of change-oriented intervention.

The summary of the NARTH Statement on Sexual Orientation Change (2012) is worth quoting:

¹¹⁰ Neil Whitehead, Christopher Rosik, "Practice guidelines for therapists", *Journal of Human Sexuality*, 2010, Vol. 2.

¹¹¹ G. Davison, "Politics, ethics and therapy for homosexuality," (in W. Paul *et al.*, *Homosexuality: Social, Psychological and Biological Issues*, Beverly Hills CA: Sage, 1982): 89-96; B. Gittings, "Gay, Proud, Healthy," Philadelphia PA: Gay Activists Alliance (1973).

¹¹² D. Begelman, "Ethical and legal issues of behavior modification," (in M. Hersen, R. Eisler, P. Miller, *Progress in Behavior Modification*, NY: Academic, 1975); T. Murphy, "Redirecting sexual orientation: Techniques and justifications," *Journal of Sex Research*. 29, (1992): 501 – 523; S. Sleek, Concerns about conversion therapy. *APA Monitor*, (October, 281997): 16; J. Smith, "Psychopathology, homosexuality, and homophobia," *Journal of Homosexuality*, 15, 1/2(1988): 59-74.

¹¹³ D. Begelman, "Homosexuality and the ethics of behavioral intervention," *Journal of Homosexuality*, 2, 3(1977): 213-218; Charles Silverstein, "Behavior Modification and the Gay community," Paper presented at the annual convention of the Association for Advancement of Behavior Therapy. NY, (Oct. 1972).

¹¹⁴ Summary of the Symposium: APA Task Force on Sexual Orientation: Science, Diversity and Ethicality <http://www.narth.com/docs/symposium2010.html>.

¹¹⁵ Philip M. Sutton, "Historic APA Symposium on Religiously Mediated Change in Homosexuality," . <http://www.narth.com/docs/APA2009SymposiumReport.pdf>

those who are highly pessimistic regarding change in sexual orientation appear to have assumed a categorical view of change, which is neither in keeping with how sexual orientation has been defined in the literature nor with how change is conceptualized for nearly all other psychological challenges. NARTH believes that viewing change as occurring on a continuum is a preferable therapeutic approach and more likely to create realistic expectancies among consumers of change-oriented intervention.¹¹⁶

It should be noted that almost without exception, those who want to ban therapy directed toward changing sexual orientation, also reject abstinence from non-marital sexual activity as a minimal goal.¹¹⁷ Therapists who accept homosexual acts as normal also accept infidelity in committed relationships,¹¹⁸ anonymous sexual encounters, general promiscuity, prostitution, auto-eroticism,¹¹⁹ pornography addiction, sado-masochism, so-called “sex change” operations, and various paraphilias. Some even support a lessening of restrictions on sex between adults and minors¹²⁰ or deny the negative psychological impact of sexual child abuse.¹²¹ Some of those who consider therapy unethical also challenge established theories of child development.¹²² Almost without exception they place blame for the undeniable problems suffered by homosexually active adolescents and adults on societal oppression.¹²³

Some forms of therapy encourage the patients to replace one form of sexual behavior with another.¹²⁴ Some therapists, for example, do not consider a patient “cured” until he can comfortably engage in sexual activity with the other sex, even if the patient is not married.¹²⁵ Others encouraged patients to masturbate using

¹¹⁶ National Association for Research and Therapy of Homosexuality (2012). *NARTH Statement on Sexual Orientation Change*. Retrieve from: <http://narth.com/2012/01/narth-statement-on-sexual-orientation-change/>

¹¹⁷ R. Barrett, R. Barzan, “Spiritual experiences of gay men and lesbians,” *Counseling and Values*, 41 (1996): 4-15.

¹¹⁸ James Nelson, “Religious and moral issues in working with homosexual clients,” (in J. Gonsiorek, *Homosexuality and Psychotherapy*, NY: Haworth, 1982): 163-175.

¹¹⁹ Marcel Saghir, E. Robins, *Male and Female Homosexuality: A Comprehensive Investigation*, (Baltimore MD: Williams & Wilkins, 1973).

¹²⁰ H. Mirkin, “The pattern of sexual politics: Feminism, homosexuality, and pedophilia,” *Journal of Homosexuality*, 37, 2 (1999): 1-24.

¹²¹ Bruce Rind, R. Bauserman, P. Tromovitch, “A meta-analytic examination of assumed properties of child sexual abuse using college samples,” *Psychological Bulletin*, 124, 1 (1998): 22-53; Smith 1988

¹²² Davison, Op. Cite.; E. Menvielle, “Gender identity disorder,” (Letter to the editor in response to Bradley and Zucker article). *Journal of the American Academy of Child and Adolescent Psychiatry*. 37, 3 (1998): 243-244.

¹²³ American Psychological Association, Lesbian, Gay and Bisexual Concerns, “Guidelines for psychotherapy with lesbian, gay, and bisexual clients,” www.apa.org/pi/lgbc/publications/guidelines.html; Kristin Hancock, “Psychotherapy with lesbians and gay men,” (in Anthony D’Augelli, Charlotte Patterson, eds., *Lesbian, Gay, & Bisexual Identity over the Lifespan*, NY: Oxford, U. Press, 1995) 398-432.

¹²⁴ M. Schwartz, W. Masters, “The Masters and Johnson treatment program for dissatisfied homosexual men,” *American Journal of Psychiatry*. 141(1984): 173-181.

¹²⁵ William Masters, V. Johnson, *Homosexuality in Perspective*. Boston: Little Brown, Co., (1979).

other-sex imagery.¹²⁶ Obviously none of this – even if it were effective – is acceptable for Catholic therapists or clients. It should be noted that even when clients enter therapy with a willing therapist and with the expressed intention of changing their pattern of sexual attraction, most therapists focus on healing the childhood wounds and adolescent emotional conflicts and developing a healthy masculine or feminine identity and healthy same sex friendships, not on stimulating opposite sex attraction.¹²⁷

For a Catholic with homosexual inclinations, the immediate goal of therapy should be freedom to live chastely according to one's state in life. Some of those who have struggled with same-sex attractions believe that they are called to a celibate life. They should not be made to feel that they have failed to achieve freedom because they do not experience desires for the other sex. Others wish to marry and have children. There is every reason to hope that some will be able, in time, to achieve this goal. They should not, however, be encouraged to rush into marriage since there is ample evidence that marriage is not a cure for same-sex attractions. With the power of grace, the sacraments, support from the community, and an experienced therapist, a determined individual should be able to achieve the inner freedom promised by Christ.

Experienced therapists can help individuals uncover and understand the root causes of the emotional trauma that gave rise to their same sex attractions and then work in therapy to resolve this pain. Men experiencing same-sex attractions often discover how their masculine identity was negatively affected by feelings of rejection from father or peers or from a poor body image that result in sadness, anxiety, anger and insecurity. As this emotional pain is healed in therapy, the masculine identity is strengthened and same sex attractions regularly diminish.

Women with same sex attractions can come to see how conflicts with fathers and/or other significant males led them to mistrust male love, or how lack of maternal affection led to a deep longing for female love. Insight into causes of anger and sadness will hopefully lead to forgiveness and freedom. All this takes time. In this respect individuals suffering from same-sex attraction are no different than the many other men and women who have significant emotional pain and

¹²⁶ J. Blitch, S. Haynes, "Multiple behavioral techniques in a case of female homosexuality," *Journal of Behavior Therapy and Experimental Psychiatry*. 3(1972): 319-322; S. Conrad, J. Winze, "Orgasmic reconditioning: A controlled study of its effects upon the sexual arousal and behavior of adult male homosexuals," *Behavior Therapy*, 7 (1976): 155-166.

¹²⁷ Elizabeth Moberly, *Homosexuality: A New Christian Ethic* (Cambridge, England: James Clarke, 1983); Joseph Nicolosi, *Reparative Therapy of Male Homosexuality*, (Northvale NJ: Aronson, 1991).

need to learn how to forgive. Forgiveness has been shown to be affective in resolving the effects of painful experiences.¹²⁸

A number of therapeutic strategies are available to those working with clients with unwanted SSA. For example, in an article entitled “The Primacy of Affect” Joseph Nicolosi discusses how Short Term Dynamic Psychotherapies and Accelerated Experiential Dynamic Psychotherapy has proven effective with some clients¹²⁹:

It is through this connectedness with the therapist that the client allows himself to feel the bodily sensations that are associated with his painful early experiences. Healing moments occur when the client feels seemingly ‘unbearable’ affect, while at the same moment, experiencing the support of the therapist. Thus, in a process of interactive repair, their attuned relationship actually changes the neurological structure of the brain.¹³⁰

Catholic therapists working with Catholic individuals should feel free to use the wealth of Catholic spirituality in this healing process. Those with father wounds can be encouraged to develop their relationship with God as a loving father. Those who were rejected or ridiculed by peers as youngsters can meditate upon the Jesus as brother, friend, and protector. Those who feel unmothered can turn to Mary for comfort.

There is every reason for hope that with time those who seek freedom will find it. However, while we can encourage hope, we must recognize that there are some who will not achieve their goals. We may find ourselves in the same position as a pediatric oncologist who speaks of how when he first began his practice there was almost no hope for children stricken with cancer. The physician's duty was to help the parents accept the inevitable and not waste their resources chasing a "cure." Today almost 70% of children recover, but each death leaves the medical team with a terrible feeling of failure. As the prevention and treatment of same-sex attraction improves, the individuals who still struggle will, more than ever, need compassionate and sensitive support. Also, some persons who initially attempt-and fail- to develop their heterosexual potential, find serenity in living celibate chastity¹³¹

¹²⁸ Robert Enright, Richard Fitzgibbons, *Helping Clients Forgive* (Washington, DC: American Psychological Association Books, 2000).

¹²⁹ <http://www.aedpinstitute.com/>

¹³⁰ Joseph Nicolosi, “The Primacy of Affect,” <http://www.narth.com/docs/affect.html>

¹³¹ Jones, (2007)

Part II Recommendations

Ministry to Individuals Experiencing SSA

It is very important for every Catholic experiencing same sex attractions to know that there is hope and that there is help.¹³² Support groups, therapists, and spiritual counselors who unequivocally support the Church's teaching are essential components of the help that is needed. Unfortunately, this help is not always readily available in all areas. Courage and its affiliated organization Encourage¹³³ works with family and friends of persons with SSA offers support that is fully consistent with the unchanging truth that Christ calls all to chastity in keeping with their particular state of life.

The failure of the Catholic community to provide for the needs of this population is a serious omission, which must not be allowed to continue. It is particularly tragic that Courage, which under the leadership of Fr. John Harvey has developed an excellent and authentically Catholic network of support groups, is not yet available in every diocese and major city.

Anecdotal reports of individuals or organizations under Catholic auspices or directly associated with the Catholic Church, counseling persons with same-sex attractions to practice fidelity in same-sex relationships rather than chastity according to their state in life are quite distressing. Catholics have a right to know the truth and those working with or for Catholic institutions have an obligation to clearly enunciate that truth.

Some clerics and pastoral counselors, perhaps because they erroneously believe that same-sex attraction is genetically determined and unchangeable, have encouraged individuals experiencing same-sex attractions to identify with the gay community, by publicly proclaiming themselves gay or lesbian, but live chastity in their personal lives. There are several reasons why this is a misguided course of action: 1) It is based on the mistaken idea that same-sex attraction is an unchangeable aspect of the individual and discourages persons from seeking help; 2) The "gay" community promotes an ethic of sexual behavior which is totally antithetical to Catholic teaching on sexuality and has made no secret of its desire to eliminate "erotophobia" and "heterosexism." (There is simply no way the positions articulated by spokespersons for the "gay" movement and the teachings of the

¹³² <http://www.usccb.org/doctrine/Ministry.pdf>

¹³³ Courage may be contacted at: (<http://couragerc.net/> ; Encourage at <http://couragerc.net/Encourage.html>.

Catholic church can be reconciled); 3) It puts easily tempted persons into places which must be considered the near occasion of sin.; 4) It creates a false hope that the Church will eventually change its teaching on sexual morality.¹³⁴ 5) The health risks for a man who has sex with another man are so high that even one slip can lead to serious illness. An example of this kind of distortion of research and Catholic teaching can be found in Michael Bayly *Creating Safe Environments for LGBT Students: A Catholic Schools Perspective*, a workbook specifically designed to promote the pro-SSA agenda to teachers in Catholic schools.

Catholics must, of course, reach out to individuals experiencing same-sex attraction, to those actively involved in homosexual acts, and particularly to those suffering from sexually transmitted diseases, with love, hope, and the authentic, uncompromised message of freedom from sin through Jesus Christ.

The Role of the Priest

It is of paramount importance that priests, ministering to parishioners troubled by same-sex attraction, have access to solid information and genuinely beneficial resources. The priest, however, can do more than simply refer to other agencies (see *Courage and Encourage* in the Appendix).¹³⁵ He is in a unique position to provide specific spiritual assistance to those experiencing SSA. He must, of course, be very sensitive to the intense feelings of insecurity, guilt, shame, anger, frustration, sadness, and even fear in these individuals. This does not preclude him from speaking very clearly about the teachings of the Church¹³⁶ the need for forgiveness and healing in Confession, the need to avoid occasions of sin, and the need for a strong prayer life. Faith can be crucial in the recovery from SSA.

When an individual confesses SSA, fantasies, or homosexual acts, the priest should be aware that these are often manifestations of childhood and adolescent traumas and associated with loneliness, insecurity and anger. A person confessing homosexual inclinations or actions may also have been a victim of sexual child abuse, or have unmet childhood needs for the love and affirmation from the same-sex parent. Unless these underlying problems are addressed, the individual may find the temptations returning and fall into despair. Those who reject the Church's teachings and encourage persons with same-sex attractions to enter into so called

¹³⁴ Michael Bayly, *Creating Safe Environments for LGBT Students: A Catholic Schools Perspective*, (Harrington Park Press, NY, 2007).

¹³⁵ For an excellent summary of what *Courage* men and women themselves say about is pastorally helpful to them, please review: *Ministering to Persons with Same Sex Attraction: What Courage Members Would Like Clergy to Know* (http://couragerc.net/Resources_for_Priests/Ministering.pdf).

¹³⁶ See CCC, n.2357-2359.

"stable, loving homosexual unions" fail to understand that such arrangements will not resolve these underlying problems. While encouraging therapy and support group membership, the priest should remember that through the sacrament, he can help individual penitents deal not only with the sin, but also with causes of same-sex attraction. The following list, while not exhaustive, illustrates some of the ways in which a priest may help the individuals with these problems who come to the Sacrament of Reconciliation:

a) Persons, experiencing same-sex attraction or confessing related sins, almost always carry a burden of deep emotional pain, sadness, and resentment toward those who have rejected, neglected or hurt them, including their parents, peers, and sexual molesters. Helping them to forgive can be the first step in healing.¹³⁷

b) Individuals experiencing same-sex attractions often report a long history of early sexual experiences and sexual trauma.¹³⁸ Homosexually active persons are more likely to have engaged in sexual activity with another person at a young age.¹³⁹ Many have never told any one about these experiences¹⁴⁰ and carry tremendous guilt and shame. In some cases, those who were sexually abused feel guilty because they reacted to their trauma by acting out sexually. The priest can delicately inquire about early experiences, assuring these persons that their sins are forgiven, and helping them to find freedom through forgiving others.

c) Individuals involved in homosexual activity may also suffer from sexual compulsions or addiction.¹⁴¹ Those who engage in homosexual activity are also more likely to have engaged in extreme forms of sexual behavior or to have exchanged sex for money.¹⁴² Addictions are not easy to overcome. Frequent recourse to confession can be a first step to freedom. The priest should remind the penitents that even the most extreme sins can be forgiven, encouraging them to resist despair and to persevere, while at the same time suggesting a support group designed to deal with addiction.

d) Persons with same-sex attractions are often abuse alcohol, prescription drugs

¹³⁷ Richard Fitzgibbons, "The origins and therapy of same-sex attraction disorder," (in C. Wolfe, *Homosexuality and American Public Life*, Washington DC: Spense, 1999): 85-97.

¹³⁸ Lynda Doll *et al.*, "Self-reported childhood and adolescent sexual abuse among adult homosexual and bisexual men," *Child Abuse & Neglect*. 18 ., (1992): 825-864.

¹³⁹ W. Stephan, "Parental relationships and early social experiences of activist male homosexuals and male heterosexuals," *Journal of Abnormal Psychology*, 82, 3(1973): 506-513; Bell, (1981).

¹⁴⁰ R. Johnson, D. Shreier, "Sexual victimization of boys: Experience at an adolescent medicine clinic," *Journal of Adolescent Health Care*, 6 (1985): 372-376.

¹⁴¹ Beitchman (1991) Goode, (1977); Saghir, *Male and Female Homosexuality*.

¹⁴² Saghir, (1973).

and illegal drugs.¹⁴³ The use of club drugs – ecstasy, crystal methamphetamine, ketamine, cocaine, gamma-hydroxybutyrate (GHB)—is unfortunately extremely common among men with SSA. Continual use of such drugs, in particular crystal meth, undermines resistance to sexual temptation.¹⁴⁴ The priest may recommend membership in a support group, which addresses these problems.

e) Despair and suicidal thoughts are also frequently a part of the life of an individual troubled by same-sex attraction.¹⁴⁵ The priest can assure the penitent that there is every reason to hope that the situation will change and that God loves them and wants them to live a full and happy life. Again, forgiving others can be extremely helpful.

f) Persons experiencing same-sex attraction may suffer from spiritual problems such as envy¹⁴⁶ or self pity.¹⁴⁷ It is important that the individual experiencing same-sex attractions not be treated as though sexual temptations were their only problem.

g) The overwhelming majority of men experiencing same-sex attraction, as well as a significant percentage of women report a poor relationship with their fathers.¹⁴⁸ The priest, as a loving and accepting father figure, can through the sacrament begin the work of repairing that damage and facilitating a healing relationship with God the Father. If God the Father is perceived as threatening, the priest can encourage devotion to St. Joseph.

The priest needs to be aware of the depth of healing needed by these seriously conflicted persons. Most will need professional help. Still the priest can be a source of hope for the despairing, forgiveness for the erring, strength for the weak, encouragement for the faint of heart, sometimes a loving father figure for the wounded. In brief, he must be Jesus for these beloved children of God who find

¹⁴³ L. Fifield, J. Latham, C. Phillips, “Alcoholism in the Gay Community: The Price of Alienation, Isolation and Oppression,” Los Angeles CA: Gay Community Service Center; Saghir, (1973)

¹⁴⁴ Milton Wainberg, Andrew Kolodny, Jack Dresher, *Crystal Meth and Men who have sex with Men: What Mental Health Care Professionals Need to Know* (NY: Haworth Press, 2006).

¹⁴⁵ Beitchman (1991); Herrell,(1999); Fergusson, (1999); Cochran (2003)

¹⁴⁶ Ed Hurst, *Homosexuality: Laying the Axe to the Roots* (Minneapolis MN: Outpost, 1980).

¹⁴⁷ Gerard van den Aardweg, *Homophilia, Neurosis and the Compulsion to Complain*, (Amsterdam: Polak, van Gennep, 1967).

¹⁴⁸ L. Apperson, W. McAdoo, “Parental factors in the childhood of homosexuals,” *Journal of Abnormal Psychology*, 73, 3 (1968): 201-206; E. Bene, “On the genesis of male homosexuality: An attempt at clarifying the role of the parents,” *British Journal of Psychiatry*, 111 (1965): 803-813; Irving Bieber, Toby Bieber, “Male homosexuality,” *Canadian Journal of Psychiatry*, 24, 5 (1979): 409-421; S. Fisher, R. Greenberg, *Freud Scientifically Reappraisal*, (NY: Wiley & Sons, 1996); Richard Pillard, “Sexual orientation and mental disorder,” *Psychiatric Annals*, 18, 1 (1988): 52-56; I. Sipova, A. Brzek, “Parental and interpersonal relationships of transsexual and masculine and feminine homosexual men, (in *Homosexuals and Social Roles*, NY: Haworth, (1983) 75-85.

themselves in most difficult situations. He must be pastorally sensitive but he must also be pastorally firm, imitating, as always, the compassionate Jesus who healed and forgave, but always reminded, "Go and do not commit this sin again".

Catholic Medical Professionals¹⁴⁹

Pediatricians need to know the symptoms of attachment disorders, Gender Identity Disorder (GID) and or the chronic feelings of unmasculinity in childhood¹⁵⁰. The pediatrician is in a unique position to identify maternal depression and hostility. Treating the mother/child dyad as a unit and recognizing the importance of early attachment can prevent many later problems. With early identification of GID and intervention, there is reason to hope that the problem can be successfully resolved.¹⁵¹ Present unhappiness eliminated, and future SSA avoided.¹⁵²

Most parents do not want their child to become involved in unsafe behavior, but parents of children at-risk are often reluctant to consider treatment.¹⁵³ Informing parents that as many as 75% of children exhibiting the symptoms of GID or chronic juvenile unmasculinity will, without intervention, experience same-sex attraction¹⁵⁴ and informing parents of the risks associated with homosexual activity¹⁵⁵ may help to overcome their opposition to therapy. Parental cooperation is extremely important if early intervention is to succeed.

Pediatricians should familiarize themselves with the literature on treatment of GID. George Rekers has written a number of books on the subject.¹⁵⁶ Zucker and Bradley provide a comprehensive review of the literature in their book *Gender*

¹⁴⁹ All medical and mental health professionals, Catholic or not, may find that *NARTH Practice Guidelines* both an informative and practical guide for providing professional care with persons with unwanted SSA. These may be retrieved from: <http://www.scribd.com/doc/115508811/NARTH-Practice-Guidelines>

¹⁵⁰ Friedman, (1980)

¹⁵¹ Zucker (1995); L. Newman, "Treatment for the parents of feminine boys," *American Journal of Psychiatry*. 133, 6 (1976): 683-687; Nicolosi (2002), .

¹⁵² Newman, (1976); Bradley (1998); Bates (1974),

¹⁵³ Zucker (1995); Newman (1976)

¹⁵⁴ Susan Bradley, Kenneth Zucker, "Drs. Bradley and Zucker reply," *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 3 (1998): 244-245.

¹⁵⁵ R. Garofalo *et al.*, "The association between health risk behaviors and sexual orientation among a school-based sample of adolescents: Youth risk behavior survey," *Pediatrics*, 101, 5 (1998): 895- 903.

D. Osmond, *et al.*, "HIV infection in homosexual and bisexual men 18 to 29 years of age: The San Francisco young men's health study," *American Journal of Public Health*. 84, 12(1994): 1933-1937; R. Stall, J. Wiley, "A comparison of alcohol and drug use patterns of homosexual and heterosexual men: The San Francisco Men's Health Study," *Drug and Alcohol Dependence*. 22 (1988): 63-73; Gabriel Rotello, *Sexual Ecology: AIDS and the Destiny of Gay Men* (NY: Dutton, 1997).

¹⁵⁶ George Rekers, "The formation of homosexual orientation," (in Patrick Fagan, *Hope for Homosexuality*, Washington DC: Free Congress Foundation, 1988).

Identity Disorder and Psychosexual Problems in Children and Adolescents, as well as numerous cases histories and treatment recommendations. Joseph Nicolosi and James Dobson have written books to help parents deal appropriately with the issue.¹⁵⁷

Physicians treating patients with sexually transmitted diseases acquired through homosexual activity can inform the patient that psychological therapy and support groups are available, and that approximately 30% of motivated patients can achieve a change in orientation. Furthermore, additional 30% are able to remain celibate or eliminate high-risk behavior. They should also question these patients about drug and alcohol abuse, and recommend treatment when appropriate, since a number of studies have linked infection with STIs to substance abuse¹⁵⁸ The use of crystal meth has been directly link to a dramatic increase in unsafe sexual activity among MSM.¹⁵⁹

Even before the AIDS epidemic, a study of MSM found that 63% had contracted a sexually transmitted infection through homosexual activity.¹⁶⁰ In spite of extensive AIDS education, in the 1990's epidemiologists were concerned that MSM would continue to be at high risk for HIV infection.¹⁶¹ As advances in AIDS treatment transformed the disease from a death sentence into a chronic illness and dramatically increased the number of HIV positive individuals. High-risk behavior increased.¹⁶²

According to an article by Dr. Ron Stall and associates, an analysis of the data from a large number of studies reveals that:

¹⁵⁷ Joseph Nicolosi, Fr. John Harvey, Don Schmirer, Dr. Dobson.

¹⁵⁸ G. Mulry, S. Kalichman, J. Kelly, "Substance use and unsafe sex among gay men: Global versus situational use of substances," *Journal of Sex Educators and Therapy*, 20, 3(1994): 175-184. Donald McVinney, "Harm reduction, crystal methamphetamine, and gay men, (in Wainberg, (2006) 164.

¹⁵⁹ Wainberg, (2006) Perry Halkitis, Leo Wilton, Jack Dresher, ed., *Barebacking: Psychosocial and Public Health Approaches*, (Haworth Press: NY, 2005).

¹⁶⁰ Bell, (1978).

¹⁶¹ D. Hoover *et al.*, "Estimating the 1978 - 1990 and future spread of human immunodeficiency virus type 1 in subgroups of homosexual men," *American Journal of Epidemiology*, 134, 10(1991): 1190-1205; M. Morris, L. Dean, "Effects of sexual behavior change on long-term human immunodeficiency virus prevalence among homosexual men," *American Journal of Epidemiology*, 140, 3(1994): 217-232; Rotello, *Sexual Ecology*.

¹⁶² Halkitis, (2005): Maria Xiridou *et al.*, "The contribution of steady and casual partnerships to the incidence of HIV infection among homosexual men in Amsterdam," *AIDS*, 17, 7 (2003): 1029-1038; Nelson, "Religious and moral issues," 173:

Nelson writes: "Given the realities of social oppression, it is insensitive and unfair to judge gay men and lesbians simply by a heterosexual ideal of the monogamous relationship. ...Some such couples (as is true of some heterosexual couples) have explored relationships that admit the possibility of intimacy with secondary partners."

...additive psychosocial health problems—otherwise known collectively as a syndemic—exist among urban MSM and that the interconnection of these problems functions to magnify the effects of the HIV/AIDS epidemic in this population. A variation of this question has been empirically tested since the very earliest days of the HIV/AIDS epidemic, in that substantial literature now exists on the relationship between substance use and HIV/AIDS,¹⁶³ depression and HIV/AIDS¹⁶⁴, childhood sexual abuse and HIV/AIDS¹⁶⁵, and violence and HIV/AIDS¹⁶⁶. Our analysis extends this literature to show that the connection among these epidemic health problems and HIV/AIDS is far more complex than a 1-to-1 relationship; rather it is the *additive interplay* of these health problems that magnifies the vulnerability of a population to serious health conditions such as HIV/AIDS.¹⁶⁷

Mental health professionals should familiarize themselves with the work of therapists who have successfully treated persons experiencing same-sex attraction. Because same-sex attraction does not arise from a single cause, different individuals may require different types of treatment. Combining therapy with

¹⁶³ Susan Cochran, et al., “Estimates of alcohol use and clinical treatment needs among homosexually active men and women in the US population,” *Journal of Consulting Clinical Psychology*, (2000) 68: pp. 1062–1071.

D. J. McKirnan, P.L. Peterson, “Alcohol and drug use among homosexual men and women: Epidemiology and population characteristics,” *Addictive Behavior*, (1989) 14:pp. 545-543.

Ron Stall, et al., “Alcohol use, drug use and alcohol-related problems among men who have sex with men: the Urban Men’s Health Study,” *Addiction*. (2001) 96: pp. 1589-1601.

Ron Stall, D.W. Purcell, “Intertwining epidemics: a review of research on substance use among men who have sex with men and its connection to the AIDS epidemic,” *AIDS Behavior* (2000) 4: pp. 181-192.

¹⁶⁴ Theo Sandfort et al., “Same-sex sexual behavior and psychiatric disorders: findings from the Netherlands Mental Health Survey and Incidence Study (NEMESIS),” *Archives of General Psychiatry* (2001) 58: pp. 85-91.

J.A. Ciesla, J.E. Roberts, “Meta-analysis of the relationship between HIV infection and risk for depressive disorders,” *American Journal of Psychiatry* (2001) 158: pp. 725-730.

David Frost, Jeffrey Parsons, Jose Nanin, “Stigma, Concealment, and Symptoms of Depression as Explanations for Sexually Transmitted Infections among Gay Men,” *Journal of Health Psychology* (2007) 12 (4): pp. 636-640.

¹⁶⁵ C. DiIorio, T. Hartwell, N. Hansen, “Childhood sexual abuse and risk behaviors among men at high risk for HIV infection,” *American Journal of Public Health*, (2002) 92: pp. 214–219.

D. J. Brennan et al., “History of childhood sexual abuse and HIV risk behaviors in homosexual and bisexual men,” *American Journal of Public Health* (2007) 97 (6): pp. 1107-12.

¹⁶⁶ G.L. Greenwood et al., “Battering victimization among a probability-based sample of men who have sex with men,” *American Journal of Public Health* (2002) 92: pp.1964-1969.

P. Jaden, N. Thinness, C.J. Allison, “Comparing violence over the life span in samples of same-sex and opposite-sex cohabitants,” *Violence Victims* (1999) 14: pp. 413-425.

L.K. Burke, D. R. Flagstad, “Violence in lesbian and gay relationships: Theory, prevalence, and correlation factors,” *Clinical Psychology Review* (1999) 19: pp. 487-512.

J.M. Cruz, R.L. Peralta, “Family violence and substance use: The perceived effects of substance use within gay male relationships,” *Violence Victims* (2001) 16: pp. 161-172.

K. H. Choi, et al., “Sexual harassment, sexual coercion, and HIV risk among US adults 18–49 years,” *AIDS Behavior* (1998) 2: pp. 33-40.

¹⁶⁷ Ron Stall et al., “Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men,” *American Journal of Public Health* (2003) 93 (6): pp. 941.

support group membership and spiritual healing is also an option to be considered. NARTH, the National Association for Research and Therapy of Homosexuality, with its publications, website, and conferences (cf. www.narth.com) offers a clearinghouse for discussion of the issue for those interested in the prevention and treatment of SSA associated problems.

Teachers in Catholic Institutions

Teachers in Catholic institutions have a duty to defend the teachings of the Church on sexual morality, to counter false information on same-sex attraction, and to inform at-risk or homosexually involved adolescents that help is available. They should continue to resist pressure to include condom education in the curriculum to accommodate homosexually active adolescents. Numerous studies have found that such education is ineffective at preventing disease transmission in the at-risk population.¹⁶⁸

"Gay" rights activists have insisted that at-risk adolescents be turned over to support groups which will help them "come out." There is no evidence that participation in such groups prevents the long-term negative consequences associated with homosexual activity. Such groups will definitely not encourage adolescents to live safely and chastely according to their state in life. Symptoms of GID in boys should be taken seriously. At-risk children do need special help, particularly those who have been victims of sexual child abuse.

Educators also have a duty to prevent teasing, bullying, and ridicule of children who do not conform to gender norms, while at the same time recognizing that this behavior is a symptom of underlying problems which need to be addressed.¹⁶⁹ Materials which use bullying prevention as an opening to promote the "gay agenda" should be avoided.

Catholic Families

When Catholic parents discover that their son or daughter is experiencing same-sex attractions or engaging in homosexual activity, they are often devastated. Afraid

¹⁶⁸ R. Stall, T. Coates, C. Hoff, "Behavioral risk reduction for HIV infection among gay and bisexual men," *American Psychologist*, 43, 11(1988): 878-885; L. Calabrese, B. Harris, K. Easley, "Analysis of variables impacting on safe sexual behavior among homosexual men in the area of low incidence for AIDS," Paper presented at the Third International Conference for AIDS. Washington DC, (1987); Hoover, "Estimating the 1978 – 1990."

¹⁶⁹ An example of a book clearly designed to undermine Catholic teaching by suggesting that the teaching can and should change is *Creating Safe Environments for LGBT Students: A Catholic Schools Perspective*, (Harrington Park Press, NY, 2007) by Michael Bayly

for the child's health, happiness, and salvation, parents are usually relieved when informed that same-sex attraction is treatable and preventable. They can find support from other parents in Encourage, PFOX, and a number of Evangelical groups.

Parents should be informed about the symptoms of Gender Identity Disorder and the prevention of gender identity problems, encouraged to take such symptoms seriously and to engage children with gender identity problems with qualified and morally appropriate mental health professionals.

All mothers and fathers can benefit from understanding how to build secure attachment through interactions between the parent and child. In this regard John Bowlby's book *A Secure Base: Parent-Child Attachment and Health Human Development* is particularly helpful.¹⁷⁰ Although this is a secular book, one cannot help but notice how the Catholic view of the importance of the family is validated. The mother and father through their interactions with their child lay the foundation not only for healthy emotional development, for faith in God as a loving forgiving father, and understanding of the spiritual motherhood of the Blessed Virgin Mary.

The Catholic Community

There was a time in the not too distant past when pregnancy outside of marriage and abortion were taboo topics and attitudes toward the women involved were judgmental and harsh. The legalization of abortion forced the Church to confront this issue and provide an active ministry to women facing an "unwanted" pregnancy and to those experiencing post-abortion trauma. In a few short years the approach of dioceses, individual parishes, and the Catholic faithful has been transformed. In the same way the attitudes toward same-sex attraction can be transformed, provided each Catholic institution does its part.

Those experiencing same-sex attractions, those who are engaging in homosexual behavior and their families often feel that they are excluded from the loving concern of the Catholic community. Prayer for persons experiencing same-sex attractions and their families offered as part of the intentions during mass is one way to let them know that the community cares for them.

Members of Catholic media need to be informed about same-sex attraction, the teachings of the Church, and resources for prevention and treatment. Pamphlets

¹⁷⁰ Bowlby, (1988)

and other materials, which clearly articulate the Church's teaching and provide information on resources for those with immediate needs in this area, should be developed and distributed from racks already present in many churches.

When a member of the Catholic media, a teacher in a Catholic institution, or a pastor, misstates the Church's teaching or gives the impression that same-sex attraction is genetically determined and unchangeable, the laity should offer information designed to correct these misunderstandings.

Bishops

The Catholic Medical Association recognizes the responsibility that a Diocesan Bishop has to oversee the orthodoxy of teaching within his Diocese. This certainly includes clear instruction in the nature and purpose of intimate sexual relations between persons and the sinfulness of inappropriate relations.¹⁷¹ The CMA looks forward to working with Bishops and priests in assisting in the establishment of appropriate support groups and therapeutic models for those struggling with same-sex attractions. .

Part III The Politics of Homosexuality and Hope

Deep Differences

The first edition of the Catholic Medical Association's booklet *Homosexuality and Hope* has been widely distributed and generally well received. It has been recognized by the World Federation of Catholic Medical Association and translated into a number of other languages. However, it has also been subject to a number of criticisms, including charges that it relies on outdated research and that its conclusions stand in sharp contrast to statements made by various professional organizations.¹⁷² In response to these challenges a thorough review of the literature was undertaken. This new edition is a result of that review. None of the newer research contradicted the sources sited in the first edition; numerous studies were found that confirmed and in some cases strengthened the points made. In this edition, we have tried to present the latest work in the field with hope of encouraging further research. It is interesting to note that those promoting a pro-SSA agenda routinely reference 50-year-old studies by Kinsey, Hooker, and

¹⁷¹ John Paul II, *Male and Female He Created Them: A Theology of the Body*.

¹⁷² American Counseling Association, *ACA code of ethics and standards of practice*, Alexandria VA (1998); American Psychological Association, *Resolution of therapeutic response to sexual orientation*, Washington, D.C. 1998.

Kallman, even though these studies were criticized when they were published for having fatal design flaws.¹⁷³

It is true that several professional associations have made strong statements in sharp contrast to the material presented in *H&H*.¹⁷⁴ A review of their sources reveals that these statements are not supported by the latest research and in some cases referenced studies which are facially invalid¹⁷⁵ or have been refuted by more recent, better designed research.¹⁷⁶

In 1973 the American Psychiatric Association removed “homosexuality” from its *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and issued a statement, which said that homosexuality “by itself does not necessarily constitute a psychiatric disorder.” And therefore “homosexuality in and of itself implies no impairment of judgment, stability, reliability or vocational capabilities.” “Homosexuality per se” is such a broad concept that both statements are in a limited way true, in that not every person who engages in homosexual behavior does so because he suffers from a psychological disorder and SSA does not always negatively impact every other aspect of person’s life. Removal of homosexuality from the *DSM* precipitated a debate over what constitutes a psychological disorder. Those who thought that homosexuality should be in the *DSM* pointed to the evidence, which showed that “homosexuality was a disorder resulting from conflicts in early childhood”¹⁷⁷ and even if, as an adult, the person was comfortable with SSA, it did not change the fact that the condition had its origins in unresolved anxiety or other negative childhood experiences. They took the view that “Any adaptation which is basically an accommodation to unrealistic fear is necessarily pathologic”^{178 179}

¹⁷³ Alfred Kinsey *et al.*, *Sexual Behavior in the Human Male* (Philadelphia, 1948); Alfred Kinsey *et al.*, *Sexual Behavior in the Human Female*, (Philadelphia, 1953); Hooker, “The adjustment of the male overt homosexual”; Franz Kallman, “Comparative twin study on the genetic aspects of male homosexuality, *Journal of Nervous and Mental Disease*, 15, 4 (1952): 283-298; Franz Kallman, “Twin and sibship study of overt male homosexuality, *American Journal of Human Genetics*, 4, 2 (1952): 136-146.

All three authors used unrepresentative, non-projectible samples and drew conclusions not supported by data.

¹⁷⁴ American Psychiatric Association, American Psychological Association,

¹⁷⁵ Kinsey, *Sexual Behavior*; Hooker, “The adjustment of the male overt homosexual”; Hamer, “A linkage between DNA markers”; LeVay “A difference in hypothalamic structure.”

¹⁷⁶ Hooker’s claim that there were no differences in psychological health between men with SSA and those without has been refuted by large well designed studies by Herrell, Fergusson, Sandfort, and Cochran, cited above.. NARTH and NARTH members responses to the APA 2009 Task Force Report

¹⁷⁷ Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis*, Basic Books: NY, 1981.

more recent statements

¹⁷⁸ Bieber, *Homosexuality*, 304.

¹⁷⁹ *Ibid*, 149

Politics played a major role in the APA's decision. Ronald Bayer, author of *Homosexuality and American Psychiatry: The Politics of Diagnosis*, who supported decision wrote that is "undeniable" that "the American Psychiatric Association responded to the concerted pressure of an angry, militant movement that had made full use of coercive and intimidating tactics."¹⁸⁰

Subsequent statements by various professional associations have not been the fruit of fresh evidence,¹⁸¹ but the result of intense lobbying by persons with SSA within the professions. Most of these statements acknowledge their dependence on the APA's decision.¹⁸² Some of these statements have gone so far as to attack those religions, which teach that homosexual acts are always contrary to the moral law claiming these teachings foster discrimination and violence.¹⁸³ Various journals have published articles attacking religious institutions for their moral teachings, encouraging therapists to help clients to leave religions that do not normalize homosexual behavior, and even claiming to have proof that religious moral teachings on sexuality are not divinely inspired, something which is surely outside their area of expertise.¹⁸⁴

In addition these associations have weighed in on the questions of the redefinition of marriage to include same-sex couples, adoption, foster care, and parenting by same-sex couples. In doing so, they have referenced invalid research and systematically ignored the evidence supporting the value to a child of growing up with his or her married biological parents.¹⁸⁵

¹⁸⁰ Bayer, *Homosexuality and American Psychiatry*, 189.

¹⁸¹ American Psychiatric Association (2000) "Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies): COPP Position Statement," referenced decades old material that has been discredited, (Kinsey, Hooker, while ignoring more recent material (Herrell, Fergusson, Sandfort, Cochran, Spitzer).

¹⁸² Letter from John Nelson, President of American Medical Association, to Joseph Nicolosi: "As you know the American Psychiatric Association (APA) does not define homosexuality as an illness or disease and current mainstream medical practice recognizes and incorporates the APA's expertise on this question."

¹⁸³ Jamie Smith, "Psychology, homosexuality, and homophobia," *Journal of Homosexuality*, 15, 1/2 (1988) 61.

¹⁸⁴ Bruce Rind, "Sexual orientation change and informed consent in reparative therapy," (in *Ex-Gay Research*) 169: "The Judeo-Christian condemnation of homosexuality is socially constructed rather than divinely inspired": American Psychiatric Association, "Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies)" COPP Position Statement, 2000: "There has also been an increasing body of religious thought arguing against traditional biblical interpretations that condemn homosexuality and which underlie types of "reparative" therapy." The body of thought by the APA cited includes John Boswell whose theories have been exposed as egregious mistranslations, ex priest Daniel A. Helminiak, and "gay" Protestant cleric Gomes of Harvard.

¹⁸⁵ Heritage Foundation, *Family Facts: Social Science Research on Family, Society & Religion*, www.heritage.org/research/features/familydatabase.

This politicization of professional associations' statement making process has confused the general public which presumes that public policy statements are supported by the most current and reliable research available.^{186 187}

Dr. Nicolas Cummings, past president of the American Psychological Association and co-author with Dr. Rogers Wright of the book *Destructive Trends in Mental Health: The Well-Intentioned Path to Harm*, is highly critical of the way in which the profession has come under the influence of "political correctness."

"The APA has permitted political correctness to triumph over science, clinical knowledge and professional integrity. The public can no longer trust organized psychology to speak from evidence rather than from what it regards to be politically correct."¹⁸⁸

Dr. Robert Perloff, another past president of the American Psychological Association, has expressed concern about pressure from activists to outlaw therapy to change sexual orientation.¹⁸⁹

The Church fully supports the efforts to eliminate unjust discrimination against persons with SSA, but this does not change its duty to speak clearly on moral issues. The Church recognizes that SSA in most cases is not something people choose and that it causes much suffering. The Church has, therefore, sought to encourage compassion. Unfortunately, the call for compassion has been misinterpreted. In 1986 the Vatican felt obligated to make it clear that "the homosexual condition" in itself is not, as some claim, "neutral or even good," but "a tendency ordered toward an intrinsic moral evil; and thus the inclination itself must be seen as an objective disorder."¹⁹⁰ In the 2005 statement explaining why

¹⁸⁶ Kirkby, "No need to lie."

¹⁸⁷ John Gonsiorek, "The empirical basis for the demise of the illness model of homosexuality," (in John Gonsiorek and James D. Weinrich, eds. *Homosexuality: Research Implications for Public Policy*, Sage: Thousand Oaks CA, 1991) 115-136. Gonsiorek argues that "research suggests that there are few differences between homosexual and heterosexual individuals related to psychiatric symptomatology and essentially no differences in areas related to performance in key areas of life functioning in the real world. A few differences are suggested: higher rates of attempted but not completed suicide, and alcohol or drug abuse possible higher among homosexual individuals. In both there appears to be a linkage with higher rates of external stress. (p. 135) More recent, larger, better-designed studies (Herrell, Fergusson, Sandfort, Cochran) have shown that there are significant differences in the rate of psychological disorders between persons with SSA and those without.

¹⁸⁸ "Former AOA President Describes his work with SSA Clients," *NARTH Bulletin* (Spring 2007) 4.

¹⁸⁹ Dean Byrd, "Former APA President supports NARTH's Mission Statement Assails APA's intolerance of differing views," *NARTH Bulletin*, (Dec. 2004); Dean Byrd, "Former APA president supports NARTH's mission statement, assails APA's intolerance of differing views," *NARTH Bulletin* (Dec. 2004) 1.

¹⁹⁰ Joseph Cardinal Ratzinger, Congregation for the Doctrine of the Faith, "Letter to the Bishops of the Catholic Church on the Pastoral Care of Homosexual Persons," Oct. 1, 1986.

persons with homosexual tendencies cannot be admitted to seminaries, the Vatican elaborated on this, explaining that the candidates for ordained ministry “must attain affective maturity” which will allow the development of “a true sense of spiritual fatherhood.” On the other hand, a man with “deep-seated homosexual tendencies,” even if he were to achieve celibacy is not a suitable candidate. The statement differentiates between deep-seated and transitory problems, which it recognizes can be overcome.¹⁹¹

Church teaching is in direct conflict with those who are seek to create a “sex positive” culture, where from childhood individuals are encouraged to seek sexual pleasure alone or with others, regardless of age, sex, number of persons involved, marital status, other relationship, or risk.¹⁹² Those who promote the “sex positive” approach view chastity, abstinence, and celibacy with disdain. This stands in sharp contrast to the consistent teachings of scripture and of the Church that the enjoyment of sexual pleasure belongs within marriage between a man and a woman. There is a massive body of research supporting the value of restricting sexual acts to marriage.¹⁹³ Marriage promotes the welfare of individuals, particularly women and children, and of society.

Those supporting the “sex positive” culture have consistently tried to win public support by hiding their actual agenda and distorting the evidence. The “sex positive” approach spreads diseases, leads to abortion, fatherless children, divorce, and emotional suffering. Those who promote a “sex positive” culture recognize the problems they create, but given their view that sexual pleasure is the highest value, they demand that society devote its resources to treating the consequences rather than preventing the problem. This explains their strident advocacy for condom education, vaccines to prevent sexually transmitted infection, and abortion. The Church’s belief that for the unmarried abstinence from sexual activity is the healthy and proper choice and that persons with SSA should refrain from homosexual acts is incompatible with this view. This philosophical debate cannot be resolved by research.

There is one further complicating problem. While pro-SSA advocates insist in public that SSA is part of their nature and can’t be changed (essentialism). This

¹⁹¹ Zenon Cardinal Grocholewski, Congregation for Catholic Education, *Concerning the Criteria of Vocational Discernment Regarding Persons with Homosexual Tendencies in View of Their admission to Seminaries and Holy Orders*, (2005).

¹⁹² “GSAs: not as innocent as they may seem: Gay Straight Alliance promotes sex-toy workshop for youth,” *California Catholic Daily* (June 25, 2007) <http://calcatholic.com/news/newsArticle.aspx?id=3a916a70-e119-4dda-a219-fa91d0a7632c>

¹⁹³ Heritage Foundation, *Family Facts*.

formulation is challenged by sex positive “social constructionists’ who reject the concept of the “natural” and believe that the categories of male and female, heterosexual and homosexual are artificial oppressive social constructions that are imposed on people by society.^{194 195} The believer in natural law would hold that human beings have an essential nature -- either male or female -- and that inclinations to the contrary are distortions of that nature. Society merely recognizes and supports the truth about the human person.¹⁹⁶,

Going even further some persons with SSA call themselves “queer” and reject all norms and any recourse to the natural. The movement toward the queer agenda can be seen in the new designation for sexual minorities LGBTQ (Lesbian, Gay, Bisexual, Transsexual [or Transgendered or just Trans] and Queer.¹⁹⁷ What links all these “sexual minorities” together, their advocacy for absolute freedom from any restriction on sexual behavior.¹⁹⁸ These ideologies reject the very concept of nature and natural law; they are incompatible with traditional scientific inquiry, as well as the Christian worldview.

Heterosexism

Those supporting the pro-SSA agenda argue that all the problems faced by persons with SSA are caused by “homophobia” (fear of persons with SSA) and “heterosexism” (the belief that sexuality between a man and woman are the norm). They argue that for persons with SSA to be free of problems homophobia and heterosexism must be eliminated through re-education and various sanctions.

¹⁹⁴ Karen Lovaas, John Elia, Gust Yep, “Shifting Ground(s): Surveying the Contested Terrain of LGBT Studies and Queer Theory,” (in Lovaas, Elia, Yep, ed., *LGBT Studies and Queer Theory: New Conflicts, Collaborations, and Contested Terrain*, (Haworth Press; NY, 2006) 5.

¹⁹⁵ Celia Kitzinger, “Social constructionism: Implications for Lesbian and Gay Psychology,” (in Anthony D’Augelli, Charlotte J. Patterson, *Lesbian, gay, and bisexual identities over the lifespan: Psychological perspectives*, NY: Oxford University Press, 1995); Noretta Koertge, “Constructing concepts of sexuality: A philosophical commentary,” (in David McWhirter, Stephanie Sanders, June Reinisch, eds., *Homosexuality/Heterosexuality: Concepts of Sexual Orientation*, NY: Oxford, 1990)

¹⁹⁶ CCC, n 2331, 2782; 2798, 2790: “The human person, made in the image and likeness of God, can hardly be adequately described by a reductionist reference to his or her sexual orientation. Every one living on the face of the earth has personal problems and difficulties, but challenges to growth, strengths, talents and gifts as well. Today, the Church . . .refuses to consider the person as a "heterosexual" or a "homosexual" and insists that every person has a fundamental Identity: the creature of God, and by grace, his child and heir to eternal life.” CDF, *On the Pastoral Care of Homosexual Persons*, n 16.

¹⁹⁷ Angela Aragon, ed. *Challenging Lesbian Norms: Intersex, Transgender, Intersectional, and Queer Perspectives*, (Haworth Press, NY, 2006); Karen Lovaas, John Elia, Gust Yep, ed., *LGBT Studies and Queer Theory: New Conflicts, Collaborations, and Contested Terrain*, (Haworth Press; NY, 2006)

¹⁹⁸ Paula Ettlbrick “Being queer means pushing the parameters of sex, sexuality, and family, and in the process transforming the very fabric of society,” (in Stanley Kurtz, “Beyond Gay Marriage,” *The Weekly Standard*, Aug. 4, 2003).

Therefore, pro-SSA political activists lobby for anti-discrimination laws and hate crime legislation.

There is evidence that many persons with SSA actually do suffer from a kind of “internalized homophobia” in that they themselves believe that SSA is inferior to other sex attraction.¹⁹⁹ Pro-SSA therapists offer “gay affirming therapy” to help them overcome this.²⁰⁰

“Heterosexism” is a pejorative name given to the “belief” that sexual relations between a man and a woman are superior to those between two persons of the same sex.²⁰¹ It is certainly true that scripture and the Church has always taught the superiority of the union between man and woman in marriage. In order to eliminate “heterosexism,” all traditional religions would have to change their doctrines, history would have to be rewritten, literature and art purged, and all legislation favoring the husband/wife family altered. Given the pervasiveness of “heterosexism” and the virtual impossibility of eliminating every vestige of it, persons with SSA will continue to live in a world where heterosexuality is the norm.²⁰² They will also continue to have problems, and continue to blame their problems on the persistence of “discrimination.” This will lead to cries for stricter laws and stronger enforcement. Persons with SSA and their advocates are already demanding that pictures of husband/wife couples be accompanied by pictures same-sex couples. In Massachusetts they are using the court ordered redefinition of marriage as an excuse to push pro-SSA education in kindergarten.²⁰³

¹⁹⁹ Ariel Shidlo, “Internalized homophobia: Conceptual and empirical issues and measurement,” (in Beverly Greene, Gregory Herek, *Lesbian and Gay Psychology, Theory, Research, and Clinical Applications*, Thousand Oaks, CA:: Sage, 1994) 176-204.

²⁰⁰ American Psychological Association, Lesbian, Gay and Bisexual Concerns, “Guidelines for psychotherapy with lesbian, gay, and bisexual clients,” www.apa.org/pi/lgbcc/publications/guidelines.html; Gail Simon & Gwyn Whitfield “What are we affirming in Gay Affirmative Psychology and Therapy? A Discourse-in-Progress: Gay Affirmative Practice and A Critical Therapy,” Paper presented for panel discussion at the Association of Lesbian, Gay and Bisexual Psychologies Conference University of Nottingham, Sept. 16, 1995. www.pinkpractice.co.uk/gayaffirm.htm This approach is mentioned explicitly in the 2009 *APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. The APA LGBT folks like to use the term “sexual minority” to engender misguided mercy concerning their alleged rights infringements. Such might be mentioned. <http://www.narth.com/docs/destructive.html> I have been actively involved in responding to this document, personally and in the name of NARTH. I was lead author of NARTH's brief Response to the 2009 APA Task Force Report: <http://www.narth.com/docs/apataskforcereportbroch.pdf>. I also was a major contributor to NARTH's formal response to this APA report: <http://www.narth.com/docs/aformalresponse.html> APA Task Force Report is at: <http://www.narth.com/docs/suttoncomm.html>

²⁰¹ Kirkby, “No need to lie.”

²⁰² For example, in June of 2007 a woman sued EHarmony.com, an organization dedicated to finding compatible marriage partners, for discrimination because it did not offer its services to people seeking same-sex partners.

²⁰³ Linda Harvey, “The Top 20 Skirmishes in the Battle Over Homosexuality in the Schools,” www.missionamerica.com; Gudrun Schultz National Gay Groups Fight Parents Over Mandatory Homosexual

There is ample evidence from around the world that “anti-discrimination” legislation can be used to restrict the freedom of the Church to preach and teach.²⁰⁴ The Church must not only defend its right to proclaim the truth it has received, but defend the rights of parents to control the education of their children and the right of public to oppose the pro-SSA agenda without fear of being accused of “discrimination” or “hate speech.”

Male and Female He Created Them

CMA supports the teachings of the Catholic Church as presented in the revised version of the Catechism of the Catholic Church, particularly the teachings on sexuality:²⁰⁵ "All the baptized are called to chastity"²⁰⁶; "Married people are called to live conjugal chastity; others practice chastity in continence"²⁰⁷; "... tradition has always declared that homosexual acts are intrinsically disordered... Under no circumstance can they be approved."²⁰⁸

It is possible, with God's grace, for everyone to live a chaste life. This includes persons experiencing same-sex attraction, as Francis Cardinal George, Archbishop of Chicago, so powerfully stated in his address to the National Association of Catholic Diocesan Lesbian & Gay Ministries: "To deny that the power of God's grace enables those with homosexual attractions to live chastely is to deny, effectively, that Jesus has risen from the dead."²⁰⁹

There are certainly circumstances, psychological disorders and traumatic experiences among them, which can, at times, render this chastity more difficult and there are conditions, which can seriously diminish an individual's responsibility for lapses in chastity. These circumstances and conditions, however, do not totally overcome the power of grace or negate free will. "^{210 211}

Indoctrination in Mass. School: Groups filing amicus brief attacking parent's right to sue schools ignoring state parental notification law, www.lifesite.net/ldn/2006/oct/06100606.html

²⁰⁴ "UK: Religious Schools May Not Teach Christian Sexual Morals "as if They Were Objectively True," <http://www.lifesite.net/ldn/2007/mar/07030504.html>; Randy Hall, "Campaign Targets 'Religion-Based Bigotry Against Gay People,'" CNSNews.com, May 04, 2007.

²⁰⁵ *Persona Humana, The Pastoral Care of Homosexual Persons.* .

²⁰⁶ CCC, n. 2348.

²⁰⁷ CCC, n.2349.

²⁰⁸ CCC, n. 2333.

²⁰⁹ Francis Cardinal George, "Address to National Association of Catholic Diocesan Lesbian & Gay Ministries," Chicago, IL, *LifeSite Daily News*. (October 26, 1999)

²¹⁰ B. Chapman, J. Brannock, "Proposed model of lesbian identity development: An empirical examination," *Journal of Homosexuality*, 14(1987): 69-80.

Catholics believe that sexuality was designed by God as a sign of the love of Christ, the bridegroom, for his Bride, the Church, and sexual activity is appropriate only in marriage. Catholic teaching holds that: "Sexuality is ordered to the conjugal love of man and woman. In marriage the physical intimacy of the spouses becomes a sign and pledge of spiritual communion."²¹² Healthy psycho-sexual development leads naturally to attraction in persons of each sex for the other sex. Trauma, erroneous education, and an ill formed conscience can cause a deviation from this pattern. Persons should not be identified with their emotional or developmental conflicts as though this were the essence of their identity.

True Compassion

Catholics must reach out with love and compassion to those who are suffering while on the other hand defending the rights threatened by pro-SSA activists. The Catholic Medical Association calls on medical personnel in all fields to treat everyone with compassion, to seek to understand the origins of SSA, and to help persons with SSA who want to live according to the Church's teaching find a way to do so.

Jeffrey Satinover, MD and Ph.D., has written of his extensive experience with patients experiencing same-sex attraction:

"I have been extraordinarily fortunate to have met many people who have emerged from the gay life. When I see the personal difficulties they have squarely faced, the sheer courage they have displayed not only in facing these difficulties but also in confronting a culture that uses every possible means to deny the validity of their values, goals, and experiences, I truly stand back in wonder... It is these people -- former homosexuals and those who are still struggling, all across America and abroad -- who stand for me as a model of everything good and possible in a world that takes the human heart, and the God of that heart, seriously. In my various explorations within the worlds of psychoanalysis, psychotherapy, and psychiatry, I have simply never before seen such profound healing."²¹³

If Catholic health professionals have in the past failed to meet the needs of this

²¹¹ Joseph Neisen, "Healing from Cultural victimization: Recovery from Shame due to heterosexism," *Journal of Gay & Lesbian Psychotherapy*, 12, 1 (1993) 49; Barry Schreier, "Of shoes, and ships, and sealing wax: The faulty and specious assumptions of sexual reorientation therapies," *Journal of Mental Health Counseling*, 20, 4 (1998): 305-314.

²¹² CCC, n. 2360.

²¹³ Jeffrey Satinover, *Homosexuality and the Politics of Truth*, (Grand Rapids MI: Baker, 1996).

patient population, failed to work diligently to develop effective prevention and treatment therapies, or failed to treat patients experiencing these problems with the respect due every person, we ask forgiveness.

The authors, in conjunction with the Catholic Medical Association, recognize that health professionals have a special duty in this area and hopes that this statement will help them to carry out that duty according to the principles of faith and reason.