

HOMOSEXUALITY AND HOPE

STATEMENT OF THE CATHOLIC MEDICAL ASSOCIATION

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CONTENTS

I CONSIDERATIONS

Introduction

1 Not born that way

2) Same sex attraction as a symptom

3) Same-sex attraction is preventable

4) At-risk, not predestined

5) Therapy

6) Goal of therapy

II RECOMMENDATIONS

1) Ministry to individuals experiencing same-sex attraction

2) The role of the priest

3) Catholic medical professionals

4) Teachers in Catholic institutions

5) Catholic families

6) The Catholic community

7) Bishops

8) Hope

PART I CONSIDERATIONS

INTRODUCTION

The Catholic Medical Association is dedicated to upholding the principles of the Catholic Faith as related to the practice of medicine and to promoting Catholic medical ethics to the medical profession, including mental health professionals, the clergy, and the general public.

No issue has raised more concern in the past decade than that of homosexuality and therefore the CMA offers the following summary and review of the status of the question. This summary relies extensively on the conclusions of various studies and points out the consistency of the teachings of the Church with these studies. It is hoped that this review will also serve as an educational and reference tool for Catholic clergy, physicians, mental health professionals, educators, parents and the general public.

CMA supports the teachings of the Catholic Church as laid out in the revised version of the Catechism of the Catholic Church, in particular the teachings on sexuality: "All the baptized are called to chastity" (CCC, n.2348); "Married people are called to live conjugal chastity; others practice chastity in continence" (CCC, n.2349); "... tradition has always declared that homosexual acts are intrinsically disordered... Under no circumstance can they be approved" (CCC, n.2333);

It is possible, with God's grace, for everyone to live a chaste life including persons experiencing same-sex attraction, as 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." (George 1999)

There are certainly circumstances, such as psychological disorders and traumatic experiences, 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 negate free will or eliminate the power of grace. While many men and women who experience same-sex attractions say that their sexual desire for those of their own sex was experienced as a "given" (Chapman 1987[1]) this in no way implies a genetic predetermination or an unchangeable condition. Some surrendered to same-sex attractions because they were told that they were born with this inclination and that it was impossible to change the pattern of one's sexual attraction. Such persons may feel it is futile and hopeless to resist same-sex desires and embrace a "gay identity". These same persons may then feel oppressed by the fact that society and religion, in particular the Catholic Church, do not accept the expression of these desires in homosexual acts. (Schreier 1998[2])

The research referenced in this report counters the myth that same-sex attraction is genetically predetermined and unchangeable and offers hope for prevention and treatment.

1) NOT BORN THAT WAY

A number of researchers have sought to find a biological cause for same-sexual attraction. The media have promoted the idea that a "gay gene" has already been discovered (Burr 1996[3]), but in spite of several attempts, none of the much publicized studies (Hamer 1993[4]; LeVay 1991[5]) has been scientifically replicated. (Gadd 1998) A number of authors have carefully reviewed these studies and found that not only do the studies not prove a genetic basis for same-sex attraction; the reports do not even contain such claims. (Byne 1963[6]; Crewdson 1995[7]; Goldberg1992; Horgan 1995 [8]; McGuire 1995[9]; Porter 1996; Rice 1999[10])

If same-sex attraction were genetically determined, then one would expect identical twins to be identical in their sexual attractions. There are, however, numerous reports of identical twins who are not identical in their sexual attractions. (Bailey 1991[11]; Eckert 1986; Friedman 1976; Green 1974; Heston 1968; McConaghy 1980; Rainer 1960; Zuger 1976) Case histories frequently reveal environmental factors which account for the development of different sexual attraction patterns in genetically identical children, supporting the theory that same-sex attraction is a product of the interplay of a variety of environmental factors. (Parker 1964[12])

There are, however, ongoing attempts to convince the public that same-sex attraction is genetically based. (Marmor 1975 [13]) Such attempts may be politically motivated because people are more likely to respond positively to demands for changes in laws and religious teaching when they believe sexual attraction to be genetically determined and unchangeable. (Ernulf 1989[14]; Piskur 1992[15]) Others have sought to prove a genetic basis for same-sex attraction so that they could appeal to the courts for rights based on the "immutability". (Green 1988[16])

Catholics believe that sexuality was designed by God as a sign of the love of Christ, the bridegroom, for his Bride, the Church, and therefore 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." E(CCC, n.2360) Healthy psycho-sexual development leads naturally to attraction in persons of each sex for the other sex. Trauma, erroneous education, and sin 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. In the debate between essentialism and social constructionism, the believer in natural law would hold that human beings have an essential nature -- either male or female -- and that sinful inclinations (such as the desire to engage in homosexual acts) are constructed and can, therefore, be deconstructed.

It is, therefore, probably wise to avoid wherever possible using the words "homosexual" and "heterosexual" as nouns since such usage implies a fixed state and an equivalence between the natural state of man and woman as created by God and persons experiencing same sex attractions or behaviors.

2) SAME-SEX ATTRACTION AS A SYMPTOM

Individuals experience same-sex attractions for different reasons. While there are similarities in the patterns of development, each individual has a unique, personal history. In the histories of persons who experience same-sex attraction, one frequently finds one or more of the following:

- Alienation from the father in early childhood because the father was perceived as hostile or distant, violent or alcoholic (Apperson 1968[17]; Bene 1965[18]; Bieber 1962[19]; Fisher 1996[20]; Pillard 1988[21]; Sipova 1983[22])
- Mother was overprotective (boys) (Bieber, T. 1971[23]; Bieber 1962[24]; Snortum 1969[25])
- Mother was needy and demanding (boys) (Fitzgibbons 1999[26])
- Mother emotionally unavailable (girls) (Bradley 1997[27]; Eisenbud 1982[28])

- Parents failed to encourage same-sex identification (Zucker 1995[29])
- Lack of rough and tumble play (boys) (Friedman 1980[30]; Hadden 1967a [31])
- Failure to identify with same/sex peers (Hockenberry 1987[32]; Whitman 1977[33])
- Dislike of team sports (boys) (Thompson 1973[34])
- Lack of hand/eye coordination and resultant teasing by peers (boys) (Bailey 1993[35]; Fitzgibbons 1999[36]; Newman 1976[37])
- Sexual abuse or rape (Beitchman 1991[38]; Bradley 1997[39]; Engel 1981[40]; Finkelhor 1984; Gundlach 1967[41])
- Social phobia or extreme shyness (Golwyn 1993[42])
- Parental loss through death or divorce (Zucker 1995)
- Separation from parent during critical developmental stages (Zucker 1995)

In some cases, same-sex attraction or activity occurs in a patient with other psychological diagnosis, such as:

- major depression (Fergusson 1999[43])
- suicidal ideation (Herrell 1999)
- generalized anxiety disorder
- substance abuse
- conduct disorder in adolescents
- borderline personality disorder (Parris 1993[44]; Zubenko 1987[45])
- schizophrenia (Gonsiorek 1982) [46]
- pathological narcissism (Bychowski 1954[47]; Kaplan 1967[48])

In a few cases, homosexual behavior appears later in life as a response to a trauma such as abortion, (Berger 1994[49]; de Beauvoir 1953) or profound loneliness (Fitzgibbons 1999).

3) SAME-SEX ATTRACTION IS PREVENTABLE

If the emotional and developmental needs of each child are properly met by both family and peers, the development of same-sex attraction is very unlikely. Children need affection, praise and acceptance by each parent, by siblings and by peers. Such social and family situations, however, are not always easily established and the needs of children are not always readily identifiable. Some parents may be struggling with their own trials and be unable to provide the attention and support their children require. Sometimes parents work very hard but the particular personality of the child makes support and nurture more difficult. Some parents see incipient signs, seek professional assistance and advice, and are given inadequate, and in some cases, erroneous advice.

The Diagnostic and Statistical Manual IV (APA 1994[50]) of the American Psychiatric Association has defined Gender Identity Disorder (GID) in children as a strong, persistent cross gender identification, a discomfort with one's own sex, and a preference for cross sex roles in play or in fantasies. Some researchers (Friedman 1988, Phillips, 1992[51]) have identified another less pronounced syndrome in boys -- chronic feelings of unmasculinity. These boys, while not engaging in any cross sex play or fantasies, feel profoundly inadequate in their masculinity and have an almost phobic reaction to rough and tumble play in early childhood often accompanied by a strong dislike of team sports. Several studies have shown that children with Gender Identity Disorder and boys with chronic juvenile unmasculinity are at-risk for same-sex attraction in adolescence. (Newman 1976; Zucker 1995; Harry 1989[52])

Early identification (Hadden 1967[53]) and proper professional intervention, if supported by parents, can often overcome the gender identity disorder. (Rekers 1974[54]; Newman 1976) Unfortunately, many parents who report these concerns to their pediatricians are told not to worry about them. In some cases the symptoms and parental concerns may appear to lessen when the child enters the second or third grade, but unless adequately dealt with, the symptoms may reappear at puberty as intense, same-sex attraction. This attraction appears to be the result of a failure to identify positively with one's own sex.

It is important that those involved in child care and education become aware of the signs of gender identity disorder and

chronic juvenile unmasculinity and have access the resources available to find appropriate help for these children. (Bradley 1998; Brown 1963[55]; Acosta 1975[56]) Once convinced that same-sex attraction is not a genetically determined disorder, one is able to hope for prevention and a therapeutic model to greatly mitigate, if not eliminate, same-sex attractions.

4) AT-RISK, NOT PREDESTINED

While a number of studies have shown that children who have been sexually abused, children exhibiting the symptoms of GID, and boys with chronic juvenile unmasculinity are at risk for same-sex attractions in adolescence and adulthood, it is important to note that a significant percentage of these children do not become homosexually active as adults. (Green 1985[57]; Bradley 1998)

For some, negative childhood experiences are overcome by later positive interactions. Some make a conscious decision to turn away from temptation. The presence and the power of God's grace, while not always measurable, cannot be discounted as a factor in helping an at-risk individual turn away from same-sex attraction. The labeling of an adolescent, or worse a child, as unchangeably "homosexual" does the individual a grave disservice. Such adolescents or children can, with appropriate, positive intervention, be given proper guidance to deal with early emotional traumas.

5) THERAPY

Those promoting the idea that sexual orientation is immutable frequently quote from a published discussion between Dr. C.C. Tripp and Dr. Lawrence Hatterer in which Dr. Tripp stated: "... there is not a single recorded instance of a change in homosexual orientation which has been validated by outside judges or testing. Kinsey wasn't able to find one. And neither Dr. Pomeroy nor I have been able to find such a patient. We would be happy to have one from Dr. Hatterer." (Tripp & Hatterer 1971) They fail to reference Dr. Hatterer response:

"I have 'cured' many homosexuals, Dr. Tripp. Dr. Pomeroy or any other researcher may examine my work because it is all documented on 10 years of tape recordings. Many of these 'cured' (I prefer to use the word 'changed') patients have married, had families and live happy lives. It is a destructive myth that 'once a homosexual, always a homosexual.'" It has made and will make millions more committed homosexuals. What is more, not only have I but many other reputable psychiatrists (Dr. Samuel B. Hadden, Dr. Lionel Ovesey, Dr. Charles Socarides, Dr. Harold Lief, Dr. Irving Bieber, and others) have reported their successful treatments of the treatable homosexual." (Tripp & Hatterer 1971)

A number of therapists have written extensively on the positive results of therapy for same-sex attraction. Tripp chose to ignore the large body of literature on treatment and surveys of therapists. Reviews of treatment for unwanted same-sex attractions show that it is as successful as treatment for similar psychological problems: about 30% experience a freedom from symptoms and another 30% experience improvement. (Bieber 1962[58]; Clippinger 1974[59]; Fine 1987[60]; Kaye 1967[61]; MacIntosh 1994[62]; Marmor 1965[63]; Nicolosi 1998[64]; Rogers 1976[65]; Satinover 1996[66]; Throckmorton [67]; West [68])

Reports from individual therapists have been equally positive. (Barnhouse 1977[69]; Bergler 1962[70]; Bieber 1979[71]; Cappon 1960[72]; Caprio 1954[73]; Ellis 1956[74]; Hadden 1958[75]; Hadden 1967b[76]; Hadfield 1958[77]; Hatterer 1970[78]; Kronmeyer 1989[79]) This is only a representative sampling of the therapists who report successful results in the treatment of persons experiencing same-sex attraction.

There are also numerous autobiographical reports from men and women who once believed themselves to be unchangeably bound by same-sex attractions and behaviors. Many of these men and women (Exodus 1990-2000[80]) now describe themselves as free of same-sex attraction, fantasy, and behavior. Most of these individuals found freedom through participation in religion based support groups, although some also had recourse to therapists. Unfortunately, a number of influential persons and professional groups ignore this evidence (APA 1997[81]; Herek 1991[82]) and there seems to be a concerted effort on the part of "homosexual apologists" to deny the effectiveness of treatment of same-sex attraction or claim that such treatment is harmful. Barnhouse expressed wonderment at these efforts: "The distortion of reality inherent in the denials by homosexual apologists that the condition is curable is so immense that one wonders what motivates it." (Barnhouse 1977)

Robert Spitzer, M.D., the renowned Columbia University psychiatric researcher, who was directly involved in the 1973 decision to remove homosexuality from the American Psychiatric Association's list of mental disorders, has recently become involved with research the possibility of change. Dr. Spitzer stated in an interview: "I am convinced that many people have made substantial changes toward becoming heterosexual...I think that's news... I came to this study skeptical. I now claim that these changes can be sustained." (NARTH 2000).

6) THE GOALS OF THERAPY

Those who claim that change of sexual orientation is impossible usually define change as total and permanent freedom from all homosexual behavior, fantasy, or attraction in a person who had previously been homosexual in behavior and attraction. (Tripp 1971[83]) Even when change is defined in this extreme manner the claim is untrue. Numerous studies report cases of total change. (Goetze 1997[84])

Those who deny the possibility of total change admit that change of behavior is possible (Coleman 1978[85]; Herron 1982 [86]) and that persons who have been sexually involved with both sexes appear more able to change. (Acosta 1975[87]) A careful reading of the articles opposing therapy for change reveals that the authors who see therapy for change as unethical (Davison 1982[88]; Gittings 1973[89]) do so because they view such therapy as oppressive to those who do not want to change (Begelman 1975[90]; 1977[91]; Murphy 1992[92]; Sleek 1997[93]; Smith 1988[94]) and view those persons with same-sex attraction who express a desire to change as victims of societal or religious oppression. (Begelman 1977[95]; Silverstein 1972[96])

It should be noted that almost without exception, those who regard therapy as unethical also reject abstinence from non-marital sexual activity as a minimal goal (Barrett 1996[97]), and among the therapists who accept homosexual acts as normal many find nothing wrong with infidelity in committed relationships (Nelson 1982[98]), anonymous sexual encounters, general promiscuity, auto-eroticism (Saghir 1973), sado-masochism, and various paraphilias. Some even support a lessening of restrictions on sex between adults and minors (Mirkin 1999[99]) or deny the negative psychological impact of sexual child abuse. (Rind 1998; Smith 1988[100])

Some of those who consider therapy unethical also challenge established theories of child development. (Davison 1982 [101]; Menvielle 1998[102]) These tend to place blame for the undeniable problems suffered by homosexually active adolescents and adults on societal oppression. All research conclusions must be evaluated in light of the biases which the researchers bring to the project. When research is infused with an acknowledged political agenda, its value is seriously diminished.

It should be pointed out that Catholics cannot support forms of therapy which encourage the patients to replace one form of sexual sin with another. (Schwartz 1984) 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. (Masters 1979) Others encouraged patients to masturbate using other-sex imagery. (Blitch 1972; Conrad 1976)

For a Catholic with same sex attraction, the 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 many 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 which 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 effected by feelings of rejection from father or peers or from a poor body image which result in sadness, anger and insecurity. As this emotional pain is healed in therapy, the masculine identity is strengthened and same sex attractions 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 emotional pain and need to learn how to forgive.

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 spoke of how when he first began his practice there was almost no hope for children stricken with cancer and the physician's duty was to help the parents accept the inevitable and not waste their resources chasing a "cure." Today almost 70% of the 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.

PART II RECOMMENDATIONS

1) MINISTRY TO INDIVIDUALS EXPERIENCING SAME-SEX ATTRACTIONS

It is very important for every Catholic experiencing same sex attractions to know that there is hope, and that there is help. Unfortunately, this help is not always readily available in all areas. Support groups, therapists, and spiritual counselors who unequivocally support the Church's teaching are essential components of the help that is needed. Since the notions

of sexuality in our country are so varied, patients seeking help must be cautious that the group or counselor supports Catholic moral imperatives. One of the better known Catholic support agencies is an organization known as Courage (see Appendix) and its affiliated organization Encourage. While any attempt to teach the sinfulness of illicit homosexual behavior may be greeted with accusations of 'homophobia', the reality is that Christ calls all to chastity in keeping with their particular state of life. The desire of the Church to help all live chastely is not a blanket condemnation of any who find chastity difficult, but rather the compassionate response of a Church seeking to imitate Christ, the Good Shepherd.

It is essential that every Catholic experiencing same-sex attractions have easy access to support groups, therapists, and spiritual counselors who unequivocally support the Church's teaching and are prepared to offer the highest quality help. In many areas the only support groups available are run by Evangelical Christians or by people who reject the Church's teaching. 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. It is most important that Church-related counselors or support groups be very clear about the nature and genesis of same-sex attraction. This condition is not genetically or biologically determined. This condition is not unchangeable. It is deceitful to counsel individuals experiencing same-sex attractions that it is acceptable to engage in sexual acts provided these occur within the context of a faithful relationship. The teachings of the Catholic Church on sexual morality are explicitly clear and do not allow exceptions. 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, 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 the Catholic teaching on sexuality and has made no secret of its desire to eliminate "erotophobia" and "heterosexism." (There is simply no way the position articulated by spokespersons for the "gay" movement and the teachings of the 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. 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.

2) THE ROLE OF THE PRIEST

It is of paramount importance that priests, when faced with parishioners troubled by same-sex attraction, have access to solid information and genuinely beneficial resources. The priest, however, must do more than simply refer to other agencies (see Courage and Encourage in the Appendix). He is in a unique position to provide specific spiritual assistance to those experiencing same-sex attraction. 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 Church (see CCC, n.2357 - 2359), the need for forgiveness and healing in Confession, the need to avoid occasions of sin, and the need for a strong prayer life. A number of therapists believe that religious faith plays a crucial part in the recovery from same-sex attraction and sexual addictions.

When an individual confesses same-sex attractions, fantasies, or homosexual acts, the priest should be aware that these are often manifestations of childhood and adolescent traumas, sexual child abuse, or 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 "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 sins in this area, 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.(Fitzgibbons 1999[103])

b) Individuals experiencing same-sex attractions often report a long history of early sexual experiences and sexual trauma. (Doll 1992[104]) Homosexually active persons are more likely to have engaged in sexual activity with another person at a young age. (Stephan 1973[105]; Bell 1981[106]) Many have never told any one about these experiences (Johnson 1985)[107] 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 addiction. (Saghir 1973[108]; Beitchman 1991 [109]; Goode 1977[110]) 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. (Saghir 1973[111]) 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 in these areas 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 and illegal drugs. (Fifield 1977[112]; Saghir 1973[113]) Such abuse may weaken resistance to sexual temptation. 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. (Beitchman 1991[114]; Herrell 1999; Fergusson 1999) 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 envy (Hurst 1980) or self pity. (Van den Aardweg 1969) 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 and women experiencing same-sex attraction and women report a poor relationship with their fathers (see footnotes 17 to 23). 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. The priest can also encourage devotion to St. Joseph.

The priest needs to be aware of the depth of healing needed by these seriously conflicted persons. He needs to 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 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 seventy times seven times, but always reminded, "Go and do not commit this sin again".

3) CATHOLIC MEDICAL PROFESSIONALS

Pediatricians need to know the symptoms of Gender Identity Disorder (GID) and chronic juvenile unmasculinity. With early identification and intervention, there is every reason to hope that the problem can be successfully resolved. (Zucker 1995 [115]; Newman 1976[116]) While the primary reason for treating children is to alleviate their present unhappiness (Newman 1976[117];

Bradley 1998[118]; Bates 1974[119]), treatment of GID and chronic juvenile unmasculinity can prevent the development of same-sex attraction and the problems associated with homosexual activity in adolescence and adult life.

Most parents do not want their child to become involved in homosexual behavior, but parents of children at-risk are often resistant to treatment. (Zucker 1995; Newman 1976[120]) Informing them of estimates that 75% of children exhibiting the symptoms of GID and chronic juvenile unmasculinity will without intervention experience same-sex attraction (Bradley 1998) and letting them know the risks associated with homosexual activity (Garofalo 1998[121]; Osmond1994[122]; Stall 1988b[123]; Rotello 1997; Signorile 1997[124]) 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. George Rekers has written a number of books on the subject. (Rekers 1988[125]) Zucker and Bradley provide a comprehensive review of the literature in their book *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents* (1995), as well as numerous cases histories and treatment recommendations.

Physicians encountering patients with sexually transmitted diseases acquired through homosexual activity can inform the patients that psychological therapy and support groups are available, and that approximately 30% of motivated patients can achieve a change in orientation. In terms of disease prevention, an 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 STDs to substance abuse. (Mulry 1994 [126])

Even before the AIDS epidemic a study of men who have sex with men found that 63% had contracted a sexually transmitted disease through homosexual activity. (Bell 1978[127]) In spite of all the AIDS education, epidemiologists predict that for the foreseeable future 50% of men who have sex with men will become HIV positive. (Hoover 1991; Morris 1994; Rotello 1997[128])

They are also at risk for syphilis, gonorrhea, hepatitis A, B, C, HPV, and a number of other illnesses.

Mental health professionals should familiarize themselves with the works 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 support group membership and spiritual healing is also an option that should be considered.

4) 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. (Stall 1988a[129]; Calabrese 1987[130]; Hoover 1991[131])

"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 the adolescent to refrain from sin and live chastely according to his state in life. Symptoms of GID and chronic juvenile unmasculinity in boys should be taken seriously. At-risk children do, however, need special help, particularly those who have been victims of sexual child abuse.

Educators also have a duty to prevent teasing and ridicule of children who do not conform to gender norms. Resources to educate teachers, lesson plans, and strategies for dealing with teasing need to be created and provided to teachers in Catholic schools, CCD programs, and other institutions.

5) 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 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. They also need to be able to share their burden with loving friends and families.

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 refer children with gender identity problems to qualified and morally appropriate mental health professionals.

6) 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 women experiencing post-abortion trauma. In a few short years the approach of dioceses, individual parishes, and the Catholic faithful has been transformed and today true Christian charity is the norm rather than the exception. 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.

The members of Catholic media need to be informed about same-sex attraction, the teachings of the Church, and resources for prevention and treatment. Pamphlets 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 can offer information designed to correct these misunderstandings.

7) 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. 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. While we see the Courage and Encourage programs as very useful and valuable and actively

promote them, we are certain that there are other modes of support and are willing to work with any psychologically, spiritually and morally appropriate program.

8) HOPE

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."(Satinover 1996)

Those who wish to be free from same-sex attractions frequently turn first to the Church. CMA wants to be sure that they find the help and hope they are seeking. There is every reason to hope that every person experiencing same-sex attraction who seeks help from the Church can find freedom from homosexual behavior and many will find much more, but they will come only if they see love in our words and deeds.

If Catholic medical professionals have in the past failed to meet the needs of this 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 Catholic Medical Association recognizes that healthcare 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 the Catholic Faith.

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The research referenced in this report is drawn from a wide variety of sources. In most cases, numerous other sources could have been cited. For those desiring to make an in- depth study of the issues raised, a comprehensive bibliography can be obtained (heartbeatnews1@cox.net) along with reviews of the relevant literature.

It should also be pointed out that many of the authors cited do not accept the Church's teaching on the intrinsically disordered nature of homosexual acts. No effort has been made to distinguish between those who do and those who don't, since those who favor prevention and treatment and those who support gay-affirming therapy present essentially consistent statistical evidence and case material, differing on the interpretation and relevance of the evidence. The endnotes contain numerous direct quotations from the material cited.

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APPENDIX

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ENDNOTES

[1] Chapman and Brannock (1987) found that 63% of the lesbians in their survey stated that they had chosen to be lesbians, 28% felt they had no choice, and 11% did not know why they were lesbians.

[2] Schreier writes in support of a therapist (Wolpe 1969) who refused to patient's request for therapy directed toward change of sexual orientation from homosexuality to heterosexual: "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 orientations.... Not all religions are judgmental and condemning. Advocating for sexual reorientation while being critical of religious reorientation again demonstrates nothing more than bias." (p.308)

[3] Burr: Cover story of The Weekly Standard, "Suppose there is a Gay Gene...What then?"

[4] Hamer claimed to have found a marker for homosexuality on the x gene.

[5] LeVay claimed to have found that a certain part of the brains of homosexual men who died of AIDS differed from that of heterosexual men and women.

[6] Byne: "Critical review shows the evidence favoring a biologic theory to be lacking. In an alternative model, temperamental and personality traits interact with familial and social milieu as the individual's sexuality emerges." (p.228) "Research into the inheritability of personality variants suggests that some personality dimensions may be heritable, including novelty seeking, harm avoidance, and reward dependence. Applying these dimensions to the above scenario, one might predict that a boy who was high in novelty seeking, but low in harm avoidance and reward dependence, would be likely to disregard his mother's discouragement of baseball. On the other hand, a boy who was low in novelty seeking, but high in harm avoidance and reward dependence, would be more likely to need the rewards of maternal approval, would be less likely to seek and encounter male role models outside the family, and would be more likely to avoid baseball for fear of being hurt. In the absence of encouragement from an accepting father or alternative male role model, such a boy would be likely to feel different from his male peers and as a consequence be subject to non-erotic experiences in childhood that may contribute to the subsequent emergence of homoerotic preferences. Such experiences could include those described by Friedman as being common in pre-homosexual boys, including low masculine self-regard, isolation, scapegoating, and rejection by male peers and older males, including the father." (p.237)

[7] Crewdson: "... no other laboratory has confirmed Hamer's findings."

[8] Horgan: "LeVay's finding has yet to be fully replicated by another researcher. As for Hamer, one study has contradicted his results."

[9] McGuire: "... some people want homosexuality to be biological or genetic because they then believe that because homosexuals are 'born that way' they will somehow be tolerated. Others advocate environmental causes since this justifies their belief that individuals 'chose a gay lifestyle'." (p.141) "Even if we knew absolutely everything about genes and absolutely everything about environment, we still could not predict the final phenotype of any individual." (p.142)

[10] Rice et al. attempted unsuccessfully to replicate the Hamer study.

[11] Bailey: A study of the male siblings of homosexually active males found that "52% (29/56) of monozygotic co-twins, 22% (12/54) of dizygotic co-twins, and 11% (6/57) of adoptive brothers were homosexual... rate of homosexuality among non-twin biological siblings, as reported by probands, 9.2% (13/142). (p.1089)

[12]Parker: Case A: "Their mother, then 39 years old, learnt only a few days before the confinement that she was having twins, as she already had a 7-year-old son was anxious that one of them should be a girl. Sensing her obvious disappointment following the normal delivery of two 6 1/2 pound sons, the labour ward Sister consoled her with the suggestion that the first-born, and one subsequently to become a homosexual, was pretty enough to be a girl. Although they were so alike that they could not be distinguished, the mother seized on this idea and put a bracelet around the first twin to ensure there would be no confusion of identity, and from then on he was treated as if he were a girl." (p.490)

[13] Marmor: "The myth that homosexuality is untreatable still has wide currency among the public at large and among homosexuals themselves. This view is often linked to the assumption that homosexuality is constitutionally or genetically determined. This conviction of untreatability also serves an ego-defensive purpose for many homosexuals. As the understanding of the adaptive nature of most homosexual behavior has become more widespread, however, there has evolved a greater therapeutic optimism about the possibilities for change, and progressively more hopeful results are being reported... There is little doubt that a genuine shift in preferential sex object choice can and does take place in somewhere between 20 and 50 per cent of patients with homosexual behavior who seek psychotherapy with this end in mind." (p.1519)

[14] Ernulf found that those who believed that homosexuals are "born that way" held significantly more positive attitudes toward homosexuals than subjects who believed that homosexuals "choose to be that way" and/or "learn to be that way."

[15] Piskur: "The major finding of this study was that exposure to a written summary of research supporting biological determinants of homosexual orientation can affect scores assessing attitudes toward homosexuals when measured immediately after the reading." (p.1223)

[16] Green: "The Supreme Court ruled in *Bowers v Hardwick* that there is no fundamental right under a substantive due process analysis to engage in homosexual behavior. Therefore, the remaining constitutional route to protecting homosexuals against discrimination is the equal protection clause of the fourteenth amendment. For the highest level of protection there, a class of persons must be declared 'suspect.' To so qualify, the class should demonstrate, inter alia, that the trait for which it is stigmatized is immutable." (p.537)

[17] Apperson: "The importance of the relationship -- or lack of it -- with the father is again emphasized, with the homosexual S[ubject]s showing marked difference from the controls in perceiving the father more as critical, impatient, and rejecting, and less as the socializing agent." (p.206)

[18] Bene: "Far fewer homosexual than married men thought that their fathers had been cheerful, helpful, reliable, kind or understanding, while far more felt that their fathers had no time for them, had not loved them, and had made them feel unhappy." (p.805)

[19] Bieber : "Profound interpersonal disturbance is unremitting in the homosexual father-son relationship. Not one of the fathers (of homosexual sons)... could be regarded as reasonably 'normal' parents." (p.114) "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." (p.311)

[20] Fisher: "Fisher analyzed the 58 studies and reported that a large majority supported the notion that homosexual sons perceive their fathers as negative, distant, unfriendly figures." A review of literature on childhood experiences of male homosexuals found "With only a few exceptions, the male homosexual declares that father has been a negative influence in his life. He refers to him with such adjectives as cold, unfriendly punishing, brutal, distant, detached. There is not a single even moderately well controlled study that we have been able to locate in which male homosexuals refer to father positively or affectionately." (p.136)

[21] Pillard: "Alcoholism occurs more frequently in fathers of HS[homosexual] men (14 fathers of HS men versus five fathers of HT[Heterosexual] men.)" (p.54)

[22] Sipova: "It was found that the fathers of homosexuals and transsexuals were more hostile and less dominant than the fathers of the control group and hence less desirable identification models." (p.75)

[23] Bieber: "In about 75 per cent of the cases, the mothers had had an inappropriately close, binding, and intimate bond with their sons. More than half of these mothers were described as seductive. They were possessive, dominating, overprotective, and demasculinizing." (p.524)

[24] Bieber: "By the time the H[homosexual]-son has reached the preadolescent period, he has suffered a diffuse

personality disorder. Maternal over-anxiety about health and injury, restriction of activities normative for the son's age and potential, interference with assertive behavior, demasculinizing attitudes, and interference with sexuality -- interpenetrating with paternal rejection, hostility, and lack of support -- produce an excessively fearful child, pathologically dependent upon his mother and beset by feelings of inadequacy, impotence, and self-contempt. He is reluctant to participate in boyhood activities thought to be physically injurious -- usually grossly overestimated. His peer group responds with humiliating name-calling and often with physical attack which timidity tends to invite among children... Thus he is deprived of important empathic interaction which peer groups provide." (p.316)

[25] Snortum studied 46 males separated from military service because of homosexual behavior and concluded: "It appears that the pathological interplay between a close-binding, controlling mothers and a rejecting and detached father is not unique to the subculture of sophisticated, upper-middle-class families who engage psychoanalysts." (p.769)

[26] Fitzgibbons: "The second most common cause of SSAD [same sex attraction disorder] among males is mistrust of women's love... Male children in fatherless homes often feel overly responsible for their mothers. As they enter their adolescence, they may come to view female love as draining and exhausting." (p.89)

[27] Bradley: "Girls with GID ...have difficulty connecting with their mothers, who are perceived as weak and ineffective. We see this perception as arising from the high levels of psychopathology observed in these mothers, especially severe depression and borderline personality disorder." (p.877)

[28] Eisenbud "Broken homes and alcoholic conditions in Lesbian women's early backgrounds as well as inadequate mothering, afford no further chance of warm inclusion. The death of a beloved mother leaves cold isolation. Even when mother is present, the Lesbian girl frequently experiences her withdrawal from her after 18 months." (p.98-99)

[29] Zucker: "...we feel that parental tolerance of cross-gender behavior at the time of its emergence is instrumental in allowing the behavior to develop...What is unique in the situation with children who develop a gender identity disorder is the co-occurrence of a multitude of factors at a sensitive period in the child's development -- that is, most typically in the first few years of life, the period of gender identity formation and consolidation. There must be a sufficient numbers of factors to induce a state of inner insecurity in the child, such that he or she requires a defensive solution to deal with anxiety. This must occur in a context in which the child perceives that the opposite-sex role provides a sense of safety or security."(p.259) "... we were unable to identify in any case reports a clinician who felt that the parents unequivocally encouraged a masculine identity in their sons." (p.277)

[30] Friedman: "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 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..." (p.432-433) "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." (p.434)

[31] Hadden: "In analytical examination of the pre-school period of life it is usually revealed that the boy who became homosexual never felt accepted by and never felt comfortable in relationships with his age peers. Quite often because of parental interference he was prevented from participation in the play activities with other children and had little opportunity of running, romping, rolling around, tugging, wrestling, and scrambling with his peers from the toddling stage to the kindergarten or school age." (p.78)

[32] Hockenberry: "The conclusion was made that the five item function (playing with boys, preferring boys' games, imagining self as a sport figure, reading adventure and sports stories, considered a "sissy") was the most potent and parsimonious discriminator among adult males for sexual orientation. It was similarly noted that the absence of masculine behaviors and traits appeared to be a more powerful predictor of later homosexual orientation than the traditionally feminine or cross-sexed traits and behaviors." (p.475)

[33] Whitam developed and administered a six item inventory to 206 homosexual and 78 heterosexual male respondents regarding their childhood interests in cross-dressing, playing with dolls preferences for affiliating with girls and older women, being regarded as a "sissy" by peers, and the nature of one's childhood sex play. Virtually all of the homosexuals (97%) reported possessing one or more of these "childhood indicators," whereas 74% of the heterosexual subjects reported a complete absence of any of the indicators in their childhood. (In Hockenberry, p.476)

[34] Thompson compared 127 male homosexuals with 123 controls: "The seven most discriminating items in order from

the highest were: (a) played baseball... with homosexuals concentrating on never or sometimes...;(b) played competitive group games (homosexuals never or sometimes...); (c) child spent time with father (homosexuals, very little...); (d) physical makeup as a child (homosexuals, frail, clumsy, or coordinated, heterosexuals, athletic); (e) felt accepted by father (homosexuals, mildly or no...); (f) played with boys before adolescence (homosexuals, sometimes...); and (g) mother insisted on being center of child's attention (homosexuals, often or always...)"(p.123)

[35] Bailey: "Male homosexuals were remembered by their mothers as less masculine and more non-athletic." (p.44)

[36] Fitzgibbons: "Weak masculine identity is easily identified and, in my clinical experience, is a major cause of SSAD in men. Surprisingly, it can be an outgrowth of weak eye-hand coordination which results in an inability to play sports well. This condition is usually accompanied by severe peer rejection. .The 'sports wound' will negatively affect the boy's image of himself, his relationship with peers, his gender identity, and his body image." (p.88)

[37] Newman: "Experiences of being ostracized and ridiculed may play a more important role than has been recognized in the total abandonment of the male role at a later time." (p.687)

[38] Beitchman: "Among adolescents, commonly reported sequelae (of child sexual abuse) include sexual dissatisfaction, promiscuity, homosexuality, and an increased risk for re-victimization. (p.537)

[39] Bradley: "In our female adolescents with GID, a history of sexual abuse or fears of sexual aggression has appeared commonly." (p.878)

[40] Engel: "Some lesbian patients [victims of sexual abuse] go through a time of confusion, not being sure whether they are with women out of choice or whether it is just because they are afraid, angry, and repulsed by men due to the sexual abuse." (p.193)

[41] Gundlach reported that 39 of 217 lesbians versus 15 of 231 non-lesbians reported they were objects of rape or attempted rape at age 15 or under. (p.62)

[42] Golwyn: "We conclude that social phobia may be a hidden contributing factor in some instances of homosexual behavior." (p.40)

[43] Fergusson et al found that in a birth cohort sample the gay, lesbian, bisexual subjects has significantly higher rates of: Suicidal Ideation (67.9%/29.0%), Suicide Attempt (32.1%/7.1%), and psychiatric disorders age 14 -21 -- Major depression (71.4%/38.2%), Generalized anxiety disorder (28.5%/12.5%), conduct disorder (32.1%/11.0%), Nicotine dependence (64.3%/26.7%), Other substance abuse/dependence (60.7%/44.3%), Multiple disorders (78.6%/38.2%) than the heterosexual sample. (p.879)

[44] Parris in a study of consecutive admissions found that the rate of homosexuality in the BPD [Borderline Personality Disorder] sample was 16.7%, as compared with 1.7% in the non-BPD comparison group. The homosexual BPD group had a rate of overall Childhood Sexual Abuse rate of 100% as compared to 37.3% for the heterosexual BPD group. "It is interesting that 3 out of 10 homosexual borderline patients also reported father-son incest." (p.59)

[45] Zubenko: "Homosexuality was 10 times more common among the men and six times more common among the women with borderline personality disorder than in the general population or in a depressed control group." (p.748)

[46] Gonsiorek discusses the treatment of homosexuals who are also schizophrenic. (p.12)

[47] Bychowski: "... homosexuals, in whom the ego has remained fixated in the stage of early narcissism, find it impossible to substitute consistent and successful dealings with reality for homosexual acts which they invest heavily with magic. The structure of these individuals is in many respects close to schizophrenia." (p.55)

[48] Kaplan: "In a sense, the homosexual has much in common with the narcissist, who has a love affair with himself. The homosexual, however, is unable to love himself as he is, since he is too dissatisfied with himself; instead he loves his ego-ideal, as represented by the homosexual partner whom he chooses. Thus for this particular type of individual, homosexuality becomes an extension of narcissism." (p.358)

[49] Berger: "A possible aetiological factor that has not been mentioned before in the literature, the abortion of a pregnancy conceived by the male patient that may have led to the patient 'coming out' or declaring homosexuality, is discussed." (p.251)

[50] APA: "Gender Identity Disorder can be distinguished from simple nonconformity to stereotypical sex role behavior by the extent and persuasiveness of cross-gender wishes, interests, and activities." (p. 536)

[51] Phillips: "The 16-item discriminate-function ... yielded correct classification of 94.4% of heterosexual men and 91.8% of the homosexual men. These results indicate that heterosexual and homosexual men are classified with equivalent accuracy on the basis of recalling having had or not having had gender conforming (masculine) experiences in

childhood." (p.550)

[52] Harry: "These data suggest that some history of childhood femininity is almost always a precursor of adolescent homosexual behavior." (p.259)

[53] Hadden: "In my experience with male homosexuals, they almost universally recognize that they were maladjusted at the time they started school. Many were recognized by their parents as needing psychiatric assistance much earlier." (p.78)

[54] Rekers: "When we first saw him, the extent of his feminine identification was so profound ... that it suggested irreversible neurological and biochemical determinants. After 26 months follow-up, he looked and acted like any other boy. People who viewed the video taped recordings of him before and after treatment talk of him as 'two different boys.'"

[55] Brown: "In summary, then it would seem that the family pattern involving a combination of a dominating, overly intimate mother plus a detached, hostile or weak father is beyond doubt related to the development of male homosexuality...It is surprising there has not been greater recognition of this relationship among the various disciplines that are concerned with children. A problem that arises in this connection is how to inform and educate teachers and parents relative to the decisive influence of the family in determining the course and outcome of the child's psychosexual development. There would seem no justification for waiting another 25 or 50 years to bring this information to the attention of those who deal with children. And there is no excuse for professional workers in the behavioral sciences to continue avoiding their responsibility to disseminate this knowledge and understanding as widely as possible." (p.232)

[56] Acosta: "...better prospects for intervention in homosexuality lie in its prevention through the early identification and treatment of the potential homosexual child." (p.9)

[57] Green: "This longitudinal study of two groups of boys demonstrates that the association between extensive cross-gender behavior in boyhood and homosexual behavior in adulthood, suggested by previous retrospective reports, can be validated by a prospective study of clinically or family-referred boys with behaviors consistent with the gender identity disorder of childhood. However, not all boys with extensive cross-gender behavior evolved as bisexual or homosexual men. No boys in the comparison group evolved as bisexual or homosexual." (p.340)

[58] Bieber: "The therapeutic results of our study provide reason for an optimistic outlook. Many homosexuals became exclusively heterosexual in psychoanalytic treatment. Although this change may be more easily accomplished by some than by others, in our judgment a heterosexual shift is a possibility for all homosexuals who are strongly motivated to change." (p.319)

[59] Clippinger: "Of 785 patients treated, 307 - or approximately 38% -- were cured. Adding the percentage figures of the two other studies, we can say that at least 40% of the homosexuals were cured, and an additional 10 to 30% of the homosexuals were improved, depending on the particular study for which statistics were available." (p.22)

[60] Fine: "Whether with hypnosis..., psychoanalysis of any variety, educative psychotherapy, behavior therapy, and/or simple educational procedures, a considerable percentage of overt homosexuals became heterosexual... If patients were motivated, whatever procedure is adopted a large percentage will give up their homosexuality... The misinformation that homosexuality is untreatable by psychotherapy does incalculable harm to thousands of men and women... All studies from Schrenk-Notzong on have found positive effects virtually regardless of the kind of treatment used." (p.85-86)

[61] Kaye: "Finally, we have indications for therapeutic optimism in the psychoanalytic treatment of homosexual women. We find, roughly, at least a 50% probability of significant improvement in women with this syndrome who present themselves for treatment and remain in it." (p.634)

[62] MacIntosh queried psychoanalysts who reported that of 824 male patients of 213 analysts - 197 (23.9%) changed to heterosexuality, 703 received significant therapeutic benefit; and of the 391 female patients of 153 analysts -- 79 (20.2%) changed to heterosexuality, 318 received significant therapeutic benefit. (p.1183)

[63] Marmor: "The clinicians represented in this volume present convincing evidence that homosexuality is a potentially reversible condition. There is little doubt that much of the recent success in the treatment of homosexuals stems from the growing recognition among psychoanalysts that homosexuality is a disorder of adaptation." (p. 21)

[64] Nicolosi surveyed 850 individuals and 200 therapists and counselors -- specifically seeking out individuals who claim to have made a degree of change in sexual orientation. Before counseling or therapy, 68% of respondents perceived themselves as exclusively or almost entirely homosexual, with another 22% stating they were more homosexual than heterosexual. After treatment only 13% perceived themselves as exclusively or almost entirely homosexuality, while 33% described themselves as either exclusively or almost entirely heterosexual. 99% of respondents said they now believe treatment to change homosexuality can be effective and valuable.

[65] Rogers: "In general, reports on the group treatment of homosexuals are optimistic; in almost all cases the therapists report a favorable outcome of therapy whether the therapeutic goal was one of achieving a change in sexual orientation

or whether it was a reduction in concomitant problems." (p.22)

[66] Satinover reviewed literature in treatment and found that in the eight years between 1966 and 1974 alone, the Medline database -- which excludes many psychotherapy journals -- listed over a thousand articles on the treatment of homosexuality. According to Satinover, these reports contradict claims that change is impossible. Indeed, it would be more accurate to say that all the existing evidence suggests strongly that homosexuality is quite changeable. Most psychotherapists will allow that in the treatment of any condition, a 30% rate may be anticipated. (p.169)

[67] Throckmorton: "Narrowly, the question to be addressed is: Do conversion therapy techniques work to change unwanted sexual arousal? I submit that the case against conversion therapy requires opponents to demonstrate that no patients have benefited from such procedures or that any benefits are too costly in some objective way to be pursued even if they work. The available evidence supports the observation of many counselors -- that many individuals with same-gender sexual orientation have been able to change through a variety of counseling approaches." (p.287)

[68] West summarizes the results of studies: behavioral techniques have the best documented success (never less than 30%); psychoanalysis claims a great deal of success (the average rate seemed to be about 25%, but 50% of the bisexuals achieved exclusive heterosexuality.)"Every study ever performed on conversion from homosexual to heterosexual orientation has produced some successes."

[69] Barnhouse. "These facts and statistics about cure are well known and not difficult to verify. In addition, there are many people to have experienced their homosexuality as a burden either for moral or social reasons who have, without the aid of psychotherapy, managed to give up this symptom; of these, a significant number have been able to make the transition to satisfying heterosexuality. Quite apart from published studies by those who have specialized in the treatment of sexual disorders, many psychiatrists and psychologists with a more general type of practice (and I include myself in this group) have been successful in helping homosexual patients to make a complete and permanent transition to heterosexual." (p.109)

[70] Bergler: "In nearly thirty years, I have successfully concluded analyses of one hundred homosexuals... and have seen nearly five hundred cases in consultation. On the basis of the experience thus gathered, I make the positive statement that homosexuality has an excellent prognosis in psychiatric-psychoanalytic treatment of one to two years' duration, with a minimum of three appointments each week -- provided the patient really wishes to change. A considerable number of colleagues have achieved similar success." (p.176)

[71] Bieber: "We have followed some patients for as long as 20 years who have remained exclusively heterosexual. Reversal estimates now range from 30% to an optimistic 50%" (p.416).

[72] Cappon reported that of patients with bisexual problems 90% were cured (i.e., no reversions to homosexual behavior, no consciousness of homosexual desire and fantasy) in males who terminated treatment by common consent. Male homosexual patients: 80% showed marked improvement (i.e., occasional relapses, release of aggression, increasingly dominant heterosexuality)... 50% changed." (p.265-268) Of female patients 30% changed.

[73] Caprio: "Many patients of mine, who were formerly lesbians, have communicated long after treatment was terminated, informing me that they are happily married and are convinced that they will never return to a homosexual way of life." (p.299)

[74] Ellis: "... it is felt that there are some grounds for believing that the majority of homosexuals who are seriously concerned about their condition and willing to work to improve it may, in the course of active psychoanalytically-oriented psychotherapy, be distinctly helped to achieve a more satisfactory heterosexual orientation." (p.194)

[75] Hadden: "From my experience I have concluded that homosexuals can be treated more effectively by group psychotherapy when they are started in groups made up exclusively of homosexuals. In such groups the rationalization that homosexuality is a pattern of life they wish to follow is destroyed by their fellow homosexuals." (p. 814)

[76] Hadden: "As each patient is brought into the group, we make it clear to him that we do not regard homosexuality as a particular disease, but as a symptom of an overall pattern of maladjustment.... I anticipate that better than one-third of the patients who persist in treatment will experience a reversal of their sexual pattern, but it may be necessary to continue in treatment for two or more years." (p.114)

[77] Hadfield reported curing 8 homosexuals: "By cure I do not mean... that the homosexual is merely able to control his propensity ... Nor .. do I mean that the patient is rendered capable of having sexual relations and bearing children; for ... he might do this by the help of homosexual fantasies. By 'cure' I mean that he loses his propensity to his own sex has his sexual interests directed towards those of the opposite sex, so that he becomes in all respects a sexually normal person." (p.1323)

[78] Hatterer reported: 49 patients changed (20 married, of these 10 remained married, 2 divorced, 18 achieved heterosexual adjustments); 18 partially recovered, remained single; 76 remained homosexual (28 palliated - 58 unchanged) "A large undisclosed population has melted into heterosexual society, persons who behaved homosexually in

late adolescence and early adulthood, and who, on their own, resolved their conflicts and abandoned such behavior to go on to successful marriages or to bisexual patterns of adaptation." (p.14)

[79] Kroneymeyer: "From my 25 years' experience as a clinical psychologist, I firmly believe that homosexuality is a learned response to early painful experiences and that it can be unlearned, For those homosexuals who are unhappy with their life and find effective therapy it is 'curable'" (p.7)

[80] Exodus North America Update publishes a monthly newsletter containing testimonies of men and women who have left homosexuality. PO Box 77652, Seattle WA 98177, see issues from 1990 - 2000

[81] "APA "Fact sheet: Homosexuality and Bisexuality: ... There is no published scientific evidence supporting the efficacy of 'reparative therapy' as a treatment to change one's sexual orientation."

[82] Herek: "As recently as January of 1990, Dr. Bryant Welch, Executive Director for Professional Practice of the American Psychological Association, stated that 'no scientific evidence exists to support the effectiveness of any of the conversion therapies that try to change one's sexual orientation' and that 'research findings suggest that efforts to 'repair' homosexuals are nothing more than social prejudice garbed in psychological accouterments." (p.152)

[83] Tripp: "From my point of view, there is no indication that fundamental changes in anybody's sex life are ever wrought by therapy, nor would they be particularly desirable anyway. A person's best sexual orientation is the one that helps him get the most out of himself, spontaneously. Killing off his guilt and his childish expectation that conformity is the road to heaven both tend to give him confidence and the energy to make a much smoother social integration... Since homosexuality is an alternate orientation and not a disease, 'cure' is patently impossible. What passes for 'cure' is surface symptom suppression or outright avoidance." (p.48)

[84] Goetze reviewed 17 studies a found a total of 44 persons who were exclusively or predominantly homosexual experienced a full shift of sexual orientation.

[85] Coleman: "... to offer a cure to homosexuals who request a change in their sexual orientation is, in my opinion unethical. There is evidence, as reviewed in this paper, that therapists can help individuals change their behavior for a period of time. The question remains whether it is beneficial for patients to change their behavior to something that is inconsistent or incongruent with their sexual orientation." (p.354)

[86] Herron: ""Changing a person's sexual behavior from homosexual to heterosexual might be accomplished by working with a potential already present, but this would not really change the person's preference. While it may appear that psychoanalysis can change a person's sexual orientation, in truth this is a limited accomplishment that happens only occasionally and even then is of questionable duration." (p.179)

[87] Acosta: "Most therapeutic success seems to be with bisexuals rather than exclusive homosexuals. The combined use of psychotherapy and specific behavioral techniques is seen to offer some promise for heterosexual adaptation with certain kinds of patients." (p.9)

[88] Davison: "... even if one were to demonstrate that a particular sexual preference could be modified by a negative learning experience, there remains the question of how relevant these data are to the ethical question of whether one should engage in such behavior changes regimens. The simple truth is that data on efficacy are quite irrelevant. Even if we could effect certain changes, there is still the more important question of whether we should. I believe we should not." (p.96) "Change of orientation therapy programs should be eliminated. Their availability only confirms professional and societal biases against homosexuality, despite seemingly progressive rhetoric about its normality..." (p.97)

[89] Gittings: "The homosexual community looks upon efforts to change homosexuals to heterosexuality, or to mold younger, supposedly malleable homosexuals into heterosexuality... as an assault upon our people comparable in its way to genocide."

[90] Begelman: "The efforts of behavior therapists to reorient homosexuals to heterosexuals by their very existence constitute a significant causal element in reinforcing the social doctrine that homosexuality is bad." (p.180)

[91] Begelman: "My recommendation that behavior therapists consider abandoning the administration of sexual reorientation techniques is based on the following considerations. Administering these programs means reinforcing the social belief system about homosexuality. The meaning of the act of providing reorientation services is yet another element in a causal nexus of oppression." (p.217)

[92] Murphy: "There would be no reorientation techniques where there no interpretation that homoeroticism is an inferior state, an interpretation that in many ways continues to be medically defined, criminally enforced, socially sanctioned, and religiously justified. And it is in this moral interpretation, more than in the reigning medical theory of the day, that all programs of sexual reorientation have their common origins and justifications." (p.520)

[93] Sleek quotes Linda Garnet, Chair of APA's Board for Advancement of Psychology in the Public Interest who stated

that reorientation therapies "feed upon society's prejudice towards gays and may exacerbate a patient's problems with poor self-esteem, shame, and guilt."

[94] Smith: ""Naturally, all parents wish their children to be happy and to resemble themselves, and if it were possible to prevent homosexual adjustment (not to mention transsexualism) most parents would welcome the intervention. On the other hand, this raises ethical issues along the lines of other 'Final Solutions' to minority problems." (p.67)

[95] Begelman: "The recommendation is not based on any abstract disagreement with the principle that patients have a right to seek aid in reducing their anxiety or upset. But it does take cognizance of the fact that the homosexual person who seeks treatment does so most of the time because he has been forced into adopting a conventional and prejudicial view of his behavior. On what ethical basis, it may be asked, are we obliged to desert the patient in favor of allegiance to an abstract set of considerations." (p.217)

[96] Silverstein: "To suggest that a person comes voluntarily to change his sexual orientation is to ignore the powerful environmental stress, oppression if you will, that has been telling him for years that he should change... What brings them into counseling is guilt, shame, and the loneliness that comes from their secret. If you really wish to help them freely choose, I suggest you first desensitize them to their guilt. Allow them to dissolve the shame about their desires and actions and to feel comfortable with their sexuality. After that, let them choose, but not before." (p.4)

[97] Barrett: "Assisting gays and lesbians to step away from external religious authority may challenge the counselor's own acceptance of religious teachings." (p.8)

[98] Nelson, a professor of Christian ethics defends homosexual infidelity: "... it is insensitive and unfair to judge gay men and lesbians 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 sexual intimacy with secondary partners." (p.173)

[99] Mirkin: "This article will argue that, like homosexuality, the concept of child molestation is a culture and class specific modern creation. Though Americans consider intergenerational sex to be evil, it has been permissible or obligatory in many cultures and periods of history. Sex with male youths is especially widespread." (p.4)

[100] Smith: "Pedophilia may be a cultural label rather than anything inherently medical or psychiatric; anthropological findings support this view." (p.68)

[101] Davison: "Bieber et al. found that what they called a 'close-binding intimate mother' was present much more often in the life history of the analytic homosexual patients than among the heterosexual controls. But what is wrong with such a mother unless you happen to find her in the background of people whose current behavior you judge beforehand to be pathological? Moreover, even when an emotional disorder is identified in a homosexual, it could be argued that the problem is due to the extreme duress under which the person has to live in a society that asserts that homosexuals are 'queer' and that actively oppresses them." (p.92)

[102] Menvielle in letter criticizing an article on GID by Bradley and Zucker (1997): "The ethical implications of whether childhood GID is a psychiatric disorder versus a manifestation of normal homosexual orientation are vital because labeling pre-homosexual children as disordered would be incorrect." (p.243) Bradley and Zucker responded: "Dr. Menvielle is naive in his assumption that these children would be happy if they were simply allowed to 'grow up' pursuing their cross-gender behavior and interests, including the desire to change sex. They are unhappy children who are using these behaviors defensively to deal with their distress." (p.244)

[103] Fitzgibbons: "Experience has taught me that healing is a difficult process, but through the mutual efforts of the therapist and the patient, serious emotional wounds can be healed over a period of time." (p.96)

[104] Doll: 42% of a sample of 1,001 homosexual men reported childhood experiences that meet the criteria for sexual abuse.

[105] Stephan: "... homosexuals reported experiencing their first orgasm at a younger age than the heterosexuals" 24% of homosexuals first orgasms occurred during homosexual contacts versus 2% of heterosexuals.(p.511)

[106] Bell: Homosexuals average age of first homosexual encounter 9.7 years. Heterosexuals' first sexual encounter 11.6 years.

[107] Johnson: "The 40 adolescent males reporting sexual victimization ranged in age from 15 to 21 years at the time of their initial clinic visit... No adolescent under 15 years of age reported having been sexually assaulted, and only six of the 40 were under age 17...Only six of the 40 patients reported having revealed the assault to anyone prior to the interview... All six patients identified themselves as currently homosexual." (p.374) "Even though nearly half of our adolescent male clinic population is under 15 years of age, all the adolescents who admitted sexual molestation were over 15 years of age. Since all the reported molestations occurred during the preadolescent years, we can only speculate that our young adolescent males did not report earlier sexual abuse. " Of the 40 reporting sexual abuse 47.5% self-identified as

homosexual. (p.375)

[108] Saghir and Robins found that while less than 6% of heterosexual men under 19 and 0% of those over 19 masturbated 4 or more times per week, 46% of homosexual men under 19, 31% of those 20 to 29, and 26% of those over 30 did so. (p.49 - 50)

[109] Beitchman: "...sexually abused school-age children of both sexes, like their sexually abused pre-school counterparts, appeared more likely to manifest inappropriate sexual behaviors (e.g., excessive masturbation, sexual preoccupation, and sexual aggression) than did both normal and clinical controls." (p.544)

[110] Goode: Never masturbated - 28% Homosexually inexperienced women versus 0% homosexually experienced. Masturbated 6 or more times in past month - 13% of HIW v. 50% of HEW.

[111] Saghir and Robins' study found 40% of homosexual men paid or received money for sex, verses 17% of controls (not homosexual) who paid for sex, none received. (p.81)

[112] Fifield: "... an alarming number of gay men and women (31.96%) are trapped in an alcohol-centered lifestyle."

[113] Saghir and Robins found that 30% of the homosexuals in their sample reported excessive drinking or alcohol dependence verses 20% of the heterosexuals. (p.119)

[114] Beitchman: "A review of studies reporting symptomology among sexually abused adolescents revealed evidence for the presence of depression, low self-esteem, and suicidal ideation."(p.544)

[115] Zucker: "...In general we concur with those (e.g. Green 1972; Newman 1976; Stoller, 1978) who believe that the earlier treatment begins, the better."(p.281) "It has been our experience that a sizable number of children and their families can achieve a great deal of change. In these cases, the gender identity disorder resolves fully, and nothing in the children's behavior or fantasy suggest that gender identity issues remain problematic.... All things considered, however, we take the position that in such cases a clinicians should be optimistic, not nihilistic, about the possibility of helping the children to become more secure in their gender identity."(p.282)

[116] Newman: "Feminine boys, unlike men with postpubertal gender identity disorders seem remarkably responsive to treatment." (p.684)

[117] Newman: "Teasing and social rejection by male peers decreases and is replaced by acceptance. During the initial 12 - 24 months of treatment, these patients begin to enjoy being accepted as boys, and their acceptance is a strong, continuing reinforcer." (p.684)

[118] Bradley: "Our experience is that such suffering diminishes radically, and self esteem improves when the parent are able to value the child and to support and to encourage same-sex behavior." (p.245)

[119] Bates: "It seems likely that it is the combination of effeminacy, fearfulness, social aversiveness; and immaturity that together constitute sufficient conditions for parents, schools, and others to seek clinical intervention for effeminacy." (p.14)

[120] Newman: "Mothers generally fear losing the son's companionship as he becomes more masculine and therefore reluctant to begin a treatment program." (p.684)

[121] Garofalo: "Gay and bisexual teenagers may take more risks, and engage in risky behavior earlier in life, than teenagers who describe themselves as heterosexual. GLB [gay, lesbian, bisexual] teenagers were more likely to consider or attempt suicide, abuse alcohol or drugs, participate in risky sexual activity, or be victimized, and to initiate these behaviors earlier."

[122] Osmond et al. conducted a household survey of unmarried men 18 through 29 years of age found that of 328 homosexual men 20.1% tested positive tested for HIV.

[123] Stall: "... the prevalence of use of particular drugs within this sample of an urban gay community is quite high and significant differences exist between the number of drugs used by the homosexual and heterosexual respondents. The finding that a sizable proportion of gay men use many different types of drugs raises the possibility that concurrent drug use is relatively common among gay men." (p.71)

[124] Signorile, quoting Steve Troy: "It's the age of AIDS and I think people's attitude is, 'I don't know how long I'm going to live... The majority of people who go to the circuit parties are HIV-positive, I really think so. Their attitude is, 'I'm going to live for the moment.' The circuit parties are the one outlet we have for total escapism. The unfortunate part of it is that when we do the drugs, we become much less inhibited. Things that we might normally not do when we have our wits about us, we actually do... And, to be honest, I can't say I'm... I can't say that I haven't done that myself. When people are on drugs, the chances of unsafe sex are greater -- like ten times higher." (p. 116)

[125] Rekers: "With major research grants from the National Institute of Mental Health, I have experimentally demonstrated an affective treatment for "gender identity disorder of childhood" which appears to hold potential for preventing homosexual orientation in males, if applied extensively in the population."

[126] Mulry: "...men who never drank prior to sex were very unlikely to have engaged in unprotected anal intercourse, whereas 90% of men who had at least one occasion of unprotected anal intercourse also drank at least some of the time prior to sexual intercourse." The report found: "a virtual absence of individuals who did not drink but did engage unprotected anal intercourse." (p.181)

[127] Bell: 62% of 575 homosexual men in a study published in 1978 had contracted a sexually transmitted disease from homosexual contacts.[128] Rotello: "Who wants to encourage their kids to engage in a life that exposes them to a 50 percent chance of HIV infection? Who even wants to be neutral about such a possibility? If the rationale behind social tolerance of homosexuality is that it allows gay kids an equal shot at the pursuit of happiness, that rationale is hopelessly undermined by an endless epidemic that negates happiness." (p.286)

[129] Stall: "Even using cross-sectional designs, the efficacy of health education interventions in reducing sexual risk for HIV infection has not been consistently demonstrated... More education, over long period time, cannot be assumed to be effective in inducing behavior changes among chronically high-risk men." (p.883)

[130] Calabrese, Harris, and Easley studying a sample of gay men living outside of the large coastal gay communities, found that neither attendance at a safe sex lecture, reading a safe sex brochure, receiving advice from a physician about AIDS, testing for HIV antibodies, nor counseling at an alternative test site was associated with participation in safe sex.

[131] Hoover: "The overall probability of seroconversion [from HIV - to HIV+] prior to age 55 years is about 50%, with seroconversion still continuing at and after age 55. Given that this cohort consists of volunteers receiving extensive anti-HIV-1 transmission education, the future seroconversion rates of the general homosexual population may be even higher than those observed here." (p.1190)

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