

# Fertility & Gender

Issues in Reproductive and Sexual Ethics

Edited by Helen Watt



Oxford—Anscombe Bioethics Centre

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Published by The Anscombe Bioethics Centre  
17 Beaumont Street Oxford OX1 2NA  
[www.bioethics.org.uk](http://www.bioethics.org.uk)

© The Anscombe Bioethics Centre 2011  
British Library Cataloguing in Publication Data  
A catalogue for this book is available from the British Library  
ISBN 978-0-906561-12-6

Typeset by Tudor Rose, Leicester  
[www.tudor-rose.co.uk](http://www.tudor-rose.co.uk)

Printed and bound by Martins The Printers, Berwick-upon-Tweed, England

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## *Who Am I?*

### Psychological Issues in Gender Identity and Same-Sex Attraction

Philip M. Sutton

I was asked to present at the Linacre Centre Conference on *Fertility, Infertility and Gender* because of my clinical experience serving persons with unwanted homosexual or same-sex attractions and behaviours (SSA).<sup>1</sup> Psychological issues related to the development and gratification of SSA are relevant for understanding the gamut of topics related to fertility and infertility, as well as the nature, motivations for and consequences of all human sexual behaviour.

In addressing homosexuality (SSA) in particular,<sup>2</sup> my comments assume an audience largely unfamiliar with relevant historical and recent clinical and scientific literature. In referencing my comments, I have chosen from a selected list of books, monographs and articles, which I believe offer a suitable introduction to this literature.

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1 There are no objective criteria for identifying oneself or another as 'homosexual.' Terms like 'gay', 'lesbian', 'bisexual', etc., while often definitively chosen or assigned labels, likewise are imprecise. 'SSA' is the conventional term used here to identify what seemingly is a common experience regardless of how defined; namely, that a person experiences some measure of same-sex attraction.

2 There is too little space here to deal with the rarer but highly publicized and politicized reality of persons who are called 'transgendered', i.e. men who believe that they are a woman trapped in a man's body or vice versa, some of whom receive hormonal and surgical treatments in order to more closely resemble the biological sex which they believe themselves to be (cf. Richard Fitzgibbons, Philip Sutton and Dale O'Leary, "The Psychopathology of "Sex Reassignment" Surgery: Assessing Its Medical, Psychological and Ethical Appropriateness", *National Catholic Bioethics Quarterly* 9.1 (2009), 97-125. Wishing and/or believing that one is, as well as trying to live as if one were, a person of the other, biological sex clearly is an expression of one's gender identity, the development of which may be understood better by considering the psychological issues discussed later in this paper. See also footnote 87 on intersex conditions.

## **I. Gender identity influences all facets of human reproduction and sexual bonding**

This paper is concerned with some of the psychological issues which influence the development of gender identity, specifically of those who experience SSA. However, the breadth of topics addressed in this book—marriage, celibacy, fertility, assisted conception, IVF, contraception, abstinence, STDs, teenage pregnancy, love, chastity, motherhood, population growth and control, sexual ethics—all of these realities influence, and are influenced by, a person's 'gender identity.' I accept and propose as a metaphysical given that human beings have a universal need to realize, become and flourish in their given biological gender. How each human being comes to identify—and identify with—his or her gender, and how congruently he or she lives accordingly, profoundly influence how these topics impact their lives. What it means to be a man or a woman, at least implicitly and often explicitly, affects all of one's decisions and actions relevant to human procreation and sexual gratification, and indeed the assumption of 'maternal' or 'paternal' roles with others.

Basic beliefs and attitudes toward one's body and personhood—and the bodies and personhood of others—influence whether, when, and how persons may attempt to procreate or avoid procreating a child, engage in sexually gratifying behaviours, and otherwise establish and maintain life-long biological and/or psycho-social relationships with those whose existence one 'facilitates' and/or finds gratifying, in fantasy and/or in reality. Answers to questions about the nature and purpose of human sexual organs, behaviours and gratification, about what is necessary and sufficient for human flourishing, and what helps or hinders the development of a gender identity which enhances or impedes human flourishing, clearly have relevance for a wide range of topics, including those discussed in this book.

## **II. Each human being, including one who experiences same-sex attraction, possesses a nature and existence which in some ways is universal, in some ways pluralistic, and in some ways unique**

When discussing psychological issues which *may* be relevant for understanding gender identity development in persons who experience same-sex attraction (SSA), it is important to remember how unique each person is. I am mindful of learning over 35 years ago in a college undergraduate elective class in business management: "*In some ways, all people are alike. In some ways, some people are alike. And in some ways, each person is unique.*" A similar idea was expressed recently in an interview given by biographer Joseph Pearce:

## Who Am I

The paradox at the heart of every human life...is that we are both ordinary and extraordinary at one and the same time. We have so much in common with each other and yet we are all special, we are all unique. We are all of the genus homo, and yet we are all individuals.<sup>3</sup>

Whether one is engaged in the psychological sciences or arts, it is necessary to remember that each person is an individual, that he or she has his or her own story with experiences, responses and choices unique to him or her. This includes those who experience SSA, as various mental health professionals who provide psychological care to those for whom SSA is unwanted have reported. As psychologist Dean Byrd observes: “There are many differences among those who struggle with unwanted homosexuality.”<sup>4</sup>

Janelle Hallman, a therapist who serves only women, remarks similarly:

While these women often share common themes in their stories, similar strengths and, therefore, similar survival strategies, women with same-sex attractions and dependencies should *never* be stereotyped or squeezed into a ‘box.’ Like everyone else, they want to be known for who they truly are, apart from their sexuality or confusions or conflicts. Every woman who has or has had same-sex attractions is also wonderfully unique and special. They have various backgrounds, families of origin, experiences, personalities, character traits, relational styles, professions, appearances, marital status, developmental needs, abuse histories, religious upbringings, and talents and giftings.<sup>5</sup>

Whether similar to or different from the stories of those who do not develop SSA, frustrations of certain longings for love and affirmation commonly are reported by those who do. Yet, as Hallman writes, those who help persons attempt to resolve unwanted SSA find that no “single factor *individually determines* or *directly*

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3 “Unmasking Oscar Wilde, and Others”, Zenit interview with Joseph Pearce (# ZE04061723—2004-06-17), at <http://www.zenit.org/article-10392?!=english>.

4 A. Dean Byrd, “Psychological Care of Men who Present with Unwanted Homosexual Attractions: An Interpersonal Approach”, in Julie Harren Hamilton and Philip Henry (eds), *Handbook of Therapy for Unwanted Homosexual Attractions* (Longwood, FL: Xulon Press, 2009), p. 84.

5 Janelle Hallman, “The Basics of Therapy for Women with Unwanted Same-Sex Attraction,” in Hamilton & Henry, *Handbook*, pp. 137-138.

causes female SSA<sup>6</sup> (emphasis in original). The same may be said for male SSA.<sup>7</sup>

In addition to the ultimate uniqueness of the influences and experiences associated with each person's development of SSA, and indeed, opposite-sex attraction, each person who experiences SSA as unwanted likewise does so out of personal, if sometimes also common, motives. For example, Julie Harren Hamilton and Philip Henry, co-editors of the *Handbook of Therapy for Unwanted Homosexual Attractions*, explain that clients who seek help to cope with and resolve unwanted homosexual attractions do so for a variety of reasons, such as: "a lack of fulfillment in their homosexual identity, incongruence with personal values, deeply held religious beliefs, personal goals of heterosexual marriage and children, and many other such internal motivators."<sup>8</sup> Other internal motivators may include concerns about preserving or reacquiring one's medical, psychological and/or relational health.<sup>9</sup>

### **III. Genetic and biological factors may influence, but do not (pre-) determine, the development of gender identity in general, or SSA in particular**

While there is no 'one size fits all' developmental blueprint for the origins of SSA, this and the following sections describe a number of factors commonly observed by clinicians and researchers, as well as reported by persons with SSA concerning their unique and common developmental experiences. Neil and

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6 Janelle Hallman. *The Heart of Female Same-Sex Attraction* (Downers Grove, IL: InterVarsity Press, 2008), p. 54.

7 Neil and Briar Whitehead in their review, citing over 460 papers and books, of what the biological, psychological, sociological and anthropological literature does and does not say about the causes of homosexuality, heterosexuality and human behaviour generally, answer the question "What is the cause of SSA?" as follows: "There is no one cause. No single genetic, hormonal, social, or environmental factor is predominant. There are similar themes, childhood gender nonconformity, sexual abuse, peer and family dynamics, sexual history, but the mix varies with individuals making individualistic responses the single overriding factor" (*My Genes Made Me Do It! Homosexuality and the scientific evidence* (Lower Hutt: Whitehead Associates, 2010), available at <http://www.mygenes.co.nz/MGMMDIInfo.htm>), pp. 271-272.

8 Hamilton & Henry, *Handbook*, p. xxi.

9 Evidence of increased medical, mental and relational health risks for those engaging in SSA behaviours compared with those who don't is significant and alarming. The risks include: *a myriad of medical problems and diseases directly related to homosexual practices; AIDS and STD's; substance abuse; suicidal ideation and attempts; psychological and psychiatric concerns, including depression, anxiety, paranoia, personality and eating disorders; and same-sex relationship violence* (see *What Research Shows: NARTH's Response to the APA Claims on Homosexuality* (Summary), available at <http://www.narth.com/docs/journalsummary.html>). Such risks must be borne in mind by those who oppose therapy for those with unwanted SSA—e.g. the Royal College of Psychiatrists (cf. [www.rcpsych.ac.uk/docs/RCPsychposstatementsexorienta.doc](http://www.rcpsych.ac.uk/docs/RCPsychposstatementsexorienta.doc)) and the British Medical Association (cf. "BMA meeting: Conversion therapy for homosexuals should not be funded by the NHS", *BMJ* 341 (2010), 3553).

Blair Whitehead explain that whatever may influence *any* and *all* of our human behaviours, including SSA, “Genes don’t make you do it. There is no genetic determinism, and genetic influence at most is minor. Individualistic reactions to random factors are very important...The fact is that nothing *makes* us do anything—neither our genes nor our environment” (emphasis in original).<sup>10</sup>

While those who promote the normalization of SSA may argue in public that people are ‘born that way,’ there is no scientific evidence to support the view that SSA is genetically or biologically predetermined. The few studies which have been mis-reported in the media as offering support for such predetermination either have been discredited or were not supported in subsequent, higher quality research.<sup>11</sup> Even the American Psychological Association has publicly declared that “there is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation...Many think that nature and nurture both play complex roles; most people experience little or no sense of choice about their sexual orientation.”<sup>12</sup>

Although genetic and biological factors do not predetermine the development of gender identity and/or SSA, they are not irrelevant. For example, Patton lists the following common personality traits observed when serving women who seek therapy for unwanted SSA:

Above average intelligence, strong sensitivity, creativity, analytic ability, curiosity, a strong sense of justice, and natural abilities and interests outside of stereotypical female interests and talents, such as being active or athletic.<sup>13</sup>

Both similarly and conversely, Nicolosi notes that “among SSA men we often see a temperament that is sensitive, emotional, relational and more aesthetically oriented than the gender-typical male.”<sup>14</sup> Nicolosi explains further that while this

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10 Whiteheads, *My Genes*, pp. 270, 271.

11 *Ibid.*, pp. 128-139, 150-157, 168-172, 174-206.

12 American Psychological Association, *What causes a person to have a particular sexual orientation? Answers to your questions: For a better understanding of sexual orientation and homosexuality* (Washington, DC: APA, 2008), available at <http://www.apa.org/topics/sexuality/orientation.aspx>; cf. A. Dean Byrd, “APA’s New Pamphlet on Homosexuality De-emphasizes the Biological Argument, Supports a Client’s Right to Self-Determination,” available at <http://www.narth.com/docs/deemphasizes.html>.

13 Mary Beth Patton, “Working with Lesbian and Bisexual Women”, in Hamilton and Henry, *Handbook*, p. 99; cf. Hallman, *Heart of Female SSA*, pp. 54-55.

14 Joseph Nicolosi, *Shame and Attachment Loss: The Practical Work of Reparative Therapy* (Downers Grove, IL: InterVarsity Press, 2009), p. 36.

“sensitivity is a great gift,” it also leaves boys “especially vulnerable to emotional injury.” In response to distressing, isolating experiences in their families and among peers, such gifts may allow “an easy escape from reality,” perhaps “into a secret world of pretense and make-believe” in which boys may feel safe(r) and over which they experience (more) control.

Similarities, differences, and complementarities in temperament between a child and his or her own parents as an infant and toddler, and with siblings and peers as the child grows, may *predispose* to but do not *predetermine* the later development of SSA. Being, and/or perceiving and feeling oneself as, too ‘different’ from one’s same-sex parent, siblings and/or peers, and likewise too similar to—or vulnerable to being harmed by—those of the opposite sex, may predispose to the development of gender insecurity or gender inferiority, which in turn may predispose to SSA.

#### **IV. Certain early life experiences influence the development of gender identity, depending on how these influences are perceived and internalized<sup>15</sup>**

Experiences throughout one’s life influence the development of gender identity. Especially in one’s infancy and early childhood, one’s gender and identity is both ‘caught’ and ‘taught,’ as a result of how one perceives others living as gendered beings, how one is related to by others as a gendered being, how ‘good’ one evaluates living, now and in the future, as one’s biological sex, and how thoroughly one internalizes these ‘lessons’ and externalizes them, in one’s interactions first within and eventually outside of one’s family.

One’s self-identity, not only as a *human* being, but also as a *male* or *female* human being, is both ‘caught’ and ‘taught’. Personal and sexual identity is the result of both ‘seeing and hearing’, i.e. experiencing, often outside of conscious awareness, the ‘answers’ to a number of questions. These include:

Who am I? Is it *good* that I exist, that I *am*?

What *is* a boy or a girl?

*Am I* a boy or a girl? Is that *good*? *Am I good enough* as I am?

*How* do boys/girls act? How *am I* supposed to act?

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15 At the beginning of this section, and in light of those which follow, it is helpful to recall John Paul II’s discussion in his *Letter to Families* of those who appropriately are called *spiritual orphans*, or “orphans of living parents” (n. 14). The Holy Father emphasizes that in addition to spouses—and unwed parents—those “who end up paying...many dire consequences” as a result of sexual immorality include “the children [who are] deprived of a father or mother and condemned to be in fact *orphans of living parents*”. A great number of the consequences of having been spiritually orphaned “are hidden in the hearts of men and women like painful, fresh wounds” (John Paul II, *Letter to Families*, n. 14, emphasis in original).

*How well (good) do I act as a boy/girl?*

How does Mom treat Dad, and other boys or men—including my brothers? Compared with me? *Is it good?* What does that say about me and my goodness, especially as a ‘boy’ or ‘girl’?

How does Dad treat Mom, other girls or women—including his mother? His and my sisters? Compared with me? *Is it good?* What does that say about me and my goodness, especially as a ‘girl’ or ‘boy’?

In early childhood and through one’s transition to adulthood, one begins to more formally ask—or at least enact implicitly answered—questions about living as an adult: What does it mean to be a *male* or a *female* person, a man or a woman? What do men/women do? How do they act? How am I supposed to act when I grow up? What is my gender identity? Given that identity: How *may*—and *must*—any man or woman live so as to flourish? How *may*—and *will*—I live well as the man—or woman—that I am?<sup>16</sup> Answers to such questions profoundly influence one’s ability to flourish as the boy or girl, and later as the man or woman, the male or female person, that one is and becomes.

#### **V. Perceived disaffirmation from and other experiences with parents, siblings, peers and/or others *may predispose to, but do not predetermine, the development of SSA*<sup>17</sup>**

Whether one is a male or female child, one enters life needing to be loved.

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16 I am mindful here of Chapter 1 of *Veritatis splendor*, ns. 6-27, in which John Paul II analyzes the answer of Jesus to the question of the rich young man: “Teacher, what good must I do to have eternal life?” (Mt. 19:16).

17 The *Catechism of the Catholic Church* (n. 2357) states: “Homosexuality...has taken a great variety of forms through the centuries and in different cultures. Its psychological genesis remains largely unexplained.” I think that this statement may best be understood in light of the variety of unique personal experiences and apparent developmental pathways through which people come to experience same-sex attraction.

The declaration that the “psychological genesis” of homosexuality “remains largely unexplained” does not mean that the Church is unaware of psycho-social factors which possibly may contribute to its genesis. For example, in *Educational Guidance in Human Love*, when discussing the “duty” of parents and educators “to identify the factors which drive towards homosexuality,” the Sacred Congregation for Catholic Education advises discerning whether a given child or person’s development of homosexuality “is a question of *physiological or psychological factors*; if it be the result of a false education or of the lack of normal sexual evolution; if it comes from a contracted habit or from bad example (*The Human Person*, n. 8); or from other factors ...[causes involved may include] lack of affection, immaturity, obsessive impulses, seduction, social isolation and other types of frustration, depravity in dress, license in shows and publications.”

More deeply, “*the innate frailty of man and woman, the consequence of original sin...can run to the loss of the sense of God and of man and woman, and have its repercussions in the sphere*

Reflecting on the women with unwanted SSA whom she has served, Hallman remarks: “They were little girls at one point. They innocently looked up into the eyes of their mother and father longing for love, comfort, attention, hugs, patience and understanding. Many of their stories are not so different than many of ours.”<sup>18</sup>

Certain life experiences, including *intra-* as well as *inter-*personal influences and environments, commonly are associated with (i.e. appear to contribute to) the development of SSA in some persons.<sup>19</sup> A risk factor model is helpful for understanding the development of SSA. Such a model recognizes that certain experiences *may predispose* a person to develop a particular way of thinking, feeling or behaving, but *do not (pre-) determine* this development or compel a person to think, feel or act in this way.

Some of the risk factor experiences associated with SSA may occur early in life, indeed even during infancy and toddler-hood. Common risk factors associated with the development of SSA feelings and behaviours include: 1) Gender atypical temperament, abilities, interests and/or physical appearance 2) *Gender incongruity* or *distortion* associated with disruptions in one’s *intrapersonal* (i.e. internal) experience of masculinity or femininity 3) *Same-sex disaffiliation* associated with disruptions in *interpersonal* experience with older members and/or peers of one’s own sex, especially parents, siblings and classmates 4) *Opposite-sex relational wounds* associated with older members and/or peers of the opposite sex, including parents, siblings, etc. 5) *Sexual abuse* from members of the same or opposite sex 6) *Habits of gratification*, which—especially if they represent ways of compensating for intolerable, recurrent feelings—may become compulsions or addictions.

While each person who experiences SSA is unique, common *themes* or *issues* have been found in the life experiences of many who develop them. For example, Byrd explains that along with one’s biological ‘givens,’

gender, a sense of maleness or femaleness, emerges in the context of early relationships. What is clear is that the gender affirming processes begin early and are subject to derailing when not reinforced or valued by significant relationships, either [with] family or friends. And gender

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of sexuality (Cf. Rom. 1, 26-28; cf., per analogia, *The Human Person*, n. 9)” (*Educational Guidance*, n. 102, emphasis added).

18 Hallman, in Hamilton & Henry, *Handbook*, p. 138.

19 While many risk factors may be common among persons who experience SSA, typically many more persons with the same attributes and/or experiences *do not* develop them. Cf. Whiteheads, *My Genes*, p. 16, Chapters 10 & 11, pp. 26, 270-271.

non-conforming children are vulnerable to a number of difficulties, including those associated with homosexuality.<sup>20</sup>

Mettler, Horizonte and van den Aardweg conclude similarly that:

upon examining the psychological and psychiatric observations and research evidence of recent decades, there is a steadily growing consensus that same-sex attractions somehow spring from failed 'gender identification' ('gender nonconformity' and the like) during childhood and adolescence, due to imbalanced parent-child interactions and peer-group maladaptation.<sup>21</sup>

SSA are understood as arising from "feelings of inadequacy with respect to one's gender identity." In effect, SSA are "compensatory reactions to inferiority feelings with respect to one's masculinity or femininity."<sup>22</sup>

Reflecting on his experience of serving hundreds of men with unwanted SSA, Nicolosi likewise observes that certain patterns of experience are common among his clients. He describes two basic patterns: 1) *pre-gender* and 2) *post-gender* type homosexuality.<sup>23</sup> Using the constructs of psycho-dynamic theory, *pre-gender* SSA involves "a failure to negotiate the gender-identity [acquisition] phase of one-and-a half to three years old"<sup>24</sup> When this phase is negotiated successfully, a boy disidentifies with his mother and identifies securely with his father. When this effort is unsuccessful, several experiences commonly are observed. A boy may have experienced insufficient maternal nurturing, which leads to his being poorly attached to the mother. "Insecure attachment" commonly is associated with the development of a "self-deficit"—i.e. a lack of a clear sense of self. Such effects are magnified should there also be "a failure to bond

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20 Byrd, in Hamilton & Henry, *Handbook*, p. 60. Byrd's quote continues, reporting that "Dean Hamer, the self-identified gay researcher, [who was touted incorrectly by the popular press as having found 'the gay gene'] noted that gender nonconformity is the single most common observable factor associated with homosexuality and concluded that 'In fact, it may be the most consistent, well-documented, and significant finding in the entire field of sexual orientation research and perhaps in all human psychology'"(cf. D. Hamer and P. Copeland, *The Science of Desire* (New York: Simon and Schuster, 1994), p. 166).

21 Peter Mettler, Belo Horizonte and Gerard van den Aardweg, "Not Looking Away, Not Playing it Down: Why Homosexuality is a Concrete Hindrance for Ordination", *The Catholic Social Science Review* 15 (2010), 5.

22 Ibid.

23 Nicolosi, *Shame and Attachment Loss*, pp. 81-85.

24 Ibid., p. 82.

with the father.” A boy’s inability to perceive and experience his father as “salient and benevolent” commonly leads to a “gender-identity deficit.”<sup>25</sup>

Although the preceding explanations are the results of clinical experiences serving primarily male clients seeking to resolve unwanted SSA, similar observations may be made about female clients. For example, while realizing that each woman she meets is “wonderfully unique and special,” Hallman also has recognized “certain diagnostic and behavioral or personality patterns among women with SSA.” This experience has led her to describe four common ‘profiles’ which guide how she serves each woman. These profiles include the following: 1) *Empty, depressed, withdrawn and isolated* 2) *Tough, angry, sarcastic and barricaded* 3) *Energetic, caretaking, drama-oriented and never ‘home’* 4) *Pragmatic, perfectionistic, distant and smugly self-assured.*<sup>26</sup> Hallman emphasizes that the terms associated with each profile are intended to identify common “characteristics or traits that have most likely emerged out of a woman’s unique survival modes and defenses [i.e., self-defeating habits of self-protection], compensations or false selves.” While such characteristics “may highlight” some of a woman’s “true strengths and authentic inner conflict[s]...they are *not* descriptive of a woman’s truest and fullest God-given self.”<sup>27</sup>

Hallman explains further that while such profiles enable the therapist to understand and establish “appropriate treatment guidelines and goals...they are primarily descriptive in nature...[I]ndeed, many women *may* identify with one profile or another, but will most likely see parts of themselves in each of the other profiles as well.” Hallman views these profiles as overlapping and “perhaps better understood as various *personas* within each individual woman based on her salient needs and the therapeutic themes experienced at different stages of her process.” It is likely that the identified needs and suggested treatment approaches for each of the profiles “will benefit every woman in due time.”<sup>28</sup> Hallman reports that she is cautious about sharing such therapy-guiding profiles with clients, lest they experience confusion or a sense of being judged or unhelpfully *labeled*.

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25 Ibid., p. 81. In a chapter entitled “Putting the Pieces Together” in *Homosexuality and the Politics of Truth* (Grand Rapids, MI: Baker Books, 1996), Jeffrey Satinover describes “just one of the developmental pathways that can lead to homosexuality, though a common one” (p. 221). The pathway described shares many features with those described above by Byrd, van den Aardweg and Nicolosi. Satinover remarks further: “In reality, every person’s ‘road’ to sexual expression is individual, however many common lengths it may share with those of others” (p. 221).

26 Hallman, *Heart of Female SSA*, pp. 158-180.

27 Ibid., p. 159.

28 Ibid.

Women—and also men—with unwanted SSA who are public about practising religious faith and who accept the teaching that homosexual behavior is inconsistent with moral maturity and human flourishing<sup>29</sup> may experience additional difficulties. As Hallman writes:

Faith-based women struggling with same-sex attraction face some unique issues, such as profound shame, sense of condemnation, fear of sharing about their struggle with others, finding more support from the gay community than their church, and possibly a long string of relational breakups.<sup>30</sup>

While some may suffer from ‘condemnation’ by fellow church-goers, or their own parents or other family members, based on the latter’s misunderstanding of the genesis or nature of SSA (e.g. the belief that people choose to develop SSA or that ‘feeling’ SSA in itself is sinful), others may suffer from a ‘misguided mercy’ within the church—or their family—that accepts, perhaps even condones or celebrates, the practice of behaviours which place the practitioner at significant risk for physical, psychological, relational and spiritual harm.<sup>31</sup>

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29 A fair reading of Revelational, Natural Law, and clinical/scientific-based knowledge and wisdom on human sexuality demonstrate that virtuous sexuality (i.e. chastity, sexual purity or integrity) fosters physical, psychological, relational and spiritual health (i.e. human flourishing) while age inappropriate sexual immaturity and sexual vice impede it.

30 Hallman, in Hamilton and Henry, *Handbook*, p. 139.

31 All human beings deserve to be treated with love, i.e. *caritas*. In service of both charity and truth, Catholic teaching makes a clear, fundamental distinction “between the homosexual condition or tendency and individual homosexual actions” (Congregation for the Doctrine of the Faith, *Pastoral Care of Homosexual Persons*, n. 3). On the one hand, as the *Catechism of the Catholic Church* teaches, Catholic tradition, based on Sacred Scripture, has always declared that “homosexual acts are intrinsically disordered” (here the Catechism is citing the CDF document *Declaration on Certain Questions Concerning Sexual Ethics* (December 29, 1975, n. 8). The Catechism notes that such acts “are contrary to the natural law. They close the sexual act to the gift of life. They do not proceed from a genuine affective and sexual complementarity. Under no circumstances can they be approved” (CCC n. 2357).

On the other hand, “[a]lthough the particular inclination of the homosexual person is not a sin, it is a more or less strong tendency ordered toward an intrinsic moral evil; and thus the inclination itself must be seen as an objective disorder” (Pastoral Care, n. 3; cf. CCC n. 2358). Like all persons, however they may be tempted to or actually behave, “men and women who have deep-seated homosexual tendencies...must be accepted with respect, compassion, and sensitivity. Every sign of unjust discrimination in their regard should be avoided” (CCC n. 2358).

Accepting persons with homosexual tendencies or behaviours does not mean condoning or excusing homosexual actions. While recognizing the “trial” which “deep-seated homosexual tendencies” may be for those who experience them (CCC n. 2358), “the Church’s wise moral tradition...[also] warns against generalizations in judging individual cases” (*Pastoral Care of Homosexual Persons*, n. 11). While recognizing that in specific instances for specific

## VI. Same-sex attractions have meaning beyond the simple desire for sexual gratification

SSA offer ‘hints’ about possible needs for emotional resolution and healing, forgiveness, interpersonal reconciliation, and growth in human and gender maturity. In general, the presence of SSA suggests the need for working on further *intrapersonal* and *interpersonal* development. This ‘un’-done work may include: unmet *needs*, unhealed *hurts*, unresolved *feelings*, unrealized *growth and maturation*, unreconciled *relationships*, unclear *boundaries*, unrealistic *hopes, fears and expectations*, an unfulfilling—and inauthentic—*self image/identity*, and unmanaged *co-occurring* (co-morbid) *difficulties*.

The categories of this undone work are overlapping. For example, unmet developmental needs and unfortunate experiences with members of one’s family of origin and/or peers would leave someone with unprocessed feelings, the need for grieving, and the challenges of growing up. Behaviours and habits of homosexual gratification, as well as many co-occurring difficulties and disorders, may be *preexisting, coexisting with and/or consequential* to the development of SSA. For some persons, these co-occurring difficulties may have developed as ways of attempting to compensate or substitute for, numb, or otherwise deal with other underlying issues, including SSA and the factors contributing to its development.

To illustrate some of the ‘un-done work’ which SSA may indicate, I offer some selected quotes from mental health professionals who have worked with persons with unwanted SSA (except where noted, emphases are added). As explained above, while the following statements may represent the life stories or challenges of some—perhaps many—persons who experience unwanted SSA, the statements may not apply to a given individual. Each person has his or her own unique story and immediate life challenges.

- Unmet *needs* and unrealized *growth and maturation*. These may include the need to experience—again or perhaps for the first time—genuine affirmation, i.e. unconditional love<sup>32</sup>; same and/or opposite sex attachment/affiliation and

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individuals, “circumstances may exist, or may have existed in the past, which would reduce or remove [or increase] the culpability of the individual,...[w]hat is at all costs to be avoided is the unfounded and demeaning assumption that the sexual behaviour of homosexual persons is always and totally compulsive and therefore inculpable. What is essential is that the fundamental liberty which characterizes the human person and gives him his dignity be recognized as belonging to the homosexual person as well. As in every conversion from evil, the abandonment of homosexual activity will require a profound collaboration of the individual with God’s liberating grace” (emphasis added).

32 The work of psychiatrist Conrad Baars (“The Homosexual’s Search for Happiness”, in Suzanne M. Baars and Bonnie N. Shayne (eds), *I Will Give Them a New Heart: Reflections on the Priesthood and the Renewal of the Church* (Staten Island, NY: The Society of St. Paul/Alba House, 2008)) on the universal human need for *affirmation* and the resolution of the effects

(dis-) identification; the development of genuinely affirming same and/or opposite sex relationships; and flourishing in one's innate masculinity (if a boy or man) or femininity (if a girl or woman).

Essentially, homosexuality is interpersonal both in its genesis and in its resolution. The attainment of *healthy, non-sexual, same-sex relationships* is a prerequisite to...begin the heterosexual journey toward wholeness...to the development of heterosexual attractions and subsequent heterosexual relationships...*allowing gender complementarity* to emerge and be nurtured and sustained.—Dean Byrd<sup>33</sup>

Homosexual desire is an obsessive *quest for masculinity, for belonging to manhood* (in the case of the lesbian woman, *for femininity, for belonging to womanhood*) and for male (or female) *affection, to compensate for inferiority feelings* regarding one's own gender.—Mettler, Horizonte, & van den Aardweg.<sup>34</sup>

At the heart of most female same-sex relationships is *an extremely deep emotional bond*...often more restrictive than fulfilling to each individual woman...referred to as fusion, merger and *emotional dependence*... [W]hen the pressure of relational need achieves maximum intensity, while at the same moment, a new woman comes along who is compassionate and empathetic or has other qualities worthy of admiration...a response of *emotional overattachment* [may be] triggered.—Janelle Hallman<sup>35</sup>

I see homosexual attraction and behavior as an attempt at “reparation” [or compensation]...attempting to “repair” normal, unmet *same-sex*

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of its absence offers insight for understanding the meaning of SSA. All human beings have the need to be “adequately affirmed during their developmental years by unselfishly loving, affectionate, mature parents and/or other significant persons.” When this happens, they have “received the gift of themselves” which enables them to “feel worthwhile, significant, and loveable.” Such persons: “know who they are. They are certain of their identity. They love themselves unselfishly. They are open to all that is good and find joy in the same...They find joy in being and doing for others. They find joy in their loving relationship with their Creator. They can share and give of themselves, be a true friend to others, and feel at ease with persons of both sexes” (p. 190). The experience of being un- or under-affirmed commonly leads to difficulties with the mature expression of sexuality, whether one's objects of attraction are heterosexual or homosexual.

33 Byrd, in Hamilton & Henry, *Handbook*, pp. 85-86.

34 Mettler, Horizonte, & van den Aardweg, 5.

35 Hallman, in Hamilton & Henry, *Handbook*, p. 149.

*affective needs* for “attention, affection and approval”, as well as *gender-identity deficits* through an erotic connection with another man. -Joe Nicolosi<sup>36</sup>

[A woman needs support] as she first addresses *her authentic dependency and attachment needs*...also...to progress through the stages of forming and solidifying a *sense of self*...to challenge core beliefs such as the assumption...she cannot exist without (her or) a special friend... to learn about and evaluate her *relational boundaries*...to constantly work on objectively naming and separating her emotional state from that of her friend...to *negotiate her own emotions* and distinguish between what she feels and what her friend is feeling...to experience her own set of emotions (and life) apart from what her friend is feeling or experiencing.—Hallman<sup>37</sup>

[A]ny of the factors which in very early life cause the innate predisposition to a heterosexual orientation to change to a homosexual one are at the same time detractors from or obstacles to *full affirmation*.<sup>38</sup> ...[U]naffirmed persons have one concern and need: to become affirmed, to be loved for *who they are* and not for *what they do*. *They are literally driven* to find someone who truly, unequivocally loves them...If affirmation by a significant other is not forthcoming, many unaffirmed persons will use their talents, intelligence and energy to try to convince themselves and the world in a variety of ways that they *are* worthwhile, important, and significant, even though they don't feel that they are. The most common ways of doing this are by the acquisition, display and use of material goods, wealth, power, fame, honor, status symbols, or sex. (bold emphasis in original)—Conrad Baars<sup>39</sup>

- Unresolved *feelings*, unhealed *hurts*, and unreconciled *relationships*: e.g. emotions or other feelings such as anxiety, depression, anger, sadness, sorrow, shame; the pain of rejection, abandonment, or not being good enough; past or present rejection by or estrangement from parents, other adults, siblings, peers, past or present ‘love objects’; and the need to forgive them, and

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36 Nicolosi, in Hamilton & Henry, *Handbook*, pp. 32-33.

37 Hallman, in Hamilton & Henry, *Handbook*, p. 150.

38 Baars, *New Heart*, p. 189.

39 *Ibid.*, p. 191.

perhaps reconcile with them—if possible and wise!<sup>40</sup>

[When there is] a lack of involvement by the father in the life of a son [who develops SSA]...a common pattern of reaction to *emotional pain* can be observed and identified. When a person is *hurt* in a relationship...first *sadness* develops, then *anger* accompanied by *low self-esteem*, and finally a *loss of trust*. It is essential to resolve the anger associated with all these types of betrayal pain...The approach that seems to be successful is to help the client face the *pain*, resolve the *betrayal anger* by working at understanding and forgiving his father and be healed of the *craving for father love*.—Fitzgibbons<sup>41</sup>

Homosexual acting-out is an attempt at *restoring [the person's] psychic equilibrium*. Through an erotic connection with another man, they unconsciously seek to *attain a self-state characterized by assertion, autonomy, and gender-relatedness*. But they have found that it eventually brings them none of these things—only a nagging feeling of *inauthenticity*, and still deeper *discouragement*.—Nicolosi<sup>42</sup>

What is central here is the notion of the homosexual's unconscious *self-pity*. The homosexual wish itself is embedded in this unconscious self-pity and *feelings of gender inferiority*...Secondly, by his *masculinity/femininity inferiority complex* or *gender inferiority complex*, the homosexual partly remains a 'child', a 'teenager'...Thirdly...specific parental attitudes and parent child relationships may predispose one to the development of a homosexual gender inferiority complex. Yet the *lack of same-sex group adaptation* weighs even more heavily as a predisposing factor...without denying the great importance of child-parent interactions, the final determining factor generally lies more, however in the adolescent's *self-image* in terms of gender, *as compared with same-sex peers*. (bold emphasis in original)—van den Aardweg<sup>43</sup>

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40 Robert Enright, *Forgiveness is a Choice* (Washington: APA, 2001), pp. 263-276; cf. Robert Enright and Richard Fitzgibbons, *Helping Clients Forgive* (Washington: APA, 2000); also Baars, "Anger and Forgiveness," in *New Heart*, pp. 215-246.

41 Rick Fitzgibbons, "The Origins and Therapy of Same-Sex Attractions Disorder", in Christopher Wolfe (ed.), *Homosexuality and American Public Life* (Dallas: Spence Publishing, 1999), p. 91.

42 Nicolosi, in Hamilton & Henry, *Handbook*, p. 33.

43 Gerard van den Aardweg, *The Battle for Normality: A Guide for (Self-) Therapy for Homosexuality* (San Francisco: Ignatius, 1997), pp. 19-20.

...the always present and commonly reported association between the individual's homosexual orientation and a *disturbance* of his or her *sense of worth and identity*...has both a causal and effectual relationship with the homosexual orientation and, when treated successfully, has a decidedly beneficial effect on the person's *capacity for happiness* even without a change in sexual orientation.<sup>44</sup> ...In the therapy of homosexual and heterosexual unaffirmed persons, the vicious circle of *feeling unloved—seeking/buying love—being frustrated—and feeling more unloved* is broken.—Baars<sup>45</sup>

*Expect and prepare for grief and depression* as [the client] lets go [and discovers] God's design for healthy intimacy...*cultivat[ing] multiple relationships with healthy limits* that are free and generous with ample give and take—Hallman<sup>46</sup>

- Unrealistic *hopes, fears and expectations* for self and others, and unfulfilling—and inauthentic—*self image/identity*: e.g. expecting self and/or others to be perfect/ideal or worthless/intolerable; not uncommonly experiencing a cyclic idolizing/idealizing, then demonizing of others to whom one is initially attracted; expecting the worst—e.g. rejection—and cooperating with its happening, in a self-fulfilling manner.

There are two ways by which unaffirmed people will try to obtain [**af-firmation**—namely unselfish, life-giving] love. First, by *always being “nice” and pleasing others*, by *never getting angry*, and by *never hurting other people's feelings*—in short by nonassertive behavior. Second, in sexual contacts using the mistaken notion that sex equals love. The more total the frustration of the fundamental need for affirmation, the greater the drive and the more *desperate* the *desire to bind another to oneself*... By and large, these sexual acts...represent a measure of the depth of a person's fundamental deprivation, since they indicate either the intensity of the *need to please* others...or the *fear of being rejected or considered “unmanly”* in the “gay” world. (bold emphasis in original)—Baars<sup>47</sup>

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44 Baars, *New Heart*, p. 194.

45 Ibid., p. 195.

46 Hallman, in Hamilton & Henry, *Handbook*, p. 150.

47 Baars, *New Heart*, p. 192.

Our clients do not come to us just to change their unwanted behavior. They come to us *to change their sense of self*—to **be** more heterosexual, and not just to “act” heterosexually; they want to feel comfortable in relationships with straight [i.e., non-homosexual] men, to learn to hold onto their masculine autonomy with women—in short, to *fulfill their latent heterosexual potential*. (bold emphasis in original)—Nicolosi<sup>48</sup>

*Fear of the opposite sex* is frequently...a symptom of *gender inferiority feelings*...[which] can be activated by members of the opposite sex, who are perceived as expecting sex roles the homosexual feels unable to perform.—van den Aardweg<sup>49</sup>

The homosexual impulse is also an attempt to *rediscover the free, expressive, open, powerful, gendered self* that each man was created to claim. The intent of the impulse is “reparative” in that its goal is *gender affirmation*; the man strives to be “seen” by other men as an attractive male.—Nicolosi<sup>50</sup>

[It is a] psychologically dangerous **decision** to identify oneself as a different species of man: ‘I **am** a homosexual.’...It may give a sense of relief after a period of struggle and worry, but at the same time it is defeatist...The self-identified homosexual takes on the [**tragic**] role of the definitive outsider...That role brings certain rewards...It makes one *feel at home among fellow homosexuals*. It temporarily takes away the tension of having to fight homosexual impulses, and yields the **emotional gratifications of feeling unique and tragic**—and of course of having sexual adventures...Real happiness, let alone inner peace, is never found that way. Restlessness will increase, as will the feeling of an inner void. Conscience will send out its disquieting and persistent signals. For it is a *false “self”* the unhappy person has identified with...Initially, it is a *seducing dream*; in time it turns out to be a *terrible illusion*...leading an unreal life, ever farther away from one’s real person [self]. (bold emphasis in original)—van den Aardweg.<sup>51</sup>

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48 Nicolosi, in Hamilton & Henry, *Handbook*, p. 28.

49 van den Aardweg, *Battle for Normality*, p. 20.

50 Nicolosi, in Hamilton & Henry, *Handbook*, p. 33.

51 van den Aardweg, *Battle for Normality*, p. 23.

- Unmanaged co-occurring *compulsions and addictions* (e.g. for sex, alcohol and other drugs, food, etc.) *as well as* disorders of mood (*anxiety, depression*) and *personality*. Gratifying SSA—as well as opposite sex attractions—may serve a ‘self-medicating’ purpose, allowing someone temporarily to numb or avoid experiencing one or more unwanted feeling states.<sup>52</sup>

Giving in to homosexual wishes [may] create a *sexual addiction*. Persons who have reached this stage have essentially two problems: their gender inferiority complex and a relatively autonomous sexual addiction.—van den Aardweg<sup>53</sup>

Increasing numbers of young people become involved in sexual experimentation and develop an addiction to same-sex activity.<sup>54</sup> ...Considering the number of sexual partners, dangerous behaviors, and other negative aspects typical of the homosexual lifestyle...[s]exual addiction may...be a major problem within the homosexual lifestyle.<sup>55</sup>—Fitzgibbons

The exhilaration of transgressive acts, the *brief, false vitality* our clients feel when engaging in sex with other men...is not satisfying for very long; in fact it is *compulsive, stereo-typic, and repetitive*.—Nicolosi<sup>56</sup>

This addictive way of relating [in which the female client] most likely medicated [powerful emotions] through her overattachments [must be addressed]...she has a *legitimate drive for relational connection and intimacy* [but she must learn to] relate to others in the limited doses that

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52 With addiction, “[t]he surfaces of body cells are chemically configured in such a way that they resemble a lock waiting for the right key to turn in it. The chemistry of certain drugs (whether produced within the body or consumed from without) is like the key that turns perfectly in the receptors of cells in certain organs of the body.” Their repeated presence and the cell’s reaction to them may become “a part of the cells’ life, creating a chemical dependency which the body feels as a need. If pleasurable sensations accompany the process and this “hooks” into some way into emotional relief, then an addictive cycle begins, minimal at the start but increasing in strength until it seems almost impossible to control.” This briefly describes what commonly happens when sexual addictions develop. “Is addictive behaviour an uncontrollable compulsion? Has the cell physiology made us do it? No, we helped it hundreds of times. But it’s possible to reverse the process and rediscover the old normalcy (or find a new one)” (Whiteheads, *My Genes*, p. 100).

53 van den Aardweg, *Battle for Normality*, p. 20.

54 Fitzgibbons, “Origins and Therapy of SSA,” in Wolfe, p. 90.

55 Ibid., p. 96.

56 Nicolosi, in Hamilton & Henry, *Handbook*, pp. 34-35.

they are able to offer. Her pattern of developing instant [emotional] intimacy must be broken and replaced with relationships—plural, not just one—that evolve over time.—Hallman<sup>57</sup>

Clients with unwanted SSA...who present to therapists, often have *co-occurring problems*...[A] score of mental health conditions are present in the general SSA population at rates three or more times greater than in the OSA [Opposite-Sex Attraction] population, involving almost every DSM [Diagnostic and Statistical Manual of Mental Disorders] category. These conditions include *bipolar*, *OCD* [Obsessive Compulsive Disorder] and *schizophrenia*, but are predominantly *mood disorders*, *depression*, *substance abuse and suicidality*...People reporting SSA have a more widespread and intense psychopathological burden than probably any other group of comparable size in society, though college-age people may have more substance abuse...Surveys in recent literature suggest objective discrimination is not to blame for suicidality, but *perceived* discrimination...[P]articular emotion/avoidant based coping mechanisms used by people reporting SSA almost entirely account for the effects of this perceived discrimination. (bold emphasis in original)—Neil Whitehead<sup>58</sup>

**VII. To be helpful, psychological care for unwanted homosexuality, like all psychological care for any presenting concern, must be given personally, one client at a time, to those who freely seek it**

Effective psychological care to any person for any presenting problem is an art, and requires a truly interpersonal, i.e. person to person, relationship focused on helping a client meet his or her realistic goals as he or she defines them. Mental health professionals wisely recognize and encourage their clients' individuality and their need, duty and right to make their own decisions. Serving clients as such begins with making possible the client's authentic *informed consent*.

As Hamilton and Henry write, obtaining informed consent from clients

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57 Hallman, in Hamilton & Henry, *Handbook*, p. 150.

58 Neil Whitehead, "Homosexuality and Co-Morbidities: Research and Therapeutic Implications," *Journal of Human Sexuality* 2 (2010), Abstract, 125; National Association for Research and Therapy of Homosexuality (NARTH) Scientific Advisory Committee, "What Research Shows: NARTH's Response to the American Psychological Association's (APA) Claims on Homosexuality," *Journal of Human Sexuality* 1 (2009), 31-76 [For a summary of JHS and the section on health risks, see <http://www.narth.com/docs/journalsummary.html>].

means explaining clearly the realistic possibility of change, including the limitations, and the often difficult process of therapy. Therapists should...present [clients] with realistic expectations: that change is not easy; that it is an ongoing process; and that, as with any issue, it often takes time [and]...that they may not experience change to the fullest degree that they desire.<sup>59</sup>

In order to ensure that clients not feel or “be forced or coerced into changing,” they “should be given full and accurate information” in order to “determine their own therapeutic goals.”<sup>60</sup>

Byrd comments that “describing one’s approach to psychological care” in general is inherently difficult. “Whatever the approach, it must [be] adapt[ed] to the particular patient” and his or her unique needs, concerns, and life circumstances.<sup>61</sup> Psychological care for unwanted SSA is no different.

Mary Beth Patton, who works exclusively with women, comments:

My client has the right to self-determination. As an adult I respect her ability to make decisions for herself. She [typically] has been wounded by the over-control of others and I want to be sure not to repeat that pattern. Collaboration is my goal. I am the expert on the big picture; she is the expert on herself...She needs to know and be assured that I am invested in her good. My goal is to delight in her as a person and in her uniqueness (not just in what she can [or cannot] do).<sup>62</sup>

Those who work primarily with men with unwanted SSA offer similar comments. As Byrd, a psychologist trained in interpersonal and cognitive behavioral therapy, notes:

In many ways, providing psychological care for men who present with unwanted homosexuality is not very different than dealing with other patient populations: the therapist begins where the patient is and demonstrates respect for patient autonomy, patient self-determination and diversity.<sup>63</sup>

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59 Hamilton and Henry, *Handbook*, pp. xxii-xxiii.

60 *Ibid.*, p. xxiv.

61 Byrd, in Hamilton & Henry, *Handbook*, p. 84.

62 Patton, in Hamilton & Henry, *Handbook*, pp. 91-92.

63 Byrd, Hamilton & Henry, *Handbook*, p. 84.

Respect for client diversity means not imposing treatment on clients, whether or not the treatment seems reasonable to the therapist.<sup>64</sup> Respect for client well-being and the ethical duty of beneficence and non-maleficence (doing good and avoiding harm) also require that therapists not yield to demands by clients for unreasonable treatment—i.e. for services which either are not beneficial or may be harmful. For example, contrary to political correctness, ‘diversity’ does not mean yielding to patient demands for hormonal treatment and sex change operations or the condoning or facilitating of medically dangerous homosexual behaviours. In countries where yielding to demands for such services is mandated by law or professional codes, the human dignity and well-being of both patients/clients and their medical and mental health professionals may warrant that the latter practise conscientious objection.<sup>65</sup>

### **VIII. Homosexuality is not innate, immutable or without significant risk to medical, psychological and relational health**

The American Psychological Association (APA) recently acknowledged that homosexuality is not ‘innate’; that psychological and social factors, as well as genetic and other biological factors (i.e. both nature and nurture) influence the development of homosexuality.<sup>66</sup> While the APA claims that there is insufficient empirical evidence to show that sexual orientation itself may be changed through therapy or other (e.g. pastoral) means, the APA does acknowledge that sexual behaviour, attraction and orientation identity are “fluid,” i.e., not fixed or immutable.<sup>67</sup> While the APA warns potential consumers that “sexual orientation change efforts” (SOCE) *may* be harmful, the 2009 *Report* also admits that “there

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64 Respecting and protecting patient rights to autonomy, self-determination and diversity is consistent with the Catholic understanding of healthcare. The *Charter for Health Care Workers* states that before being treated, “the patient should be asked for an *informed consent*” (emphasis in original). This means that before intervening, “the health care worker should have the express...consent of the patient,” which includes giving the patient a “precise idea of his illness and the therapeutic possibilities, with the risks, the problems and the consequences that they entail”. This enables the patient to make his or her choice of whether, when and how to be cared for “with full awareness and freedom” (Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers*, n. 72). On the other hand, clients may have a duty to seek reasonable help to discontinue self-injurious behaviours. “Every person also has the *responsibility of caring for him or herself*. This includes the duty to seek, understand and cooperate with any ‘ordinary’ and ‘proportionate’ course of treatment” (ns. 63-64, emphasis in original).

65 *Ibid.*, ns. 40-144.

66 APA, *Answers to your questions*, 2008.

67 American Psychological Association, *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (Washington, DC: APA, 2009), p. 14; cf. pp. 2, 63, 77 (available at <http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>).

are no scientifically rigorous studies of recent SOCE” which support the APA’s concern.<sup>68</sup>

In a proactive response published several months *before* the anticipated 2009 APA *Report*, the National Association for Research and Therapy of Homosexuality (NARTH) reviewed over a century of experiential evidence, clinical reports, and research literature. NARTH’s own report, *What Research Shows (WRS)*, documents that it is possible for both men and women to change from homosexuality to heterosexuality; that efforts to change are not generally harmful; and that homosexual men and women do indeed have greater risk factors for medical, psychological and relational pathology than do the general population.<sup>69</sup>

A decade before *WRS* was published, Jones and Yarhouse<sup>70</sup> reviewed the historical and then more recent evidence for intentional change in unwanted homosexuality and concluded the following:

1. In light of reports of successful change...the position that homosexuality is unchangeable seems questionable.<sup>71</sup>
2. Definitions of [successful change] vary across studies. Positive outcome has been defined in the following ways: reduced preoccupation with homosexual thoughts, reduced homosexual activity, reduced anxiety about heterosexual functioning, increased heterosexual activity, increased heterosexual fantasy, celibacy, heterosexual marriage and reports of sexual orientation from homosexual to heterosexual.<sup>72</sup>
3. Complete alteration of sexual orientation to replace homosexual with heterosexual erotic orientation...may well be impossible for some by any natural means. Yet the position that homosexuality is unchangeable seems questionable in light of [the nature and number of] past reports of successful change.<sup>73</sup>

Jones and Yarhouse’s conclusions and their cautions about the possibility, na-

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68 Ibid., p. 83.

69 NARTH, “What Research Shows”, pp. 1-128.

70 Stanton Jones and Mark Yarhouse, *Homosexuality: The Use of Scientific Research in the Church’s Moral Debate* (Downers Grove, Illinois: InterVarsity Press, 2000).

71 Ibid., p. 148.

72 Ibid., p. 151.

73 Ibid., p. 148. Jones and Yarhouse comment further: “Even the most optimistic empirically grounded spokespersons for ‘complete change of sexual orientation’ by psychological means say that [such] change is most likely when motivation is strong, when there is a history of successful heterosexual functioning, when gender identity issues are not present, and when involvement in actual homosexual practice has been minimal”, p. 148.

ture and extent of change have been supported by more recent studies which are documented in WRS.<sup>74</sup> As mentioned above, even the American Psychological Association acknowledges the diversity and “fluidity”—i.e. changeability—of homosexual “*sexual behavior, sexual attraction, and sexual orientation identity*” (emphasis added).<sup>75</sup>

In a chapter entitled “Can sexual orientation change?”<sup>76</sup> the Whiteheads review the clinical and research literature on both *assisted* (i.e. professionally or pastorally facilitated) and unassisted or *spontaneous* change in sexual orientation. They note that spontaneous change occurs in both directions (i.e. from homosexual to heterosexual, and also vice versa).<sup>77</sup> Overall, “homosexuality is much more fluid than heterosexuality,” especially among adult women, but also for adult men.<sup>78</sup> This is even more true for adolescents. For example, among teenagers “in the 16 to 17 year age group, 98% will move from homosexuality and bisexuality towards heterosexuality.” And, “16-year olds who claim they are opposite sex attracted will overwhelmingly remain that way.”<sup>79</sup> In answer to the question posed by the chapter heading, the Whiteheads summarize:

There is abundant documentation that people with SSA do move toward a heterosexual orientation, often with therapeutic assistance, but mostly without it. Some achieve great change, some less, but it is clear that sexual orientation is fluid, not fixed...There seems a good possibility that various degrees of change may happen with the right support including therapy of various kinds.<sup>80</sup>

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74 A. Dean Byrd and Joseph Nicolosi, “A meta-analytic review of treatment of homosexuality”, *Psychological Reports* 90 (2002), 1139–1152; A. Dean Byrd, Joseph Nicolosi and Richard Potts, “Clients’ perceptions of how reorientation therapy and self-help can promote changes in sexual orientation”, *Psychological Reports* 102 (2008), 3–28; Stanton Jones and Mark Yarhouse, *Ex-gays? A Longitudinal Study of Religiously Mediated Change in Sexual Orientation* (Downers Grove, Illinois: InterVarsity Press, 2007); *Ex Gays? An Extended Longitudinal Study of Attempted Religiously Mediated Change in Sexual Orientation* (available at <http://www.narth.com/docs/Symposium.pdf>); Elan Karten and Jay Wade, “Sexual orientation change efforts in men: A client perspective”, *The Journal of Men’s Studies* 18 (2010), 84–102; Robert Spitzer, “Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation,” *Archives of Sexual Behavior* 32 (2003), 403–417.

75 APA, *Task Force Report*, p.14; cf. pp. 2, 63, 77.

76 *My Genes*, pp. 224–263.

77 *Ibid.*, pp. 224–231.

78 *Ibid.*, p. 228; cf. pp. 224–225.

79 *Ibid.*, p. 265; cf. pp. 231–235.

80 *Ibid.*, p. 259. The Whiteheads end this paragraph with a caution: “The problem in the present

## Who Am I

The following statement is a fitting summary of the psychological issues associated with gender identity, genuine needs for loving and being loved wisely, and the hopeful possibilities which psychological and pastoral care may afford those who experience unwanted SSA. In the statement, Hallman expresses her intention to serve the overall well-being of her female clients by supporting the understanding, healing, growth and maturity of every dimension of their lives, one client at a time.

My ultimate goal as a therapist with a woman in conflict with SSA is to provide an environment in which she can *apprehend her true identity as a feminine being* and develop a *stability* as she walks through the ebbs and flows of *intimacy within her same and opposite-sex relationships*. I want to help her reach a place of *security in her own sense of self and within a broader healing community* so she no longer lives out of a desperate grasping for security outside of herself and God. I want to invite her into a *radical self-love and self-acceptance* that frees her to live an other-centered life rather than a life consumed by desperation. If she operates from a spiritual perspective, I delight in leading her to *the Truest Lover of her soul* and supporting her as she *recognizes her life's ultimate purpose and meaning*. I long to bless her with *existence, attachment, love, friendship, fellowship*, and an *enduring and experiential knowledge that she is the beloved*, just as she is.<sup>81</sup> (emphasis added)

Many of Hallman's observations about serving women are relevant to serving men as well. Similar ideas are expressed in *Growth Into Manhood: Resuming the Journey*, written by Alan Medinger, founder of Regeneration, a gender-affirming ministry. Medinger explains that all men—not just men with SSA—need to discover their manhood as something they learn to give to others. “We grow as men when we see our manhood as something we desire [not only for our own sakes, but also] for the sake of others. When we desire manhood so that we can protect and defend, help and serve, provide safety and security for others, we will grow into men.” Men develop their manhood through “the practice of helping, protecting and serving” others.<sup>82</sup>

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hostile social climate may be finding such support” (cf. pp. 241-246).

81 Hallman, *Heart of Female SSA*, pp. 34-35.

82 Alan Medinger, *Growth Into Manhood: Resuming the Journey* (Colorado Springs, CO: Waterbrook, 2000), p. 223.

Medinger offers an example of a man—and a woman—with SSA who grow into more mature manhood (and womanhood). He describes a scene from *And the Band Played On* written by gay author Randy Shilts:

A homosexual man, mild and passive in nature, comes down with AIDS. The person who takes care of him in his final months is a bold, aggressive lesbian woman. The two are close friends; in fact you can soon see that they genuinely love each other. As the man becomes increasingly sick, his tough lesbian friend becomes more and more tender and fragile. Her strength seems to fade away as her love for the dying man cuts deeper into her heart. For his part, the more vulnerable she becomes, the more the man desires to protect her. Wanting to shelter her fragile heart, he grows stronger and stronger. What Randy Shilts was describing was the forming of a man and a woman.<sup>83</sup>

While the preceding quote is *not* an example of intended *therapeutic* change, it does illustrate the power and the possibility for change that genuine human caring may offer those who need, want and seek it. For those who do wish to explore the option of psychological care to help resolve unwanted homosexual attraction, behaviour and/or identity, there are a variety of approaches which offer such care, pastoral as well as therapeutic.<sup>84</sup>

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83 Ibid.

84 Hamilton & Henry, p. xxiv; cf. Jones & Yarhouse, *Homosexuality: Use of Scientific Research; Ex-Gays?; NARTH, What Research Shows.*

In *New Vocations for a New Europe*, the Pontifical Work for Ecclesiastical Vocations offers parallel guidelines for assisting persons in their growth in affective maturity, which includes sexual self-control and the resolution of same-sex attractions. *New Vocations* emphasizes that there are two experiential certainties which make a person *affectively free* and *mature* enough to choose, live and love well in their state in life: first, the certainty of *having already been loved*, and second, the certainty of *knowing how to love*. Coming to these certainties may require that a person be *'reconciled'* with difficulties with significant persons or events from the past. One of the means and ends of this process involves the realistic recognition that one's difficult past life was a *grace*, not just a trial, and is a reason for present *gratitude*, as well as *lament*.

Other Church documents likewise offer hope to those who seek professional, as well as pastoral, care for dealing with unwanted same-sex attraction. In *Educational Guidance in Human Love*, the Sacred Congregation for Catholic Education instructs pastoral caregivers to receive persons with homosexual difficulties "with understanding" and to offer them support "in the hope of overcoming their personal difficulties and their social mal-adaption." Also, with "the causes having been sought and understood, the family and the teacher will offer an efficacious help in the process of integral growth: welcoming with understanding, creating a climate of hope, encouraging the emancipation of the individual and his or her growth in self control, promoting an authentic moral force towards conversion to the love of God and

Psychiatrist Rick Fitzgibbons offers encouragement, wisdom and ‘hope’ to youth and adults with unwanted SSA—and their loved ones.

We know how to identify the origins of same-sex attractions and behaviors. We have treatment for weak masculine and feminine identity, for mistrust of those of the opposite sex, for betrayal anger, for sexual addiction, and for other conflicts associated with same-sex attraction disorder. Yet [there may be] little meaningful healing without the use of spirituality. If we combine spirituality and good psychotherapy, as in the treatment of alcoholism, we can expect resolution and healing for those who struggle with same-sex attractions and behaviors.<sup>85</sup>

Using appropriate psychological and—if timely—spiritual aids also may help clients to achieve satisfactory, i.e. mutually affirming and non-erotic, relationships with other men and/or women as realistic means and ends *in*, as well as *of*, therapy.<sup>86</sup>

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*neighbour, suggesting—if necessary—medical-psychological assistance from persons attentive to and respectful of the teaching of the Church”* (n. 103, emphasis added).

And in *The Truth and Meaning of Human Sexuality*, the Pontifical Council for the Family, in addition to stressing the importance of accepting all persons with homosexual attractions “with respect, dignity and delicacy” and avoiding “all forms of unjust discrimination” toward them, advises that “*Especially when the practice of homosexual acts has not become a habit, many cases can benefit from appropriate therapy...If parents notice the appearance of this tendency or of related behavior in their children, during childhood or adolescence, they should seek help from expert qualified persons in order to obtain all possible assistance*” (n. 104, emphasis added).

85 Fitzgibbons, “Origins and Therapy of SSA,” in Wolfe, p. 97.

86 Satinover (*Homosexuality and the Politics of Truth*) concludes his chapter on “Putting the Pieces Together” as follows: “If [a man] enter the path to healing, he will find that the road is long and difficult—but extraordinarily fulfilling...From the secular therapies he will come to understand what the true nature of his longings are (sic), that they are not really about sex, and that he is not really defined by his sexual appetites...From communities of faith that turn to him in understanding, offering not only moral guidance but genuine healing, he will gain much in addition. Most importantly, the love he sought so vainly when young and finally turned away from he will find in the arms of a loving God...[T]he presence of this love makes it possible to lay those old defenses down and face fearlessly the wounds that have inflicted so much pain and distorted so much of his life over so many years...Of course, the old wounds will not simply disappear, and later in times of great distress the old paths of escape will beckon. ...In time, knowing that they really have little to do with sex, he will even come to respect and put to good use what faint stirrings remain of the old urges. They will be for him a kind of... signal...that some old pattern of longing and rejection and defense is being activated. And he will find that no sooner does he set his house in order than indeed the old urges once again abate...If he is fortunate enough to be able to place all of this in the context of faith, then he will find that he has traveled far along the ancient pathway toward sanctification...On this road he will always have as his companion the Great Companion” (pp. 227-228).

## IX. Concluding remarks

Each of the topics addressed in this book is informed by two sadly—and, for some, tragically—disputed truths. As evidenced by empirical science and natural philosophy, as well as Judeo-Christian Revelation (Genesis 1:27), at the first moment of their existence (i.e. conception), human beings are not only ‘human’ but also either ‘male’ or ‘female’.<sup>87</sup> Likewise sadly disputed, yet similarly well-attested, is the fact that human sexuality is intended for *both* procreation and unity within a permanent (“as long as we both shall live”), faithful and fruitful relationship (i.e. covenant) between one man and one woman and that children have a right to be conceived, born and educated (i.e. raised to maturity) as the fruit of their biological parents’ conjugal (integrally unitive and procreative marital) love.

While I am a psychotherapist, trained in clinical psychology and marriage and family therapy, this paper was not intended to and does not offer detailed suggestions for *how* to help people choose to act or live differently. Perhaps it may help readers better understand some of the psychological issues experienced by those tempted to gratify SSA or opposite sex attractions (OSA) in unchaste ways, who can be motivated to grow in celibate chastity and in chaste opposite sex attractions and behaviour, leading for some to marriage and ‘responsible parenthood’. The pragmatics of influencing and assisting people to make right or better choices, whether through therapeutic, pastoral, or other modes of education, has not been my main concern here: others have written elsewhere about the ethics, nature and efficacy of psychological—and pastoral—care for unwanted SSA.<sup>88</sup>

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87 A distinction between *transsexualism* and the *intersex* conditions is warranted. *Transsexuals* are persons born with an otherwise normal male or female body who claim, nevertheless to *be*, i.e. to have the ‘brain sex’ of, their non-biological sex. Persons with one of the *intersex* conditions have been “born with sex that is not considered standard for either male or female” (*Gender Recognition: A guide to the Gender Recognition Act (UK)* (London: The Evangelical Alliance and Parakleo Ministry, 2006), p. 21). Without denying the real difficulties which persons with transsexuality or one of the intersex conditions may have trying to live according to their conceived/birth sex, recognition of the truth that one has been ‘created male or female’ and attempting to live by that ‘fact’ of one’s existence is fundamental for human flourishing, even when one is distressed or otherwise not ready or willing to do so psychologically/ behaviorally, or one’s atypical chromosomes, external genitalia, or internal reproductive system make this difficult. See the discussion of the research on persons with intersex conditions, and the relationship between the gender identity with which they were raised and the gender identity they chose when offered the opportunity in Whitehead & Whitehead (*My Genes*, pp. 103-114).

88 A. Dean Byrd, *Treatment of Male Homosexuality: A Cognitive-Behavioral and Interpersonal Approach*, <http://www.narth.com/docs/byrd.html>; William Consiglio, *Homosexual No More: Practical Strategies for Christians Overcoming Homosexuality* (Baltimore, MD: Regeneration Books, 2000); Hallman, *Heart of Female SSA*; Hamilton & Henry, *Handbook*; Jones & Yarhouse, *Homosexuality: Use of Scientific Research; Ex-Gays?*; Alan Medinger, *Growth Into*

Yet I think that understanding the psychological issues, i.e. the risk factors and bio-psycho-social realities that those who experience unwanted SSA may face, may also be helpful for understanding how men, women and children may be more vulnerable to ethically wrong life choices in other issues concerning human fertility and sexual union. I think that the difficulties commonly faced by many persons who experience SSA are similar to those faced by people tempted to exceed any of the limits of what is beneficially possible (i.e. ethical) concerning human procreation and other aspects of sexual coupling.<sup>89</sup>

In closing, I am mindful of some of the basic questions which are answered and lived out in some way by each person inevitably, but perhaps unreflectively. What does it mean to be a (male or female) human being? Is it good to be a (male or female) human being? What is the place of mothering—and fathering—in biological, as well as spiritual parenting, in the lives of children and the adults responsible for their procreation—and education? How necessary are permanence, fidelity and fecundity to the relationship in which one experiences sexual gratification? Such questions impact, and are impacted by, the gender identity that all persons come to develop, always implicitly, but often explicitly, both as a factor in and consequence of developing SSA.

It may be helpful for anyone who aspires to love in truth (Eph. 4:15) him- or her- self, or others who experience same-sex attractions, to recall a clear and authoritative teaching of the Catholic Church. The Congregation for the Doctrine of the Faith in *On the Pastoral Care of Homosexual Persons* teaches that:

A homosexual person, as every human being, deeply needs to be nourished at many different levels simultaneously...The human person, made in the image and likeness of God, can hardly be adequately described

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*Manhood: Resuming the Journey*; Nicolosi, *Shame and Attachment Loss*; Leanne Payne, *The Broken Image: Restoring Personal Wholeness Through Healing Prayer* (Westchester, IL: Crossway Books, 1981); van den Aardweg, *Battle for Normality*.

89 In the mission statement read at the beginning of each Courage group meeting which I lead, there appears the following: “*Scripture and Catholic Tradition teach that sexual activity is intended only for a man and a woman within the covenant of permanent, faithful marriage. All unchaste behavior is wrong, including fornication, contraception, adultery, masturbation, pornography and homosexual behavior. We live in a culture which accepts and encourages any kind of sexual activity. Our secular culture promotes the belief that homosexual activity is natural and good for those who experience same sex attractions. So it is not surprising when Catholic men and women who do experience same sex attractions also feel confusion and isolation when they try to remain faithful to the Church’s teaching on chastity.*” While there is no intent to offend, it is recognized that whoever rejects Natural Law and Revealed truths about human sexuality and procreation, including *magisterium*-faithful teaching concerning homosexuality, may take offense at the explicit mention of and support for Natural Law and Divine Revelation, whether at a meeting or elsewhere.

by a reductionist reference to his or her sexual orientation. Every one living on the face of the earth has personal problems and difficulties, but challenges to growth, strengths, talents, and gifts as well. Today, the Church provides a badly needed context for the care of the human person when she refuses to consider the person as a “heterosexual” or a “homosexual” and insists that every person has a fundamental identity: the creature of God, and by grace, his child and heir to eternal life.<sup>90</sup>

This reminder of the created goodness and intrinsic personhood, dignity and worth of those who experience SSA serves as a fitting ending. While there appear to be common experiences and gender identity issues shared by some, sometimes many, persons who experience SSA, finally each person has his or her own story, which warrants respectful and compassionate attention, understanding and care. As Benedict XVI exhorts: “I invite everyone to look into the face of the other and to see that he [or she] has a soul, a story and a life: He [or she] is a person and God loves him [or her] as He loves me.”<sup>91</sup> Whether one is a therapist, pastor or civil servant, someone with or without unwanted SSA, one should heed this invitation to attempt to understand and honor the “soul, story, and life” of each man or woman one encounters.

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90 Congregation for the Doctrine of the Faith (1986), *Letter to the Bishops of the Catholic Church on the Pastoral Care of Homosexual Persons*, n. 16. It is helpful to place this quote in the context of an earlier passage from the document. “[T]he Catholic moral perspective...finds support in the more secure findings of the natural sciences, which have their own legitimate and proper methodology and field of inquiry. However, the Catholic moral viewpoint is founded on human reason illumined by faith and is consciously motivated by the desire to do the will of God our Father. The Church is thus in a position to learn from scientific discovery but also to transcend the horizons of science and to be confident that her more global vision does greater justice to the rich reality of the human person in his spiritual and physical dimensions, created by God and heir, by grace, to eternal life” (n. 2).

91 Benedict XVI (10 JAN, 2010) Angelus address, available at [http://www.vatican.va/holy\\_father/benedict\\_xvi/angelus/2010/documents/hf\\_ben-xvi\\_ang\\_20100110\\_battesimo\\_en.html](http://www.vatican.va/holy_father/benedict_xvi/angelus/2010/documents/hf_ben-xvi_ang_20100110_battesimo_en.html).