NARTH BULLETIN

Vol. 14, No. 1 | National Association for Research and Therapy of Homosexuality (N.A.R.T.H.) | Spring 2006

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Ethical Treatment For People Who Present With Unwanted Homoerotic Attractions

Guidelines For Therapists

By Michael S. Buxton, Ph.D., MFT
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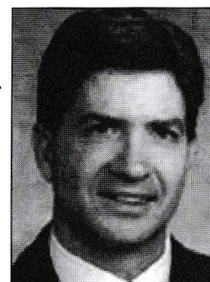
Many people in therapy who have homosexual feelings are in the initial stages of exploring the meaning of these attractions with people they trust.

They wonder what the future holds for them, and if marriage and family can be a reality. They wonder about their place in society—among peers, family, and various communities of people in which they are involved. Some are questioning their faith and values, and wonder how society will respond to them.

A consistent hope for some of these people is that same-sex attractions (SSA) can be reduced or eliminated, and that joyful heterosexual functioning can emerge. These clients tend to look especially to their therapists for assistance, partly because no one else seems to understand the issues involved or exactly how to help. It is an issue that many people, increasingly more publicly, have opinions about, but to which almost no one seems to know how to respond.

This paper is an effort to explore issues related to ethical, therapeutic treatment. Ethical and therapeutic treatment concerns the manner in which a person is treated by the therapist so as to promote trust, mental health, and personal development. At the heart of ethical considerations is how to reduce or eliminate harm, and promote health. Based on available research and clinical stories, I have categorized potential ethical dilemmas and biases of three varieties of therapists—


Michael S. Buxton Ph.D., MFT

1) those who help clients with their goals to reduce SSA and where possible, increase heterosexual attraction

2) theoretically non-committed therapists whose beliefs might not agree with aspects of GLB identity or behavior, yet remain skeptical about change, and

3) GLB advocating or affirming therapists whose goal is to assist clients in accepting a GLB identity. My hope is that the issues raised here will spark discussion and deeper pondering of personal bias, so that ethical practices can improve and clients' needs can be met. Although I offer my opinions and biases throughout, the reader is invited to respond to the issues involved. The

(Continued on page 2)

guidelines used to assess ethics and harm are taken from the Code of Ethics for the American Association for Marriage and Family Therapy (2001) and the American Psychological Association (2002).

Ethical Dilemmas And Biases Among Three Types Of Therapists

Category One: Therapists who undertake to assist clients to reduce SSA and promote heterosexual functioning.

It is valuable to understand what may constitute harm from the experience of therapists and men and women who have undergone therapy in an attempt to develop stronger heterosexual attractions. The following problems are cautions to therapists, based on the work of Beckstead (2001), Haldeman (2002), and Shildo and Schroeder (2002).

Therapists who undertake to assist clients to reduce SSA and promote heterosexual functioning may tend to *err* in the following ways, and should consider the ethics involved. These therapists may: **Over-promote heterosexual potential** and over-induce a client to believe that change is possible in every case. Therapists may be guilty of presenting unrealistic goal expectations, and work beyond the client's capacity to incorporate different attitudes and directives. A therapist who does this may be guilty of AAMFT ethics code 1.7, "MFT's do not use their professional relationships with clients to further their own interests." A therapist who presses too hard may neglect to consider co-morbid diagnoses that may constrain changes in sexual development.

Tie personal worth, salvation, or social role viability to heterosexual functioning. Clients of faith have typically thought through the implications of having SSA many times over, and are usually worried and may feel discouraged about not having stronger heterosexual feelings. Such a client may be experiencing a crisis of faith. A therapist may imply "wrongfulness" of homosexuality by his or her approach in a way that the client may internalize that message, believing he is condemned or less socially viable.

Vulnerable clients, at the beginning of therapy, have difficulty distinguishing between self-worth and their homosexual feelings, thoughts, and actions. Too strong of an approach at this phase may confuse a client unnecessarily. Time may be necessary to form a therapeutic alliance, in which the client is assured that her self-worth is not tied to either homosexuality or the direction she may take with these attractions. A strong therapist agenda may preempt a client from feeling safe to contemplate "out-loud," discrepancies in his or her own values, thoughts, and goals.

Prematurely attempt to end clients' ambivalence about their condition, by rushing to goal-setting toward increasing heterosexual feeling. Some clients are past a contemplative stage—they want to work toward greater integration within a GLB framework; others, and perhaps the majority of clients who present for therapy with NARTH members, want to work toward heterosexual functioning. A significant number are pre-contemplative or in contemplation. A therapist who has strong values about heterosexuality may prematurely try to persuade the client into goal setting and action before he or she is ready. Such a client may naively trust the therapist, but not have the emotional or mental solidarity to accomplish what the therapist is asking. This client is likely to feel like a failure and that change is impossible for him.

Unintentionally create a dependent or conditional therapeutic relationship with the client, which can border on exploitation. As clients increase trust in the therapist (who is sometimes perceived as a last

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THE NARTH BULLETIN

Editor: FRANK YORK

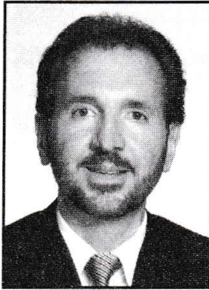
Publications Director: Linda Ames Nicolosi

The *NARTH Bulletin* is published three times yearly by the National Association for Research & Therapy of Homosexuality, a non-profit educational association. For information contact NARTH,

"Victory on the Bow of a Ship"

A Note From The President

The Conference Papers from our 2005 conference are available for purchase on our web site. Included in this 190-page document is an article by Dr. Jeffrey Satinover titled, "The Trojan Couch: How the Mental Health Guilds Allow Medical Diagnostics, Scientific Research and Jurisprudence to be Subverted in Lockstep with the Political Aims of their Gay Sub-Com-ponents."


Joseph Nicolosi, Ph.D.

In this stunning indictment, Dr. Satinover carefully documents how gay activist organizations have misquoted and misused studies to promote their political agenda in our courts. Satinover shows how judges are issuing rulings on public policy issues involving sexual orientation based upon misinformation and outright inaccurate use of studies.

As Dr. Satinover observes: "The APA and others have so often repeated ... falsehoods that the public and even the Supreme Court now take for granted that science has demonstrated that homosexuality is a perfectly normal variant of human sexuality if it is fixed early in life and does not change: that it is a matter of 'orientation' or 'identity.'"

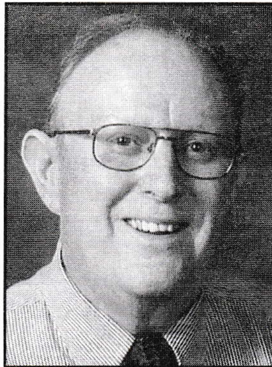
Dr. Satinover's critique shows how compromised the mental health field is to political correctness. Don't miss this excellent study.

Clinical/Therapeutic

Important New Survey Of Psychologists' Attitudes On Homosexuality

By Edward ("Ned") Stringham, Ph.D.

In late 2005, *Psychotherapy: Theory, Research, Practice and Training,* published a survey of 437 APA psychologists. They were asked a series of fifteen closed-ended questions about their perspectives of homosexuality, gay-affirmative therapy, and "aversive" treatments for homosexuality.


Edward Stringham, Ph.D.

This survey was similar to one that was administered to 139 APA psychologists ten years earlier (Jordan & Deluty, 1995).

A comparison of the two studies' results provides vital information for NARTH members who hope to influence the mental health profession to become more accepting of NARTH's positions including the right to provide reparative therapy to those with unwanted Same-Sex Attractions (SSA).

The study's authors give evidence that their research design is sound. The survey was mailed to 1,000 randomly selected psychologists (500 male and 500 female) with the authors reporting a robust return rate of 43.7%. A review of the respondents indicates no significant demographic differences from the general sample. The respondents were 54.2% female and 45.8% male with 88.6% being heterosexual, 6.6% homosexual, 3.9% bisexual and 0.9% unknown. Chi-square analyses were used to determine statistical significance although no specific statistical analyses are provided.

With the best research (e.g. Laumann et al., 1994) only reporting about 2% of the population being homosexual, this sample has a higher percentage of gay and bisexual respondents than the American public, even if it is indeed representative of APA psychologists. Therefore, on some issues it appears likely that the opinions of those in the organization will differ significantly from the viewpoints of the mainstream of the American population.

(Continued on page 4)

Conclusions Of Kilgore, et al. (2005)

The authors reached four conclusions about trends in psychologists' opinions. First, "There has been an increase in the number of psychologists with a gay-affirmative view and approach with gay-lesbian-bisexual (GLB) clients." Whereas in 1995 (Jordan & Deluty) 83.3% of those surveyed viewed homosexuality as either "acceptable" or "somewhat acceptable," that number climbed to 95% in 2005. **Similarly, those holding the perspective that homosexuality was either "unacceptable" or "not as acceptable as a heterosexual lifestyle" fell from 14.4% to 4%** in the same ten-year period. Perhaps even more telling was this figure — *58% of those surveyed by Kilgore et al. (2005) described their approach as "gay-affirmative" compared to only 5% of the participants in a 1991 survey of 1,481 psychologists by Garnets, et al.*

Second, the authors contend that "There has been a decrease in the number of psychologists viewing homosexuality and bisexuality as psychopathological." Jordan and Deluty's (1995) results showed that 17.9% of psychologists viewed homosexuality as either a psychosexual disorder or as a personality disorder. By contrast, only 6% of those surveyed by Kilgore et al. (2005) characterized it in either of those ways or as "a mental disorder." *Furthermore, those stating that homosexuality was "not a disorder at all" climbed from 25.9% in 1995 to 81% in 2005.*

The third conclusion is that, "There is a relationship between formal education or training in gay-affirmative therapy (GAT) based on sexual orientation, gender and age." Most noteworthy was the statistic that 32% of those in the 30-39 age range had been given GAT training whereas only 9% of the professionals between the ages of 60-69 had received it.

Surpising Gender Difference

Fourth, "More female than male psychologists display gay-affirmative therapeutic approaches-attitudes toward GLB issues." Gender differences in GAT endorsement or usage were not mentioned by Jordan and Deluty (1995), but Kilgore et al., (2005) provide evidence that the gender variable more frequently distinguished opinions about homosexuality than any other variable examined in the study. For example, 67% of females utilize GAT while 88% endorse its use. The corresponding figures for male professionals were 47% who utilize and 67% who endorse. Even more telling is the difference in support for "aversive" therapies for homosexuality with only 1% of the women endorsing while 7% of the men do so.

The authors give many revealing comments in this article. First, they view the pro-gay shift in psychologists' opinions as very positive, although they allude to the presence of NARTH as a troublesome indicator that the professional community has not yet achieved consensus. Second, they attribute the greater propensity of females to adopt pro-gay attitudes to males' heightened vulnerability to "internalized homophobia." No references, however, are cited to support this claim about men.

Third, reparative therapy is labeled as an "aversive" approach, i.e., one that presumably involves controversial methods such as pain infliction.

Fourth, the authors include two recommendations for doctoral psychology programs. They advocate the continued "development and implementation of curriculum for GAT" and that its future expansion include an affirmative approach for clients who are transgendered.

What Do These Results Mean For NARTH?

This study's results are not good news for NARTH, although they need not be as troubling as they might first appear. There clearly has been an opinion shift within the ranks of the APA membership. Fewer of our colleagues are likely to endorse or even be sympathetic toward NARTH's positions about the treatability of SSA or the undesirability of homosexual practice.

NARTH 2005 Conference Report Available In PDF Format!

You can now download (to a saved file on your computer or print out your own copy) the 190 page NARTH 2005 Conference Report. This is the collection of the papers presented at the 2005 Marina del Rey, California conference and includes many outstanding clinical presentations and scientific reports. No waiting. Nothing will be mailed. An adobe file will be emailed to you. Price: $15.

Therefore, we can expect that further efforts might be made within APA to marginalize both NARTH and those who support our viewpoints.

It should be remembered, however, that Kilgore's (2005) sample was not representative of all mental health professionals, or even of all psychologists, but only of those who belong to the APA. Indeed, several relatively new organizations for counseling professionals have attracted members from the ranks of those who are disillusioned with the decline of scientific objectivity and with the rise of a narrow, leftist political agenda. Wright and Cummings' (2005) brilliant work provides strong evidence of a pervasive, intentional bias within the APA. It only seems reasonable to conclude that an atmosphere that chills discussion and dissent would tend to drive out those who do not subscribe to the party line.

We Must Not Watch Silently

Nevertheless, NARTH can not afford to watch silently as our fellow professionals, lacking any balance in the perspectives they hear, drift under the influence of our opponents. Professional organizations carry sizeable weight over decisions affecting research funding, foundation allocations and university appointments, not to mention legislation. Therefore, despite the enormous obstacles we face, we can not and we need not concede defeat in the APA.

Neither can we rest complacently on assurances of support from the general public. As former APA president Robert Perloff stated in his November, 2004 address to NARTH, the clearest interpretation of recent results at the ballot box is that the American populace strongly sympathizes with NARTH's views. This is certainly heartening news. It is important to remember, however, that Dr. Perloff was primarily alluding to the strong affirmation by citizens of Defense of Marriage Act initiatives designed to prohibit legal recognition of same-sex unions.

In another domain, however, there has been a different set of outcomes. Currently, 17 states and 84 municipalities have enacted or passed anti-discrimination employment legislation based on sexual orientation. Recent additions to this group include the state of Maine, where voters confirmed the decision of their elected assemblies, and the city of Indianapolis, an urban center nestled in the heart of one of the "red states," which now has one of the nation's most stringent gay rights employment statutes. In total, 49% of the American population now lives in a jurisdiction covered by one of these laws. These legislative trends probably reflect shifts in public opinion documented by Sears & Osten (2003) such as the gradual decline in the percentage of people who view homosexuality as undersirable.

The Kilgore et al., (2005) study is a clarion call for NARTH to take action on multiple fronts. While NARTH's existence continues to be a cogent reminder of an alternative perspective of sexual orientation issues, there is a compelling need to increase awareness of the legitimacy of NARTH's work and its positions among the APA membership, the scientific community at large and the general public.

Classification As An 'Aversive' Approach

It is important to correct distortions about the nature of reparative therapy. Upon reading Dr. Joseph Nicolosi's (1991) work on the subject, one might possibly classify reparative therapy in a variety of ways: developmental, interpersonal, cognitive, psychodynamic or even as family systems. However, there are no allusions either in Nicolosi or in any other work describing this approach to any aversive techniques such as pain infliction. Reparative treatment simply is *not* an aversive approach, it never has been, and those who call it such are likely writing from perspectives distorted by stereotyping and stigmatization rather than being informed by careful study and refined by scientific scrutiny.

In the opinion of this author, it will also be critical for NARTH to develop a strategic plan to inform and educate both our fellow professionals and the general public about defining issues such as the psychological correlates of homosexual behavior, scientific evidence about the origins of homosexuality, and the effectiveness of various approaches to reorientation. Indeed, to some extent NARTH has already done this, for example, through its publications. In addition, several within the organization have also been making noteworthy, independent efforts. How much more effective might this work be if it was developed and implement-

mented corporately? It is this author's intent to propose such a plan in the next issue of the *NARTH Bulletin.*

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Edward "Ned" Stringham, Ph.D., is a clinical psychologist who practices in Lincoln, Nebraska.

Latest Research On Gays, Bisexuals, And Transgenders In Substance Abuse Programs

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

Previous studies looking at correlations between sexual orientation and substance abuse had been criticized largely because of sampling issues. The samples in earlier studies were mainly drawn in places where lesbian, gay, bisexual, and transgender (LGBT) individuals congregated socially (namely, gay bars).

This article reviews the latest findings in: Cochran, B. N. & Cauce, A. M. [March, 2006]. "Characteristics of lesbian, gay, bisexual, and transgender individuals entering substance abuse treatment," *Journal of Substance Abuse Treatment*, 30, 135-146.)

Previous criticisms were that these samples overestimated the prevalence of substance abuse problems and pathology within the LGBT community. However, the present study, supported in part by a grant from the National Institute of Drug Abuse, gathered its sample outside of social arenas. The researchers compared substance abuse problems, psychopathology, and medial service utilization of both heterosexuals and non-heterosexuals in a sample size of over 17,000. Both groups were studied on matched criteria, that being that they had to be over 18 years of age and entered into a state-approved chemical treatment program. Therefore, the researchers claim that their study provides a more representative sample of both groups when investigating their substance abuse characteristics.

The findings of the study showed that openly LGBT individuals enter treatment with more severe substance abuse problems, greater psychopathology, and greater medical service utilization when compared to heterosexual clients.

As it related to substance abuse issues, the findings showed that while heterosexuals are more likely to endorse alcohol as a primary drug of abuse, LGBTs steered toward harder substances such as metham-

phetamines and crack. LGBT clients abused drugs more frequently than their heterosexual counterparts. In terms of psychopathology, LGBT clients took psychotropic medications in twice the proportion of heterosexual clients. As far as domestic violence, openly LGBT were significantly more likely to be victims of domestic violence than the heterosexual population. In terms of overall health care utilization, LGBT individuals more frequently sought services than heterosexual individuals. When it came to interfacing with the legal system, however, heterosexuals were more likely to have legal involvements than LGBT clients. In conclusion, the researchers state "Although theses findings cannot resolve the question of why LGBT individuals might abuse substances, the results point to a pattern of more severe problems among openly LGBT clients than among heterosexual clients." (p. 144).

This study adds weight to the many other discussions citing greater pathologies within the LGBT population. The authors, however, suggest the findings be used to justify more "LGBT-specific substance abuse treatment programs." In spite of their unwillingness to consider broader intrepretations of the study's findings, the *Journal of Substance Abuse Treatment* should, I believe, be congratulated for publishing this research.

On Spontaneous Changes In Sexual Orientation

by Frank York

Dr. Jeffrey Satinover, in his recently-published NARTH paper, "The Trojan Couch," points out that sexual orientation has been found to be unstable over time in both males and females. This finding has been reported in many studies, including the research of Edward O. Laumann, John H.Gagnon, Robert T. Michael, and Stuart Michaels in *The Social Organization of Sexuality: Sexual Practices in the United States,* (University of Chicago Press, 1994)

According to Satinover, Laumann and his colleagues "found to their surprise that its [homosexual orientation] instability over the course of life was one-directional: declining, and very significantly so."

Homosexuality tended spontaneously to "convert" into heterosexuality as a cohort of individuals aged, and this was true for both men and women—"the pull of the normative, as it were," said Satinover. One of the main discoveries of Laumann was that homosexuality, as a fixed trait "scarcely even seems to exist." (Quote from Laumann, Michael, Gagnon in *Family Planning Perspectives*, Jan-Feb 1994.)

A study published in *Archives of Sexual Behavior,* (April 2005) also confirms the flexibility of sexual orientation. "Sex Differences in the Flexibility of Sexual Orientation: A Multidimensional Retrospective Assessment," by Kinnish, Strassberg, and Turner, surveyed self-identified homosexuals, bisexuals, and heterosexuals, to determine if there were differences between males and females in the flexibility of their sexual orientations.

The authors note that while most researchers have maintained the position that sexual orientation is stable across the lifespan, this view has been challenged in recent years by other researchers who say that "sexual orientation is inherently flexible, evolving continuously over the lifespan. From this perspective, individuals may experience transitions in sexual orientation experiences, social interactions, and the influence of the cultural context."

Lesbians, in particular, have been found to be more flexible in their sexual orientation than male homosexuals. Researchers have described this flexibility variously as "greater fluidity and ambiguity," "choices or social and political constructions," and that women are more responsive to "culture, learning and social circumstances."

They found that lesbian participants were far more likely than gay men to report having previously identified as something "other than homosexual -- most of the women had previously identified as heterosexual, while for the males, the modal prior identification was as bisexual (rather than heterosexual)." Thus, it was concluded that the women demonstrated greater fluidity (moving from heterosexual to homosexual) than did the men."

The New Handbook Of Psychotherapy And Counseling With Men (2005).

Edited by G. E. Good and G. R. Brooks. San Francisco: Jossey-Bass.

Reviewed by James E. Phelan, MSW, Psy.D.; Robert Vazzo, MA, M.MFT

The New Handbook of Psychotherapy and Counseling with Men is intended to be an authoritative guide for therapists and counselors working with men. Undeniably, the text provides useful information. The editors' goal is to facilitate a guide that helps practitioners provide men with "full access to the widest range of social, emotional and psychosocial skills" (p. 11).

However two chapters exhibit biases which make the text an incomplete and inaccurate reference for readers. The handbook, therefore, does not accomplish what the editors set out to do. Those two chapters are as follows.

Chapter 24: Douglas C. Haldeman, "Psychotherapy with gay and bisexual men"

Douglas C. Haldeman, a private practice psychologist in Seattle, has authored several books and articles on lesbian, gay and bisexual topics. When discussing the issues of changing sexual orientation, Haldeman in this chapter writes, "even if it were desirable to do so, there is no evidence to suggest that sexual orientation can be changed." He then cites, by way of his own work, that the "majority of individuals seeking change ... do so in response to considerable internalized social pressure" (p. 373).

Haldeman, however, blatantly disregards the literature that does suggest change is possible. One notable research which was conducted by Dr. Robert Spitzer of Columbia University should have been discussed in this context for the reader to have a fair assessment. How can this be an objective handbook, when the author irresponsibly fails to note such research was even conducted, regardless of his opinion of the findings? Rather, he seduces the reader into the notion that "there is *no* evidence to suggest that sexual orientation can be changed" (p. 373, emphasis added).

When discussing the context of adolescence, he says that a teenager's sexual orientation is "immutable." This type of statement simply disregards the many discussions about adolescents' sexual confusion and sexual fluidity widely found throughout the literature.

Haldeman says that therapists and counselors should assume that "sexual orientation is not necessarily congruent with sexual identity." He says that an individual may have a "primarily homosexual orientation while maintaining a primarily heterosexual sexual identity" (p. 371). He then gives a case illustration of a man who has been married for 10 years and who has two children. In this case, he argues that the man has a homosexual orientation. But again, there is no discussion of the possibility of the role of sexual fluidity, of the power of sexual addiction even when sexual orientation has changed, or even the role of bisexuality.

"Bisexual" is a term he uses loosely from the beginning of the chapter without any explanations to its possible meanings. This represents a poor approach to a very controversial issue. Anyone studying sexuality knows that bisexuality is a complex topic, and nothing is exclusive in both its term and role.

Haldeman states, "Gay and *bisexual* parents are often confronted with the commonly held but *scientifically baseless* misconceptions that gay parents influence a child's gender role identity, conformity, and sexual orientation" (emphasis added). However, he chooses to cite just one review (another notation of bias) that says that there is no basis for concern. Again, this reveals the narrow perspective the author takes, driv-

en more from a sociopolitical agenda, rather than a scholarly look at the issue in totality.

Haldeman offers virtually nothing new in the area of discussing the issue of gay psychotherapy. Rather, he regurgitates the common longitudinal theme that says that society reinforces negative social messages about homosexuality, thus the pathology associated with a homosexual orientation. He implies that every gay person with a problem comes to therapy saying, "Look, I'm here because society messed me up!"

Unfortunately, the editors of the book sought out a gay activist to write this section of the book. A variety of different cases from various clinical perspectives would have lessened the obvious bias on the subject.

Chapter 25: Maples, M. R. & Robertson, J. M, "Counseling men with religious affiliations"

The authors begin by acknowledging that North America is a highly religious population, albeit diversified. The chapter intriguingly asks why men are drawn to religion and questions whether it is masculine, feminine, or androgynous, citing that "...in many religious traditions the traits that defined a man as spiritually healthy have been very similar to those that have defined him as masculine" (p. 387).

We thought this was a very thought-provoking observation. They also suggest that religion can help men overcome problems such as alcohol abuse, depression, suicide, poor physical health, aggression, and martial dissatisfaction.

They cite studies that suggest religious commitments have been shown to be instrumental in helping men make significant improvements in relieving depressive symptoms and alcohol use.

The authors then state that it is helpful for counselors to know about the many "gay-friendly movements that exist within the larger religious communities" (p. 393).

Among those gay-friendly groups are, for example, Roman Catholic (the group, Dignity), Latter-Day Saints (with its gay group, Affirmation), and Jewish (World Congress of Gay, Lesbian, and Bisexual Jewish Organizations), to name a few.

Unfortunately, the authors kept this discussion at its narrowest, consistent with the bias of the previous chapter, and neglecting to discuss the movements existing within the larger religious traditions that have organized to help men seek freedom from unwanted homosexuality and according to their religious and moral convictions.

They had the perfect opportunity to discuss that issue and those organizations that deal with them. Among those are for example, Roman Catholic (Courage), Evangelical Christian (Exodus International), Latter-Day Saints (Evergreen), and Jewish (JONAH), to name a few. I assume it is no accident that these organizations were left out of this chapter. The editors of the book would have done justice to include the other sides of the discussion of religion and homosexuality.

It is ironic that the book's editors goal was to help practitioners provide men "full access to the widest range of social, emotional and psychosocial skills." They could have served clinicians better by inviting all perspectives of working with gay and bisexual men, not just those that reflect the author's own preferences.

'Diversity Day' Canceled To Avoid Ex-Gay Viewpoint

Officials at Viroqua High School (Wisconsin) canceled a planned Diversity Day in March 2006 after the Liberty Counsel suggested that an ex-gay viewpoint should be represented during the event. Instead of permitting an ex-gay to speak to give a diverse viewpoint from the gay couple scheduled to speak, the event planners shut down the day altogether. According to event planner Ellen Byers, "Non-positive groups were not what we were going for."

Chris Kruger with the gay Pride Center, said: "Having a Christian viewpoint there would not necessarily be a bad thing. However, if it was a hateful group, one that would not present an atmosphere where we would feel comfortable talking, then that would definitely impede a discussion."

A Tribute To Charles Socarides

By A. Dean Byrd, Ph.D., MBA, MPH

"Homosexuals need and deserve our tolerance, our understanding and our compassion."

-- Charles Socarides

Charles W. Socarides M.D.

One of the founders of the National Association of Research and Therapy of Homosexuality, Charles W. Socarides, M. D., died of cardiac arrest on December 25, 2005.

Dr. Socarides was instrumental in bringing together the seminal group which formed the foundation of NARTH in New York City nearly 15 years ago. The small group of less than 20 mental health professionals from different parts of the country met to respond to the growing number of those men and women who were unhappy with their homosexual adaptation, whose deepest beliefs told them that they were created for sexual complementarity and who sought professional help in reconciling their unwanted sexual attractions with their authentic selves. From this small group spearheaded by Dr. Socarides, NARTH has grown to a vibrant organization of more than 1500 today.

Dr. Socarides was as psychiatrist, psychoanalyst, and in the tradition of Sigmund Freud, a social critic as well. He was concerned about an American society that was all too quick to accept the innate, immutable theory of homosexuality. Indeed, his years of research and clinical practice revealed that unwanted homosexual attractions were more fluid than fixed.

With more than 50 years of clinical practice and with the publication of more than 80 books and professional papers devoted to the treatment of unwanted homosexuality, Dr. Socarides was a formidable discussant, a brilliant thinker and a passionate teacher.

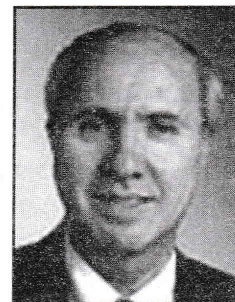
A graduate of Harvard University and New York Medical College, Dr. Socarides was a Clinical Professor at Albert Einstein College of Medicine until his retirement in 1996. He continued to maintain a clinical practice working with men and women who were troubled by their unwanted homosexuality.

Dr. Socarides was accorded many accolades during his long tenure including the Distinguished Professor Award from the Association of Psychoanalytic Psychologists, British Health Service. He lectured on his research findings in London at the Anna Freud Child Development Clinic, the Portman Clinic, the Tavistock Clinic and at the British Psychoanalytic Society.

Charles was an esteemed colleague and personal friend. He was a champion of patient autonomy and an advocate for patient self-determination.

Perhaps there is no better word to describe Charles Socarides than "tenacious." He took many unpopular positions but was secure in his opinions and forceful in the presentation of his views.

The love of his life, his beloved Claire, was his greatest supporter and he, hers. Whenever he talked of her, it was always with much adoration and joy.



A. Dean Byrd Ph.D.

Dr. Charles W. Socarides was one of those rare professionals whose compassion for those who suffer was immeasurable. Indeed, he dedicated one of his many books, *A Freedom Too Far*, to his patients "whose courage and endurance for self-knowledge" was accorded his utmost respect and admiration.

Charles Socarides' presence will be greatly missed and the world lessened by his absence. However, his influence will be felt as NARTH members and supporters seek to serve those to whom he dedicated his time and talents.

NARTH's web site features several articles by Dr. Socarides or about him. The NARTH Bookstore sells *Homosexuality: A Freedom Too Far* for $25.

A Tribute:
Dr. Charles Socarides, Lover Of Humanity

By Benjamin Kaufman, M.D.

At one time, the name of Charles Socarides was known throughout the world to every student of sexual development. Familiarity with Charles' work was required, particularly for those training to become psychoanalysts.

Now, for most men and women, simply to become such an icon with an unquestioned place in the heady atmosphere of the intellectual elite would be sufficient. To have achieved stature, name recognition, and be acknowledged internationally among one's colleagues as a distinguished member of prestigious faculties and professional organizations would be more than enough to satisfy a lifetime of ambition. Charles Socarides could have, for the rest of his life, settled back with a worldwide reputation. He could have remained aloof and apart from the trenches where the fiercest of cultural battles was just beginning to be fought. But in his 70th year, after forty years as a clinician and a scholar, Charles entered those trenches using his psychoanalytic knowledge to become a social critic in addition to being a clinician, researcher and scholar.

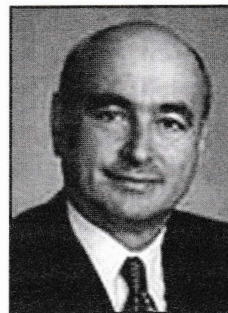
The impetus for Charles's calling to the cultural wars began in 1973 when politicized professional organizations turned a hundred years of hard-won scientific discovery, knowledge and theory of psycho-sexual development upside down and inside out. At that time, the diagnosis of "homosexuality" was removed from the manual of psychiatric diagnosis of mental illness, which was intended to reduce discrimination and accommodate those in psychic pain from incomplete sexual development. Over the years, this original intent has been elaborated and expanded into a variety of public policies, all of which Charles referred to as being part of the re-drawing of male/female design to make homosexuality the equivalent of heterosexuality in marriage, child-rearing, education, and in every institution of public life.

Charles always supported tolerance, but courageously emphasized the distinction between tolerance and approval of the paraphilias. He asserted that "there is one thing I know as a psychoanalyst, I know this: people don't get to the bottom of their pain by lying about it to themselves or to the world."

Charles pointed out that "...at this moment in history ...a new sexual revolution has become inextricably bound to the concept of freedom." Charles was first among psychoanalytic clinicians to take to the public square and ask — but freedom *from* what, and *for* what? Does this freedom bring real happiness or empty promises? Is any form of sexuality as good as any other? And are we better off being set free of the constraints of responsibility and tradition? Charles poses these questions and many others in his work referring to the paraphilias, *A Freedom Too Far.*

I was familiar with Charles' academic writings on sexuality for many years. His publications stood alongside the most well-known of the theory builders and clinicians who influenced my training as a psychiatrist and later as a psychoanalyst. I was surprised to read that he had been picketed and protested at one of his talks, as I would have expected him to be just another psychoanalytic scholar whose work put him above the cultural fray, not one who would get into the cultural trenches and risk a pristine career.

I met Charles in 1991. I learned that he and I shared the belief that we needed an organization where teachers and social critics would not be alone and isolated. We called on Joe Nicolosi, who was already as hard at work on the West Coast as Charles was on the East. Charles pulled a fast one and got us a room at The Waldorf Astoria during the December 1991 meeting of the American Psychoanalytic Association. We were surprised that 25 people showed up including Dean Byrd, the late Harold Voth, and Toby Beiber. Our committee created NARTH.



Benjamin Kaufman, M.D. .

Charles said at that time "...you know they're going

(Continued on bottom of page 12)

Division 44 Psychologist Urges Colleagues To Be Social-Political Advocates

He says researchers avoid doing some gay-health studies for fear of results.

The Fall 2005 issue of the American Psychological Association's Division 44 newsletter features an article by Michael R. Stevenson on the importance of gay psychologists acting as advocates for lesbian/gay/bisexual/transgender issues.

According to Stevenson, "Psychologists possess both the data and the skills to advocate as content experts, role models, and witnesses. We can help to diminish the influence of heterosexist norms. We can influence the educational development of all health and mental health professionals." Stevenson believes that much of this advocacy can be accomplished through the APA's Public Policy Office and its Office of Lesbian, Gay, and Bisexual Concerns. This work is carried on at the federal level to influence public policy decisions.

In addition, Stevenson believes that gay political advocacy can be accomplished through the Coalition to Protect Research, "which came into being after Congress threatened to de-fund significant research on sexual behavior." Says Stevenson: "Making the assumption that researchers are better equipped to judge the merit of scientific research than are most politicians, the Coalition lobbies against efforts to restrict funding for peer-reviewed research."

Stevenson urges gay psychologists to offer their services as "expert witnesses" on various levels and to help develop educational materials that "affirm diversity, broadly defined." He also urges support for organizations such as the Institute for Gay and Lesbian Strategic Studies (IGLSS) "in its efforts to debunk the myths and misinformation promoted by those who would prefer we return to the closet."

'Political Uses Of Data' Are A Concern To Gay Advocates

He also urges that more research be done on health concerns of those within the LGBT community. Stevenson notes, however, that many gay researchers are reluctant to conduct such research for fear that it might be used by those who would wish to re-pathologize homosexuality. "Having worked so hard to de-pathologize homosexuality, researchers interested in LGBT concerns may be reluctant to investigate health-related behaviors in fear of the potential political uses of such data."

(Continued from page 11)

to wipe the floor with us." We didn't have long to wait, as we were immediately noticed by The American Psychiatric Association and their Committee on Gay, Lesbian, and Bisexual issues. The Journal of The American Psychiatric Association reported that the GLB committee proposed finding a way to "isolate" NARTH.

It was really to Charles Socarides that this attempt to silence NARTH was directed, as he was the most outstanding, outspoken, and listened-to member of the American Psychoanalytic and American Psychiatric organizations who was willing to take such a position. It was Charles who would be the one to provide the most unyielding lift-off energy with his fundamentalist Greek commitment to science, and his truthful, direct talk, in which the rest of us found support for our own convictions. He liked to cite a psychoanalytic researcher who said something like this: "...make one concession on science, and you might as well pack it in." But Charles will always be remembered best by his patients whom he loved and helped to find the happiness he felt every human deserved.

Benjamin Kaufman, M.D. is co-founder of NARTH and serves as Clinical Professor of Psychiatry, University of California at Davis, Psychoanalyst.

Ethical Treatment
(Continued from page 2)

hope), they may work in order to please him or her, thus undermining a more intrinsic motivation for their own work. This can lead to premature beliefs or expressions of cure in which the client reports more progress than is accurate. It also places a bind on the client who eventually decides to engage in a homosexual relationship, which could induce shame and secrecy. This is a breach of AAMFT ethical code 1.3: *Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid condition...with clients that could impair professional judgment or increase the risk of exploitation.* Too strongly leading a client can establish expectations the client is not prepared to manage, and the dependent client may hide this bind.

Over-emphasize cause-and-effect relations about the etiology of the individual's attractions, i.e., "you have homosexual feelings because...." Over-simplification of causes or too much emphasis on "why" a person has these feelings trivializes the array of experiences and real causes—known and unknown—a person has in the development of his or her own brand of sexuality. Further, it may appear to the client that since cause-and-effects can be easily known, solutions should just as easily follow. A lot of frustration can ensue if this does not turn out to be true for the client.

Have real homophobia or homo-negative beliefs and expressions. A therapist may believe that a person can never experience happiness, comfort, or relational value in GLB relationships, when clearly many people report that they do. A therapist may misrepresent the array of experiences and feelings reported by GLB people. A therapist may feel disgusted by hearing accounts of homosexual activity. Feminine expressiveness in men or masculinity in women may be appalling to the therapist. Such attitudes may lead the therapist to downplay the real pain of a client who has experienced direct or indirect prejudice in a society that consistently misunderstands this issue. Every therapist has some limit as to what is difficult to hear or tolerate, and has an ethical mandate to be aware of his or her beliefs, biases, and limitations. A therapist who has difficulty tolerating clients with homosexual concerns should refer them, in accordance with AAMFT ethical code 1.1: *MFT's assist persons in obtaining other therapeutic services if the therapist is unable or unwilling, for appropriate reasons, to provide professional help.*

Believe that everyone has the same heterosexual potential, "If only you can apply principles A, B, and C." Not distinguishing among characteristics and capacities of individuals who present for help inevitably leads to error in clinical judgment and therefore places unrealistic expectations on clients. The overly optimistic "conversion" therapist may never value and avoid discussions of GLB options, when the client needs to discuss such. APA ethical principle A states *psychologists seek to safeguard the welfare and rights of those with whom they interact professionally*. The right to choose and have the therapist be available to openly and non-judgmentally discuss choices is perhaps the most fundamental element of therapy.

Haldeman (2002) observed "...I have noted that different patients manifest different responses to their treatments. For some, particularly those who have been made vulnerable by repetitive, traumatic anti-gay experiences, or those who have been subjected to aversive treatments, conversion therapy has proved to be harmful" (p. 261).

Clients who have long-standing homosexual feelings and report little-to-no heterosexual desires routinely have more difficulty developing heterosexual feelings than clients who report sensing homosexual urges later or who have some heterosexual attraction (Nicolosi, Byrd, & Potts, 2001). They may be more susceptible to therapeutic harm or disappointment in not achieving heterosexual functioning, and may feel quite compelled toward GLB explorations. Any therapist who performs therapy with clients with homosexual concerns who want to work toward change, should be cautious in his or her expectations and safeguard against harm.

Category Two: Therapists who are willing to work with clients with unwanted homo-erotic attractions, and are unsure about their own competency to treat such or who are consistently skeptical about the pos-

sibility of change, even though they have entered into an agreement to help the client. These therapists may:

Feel pressure to take too literally a request to change sexual orientation. A client who, through despair or demandingness, "must" change his or her orientation may frighten, unnerve, or anger a therapist. Taking sexual orientation too literally means that the client or therapist is overly-anxious to get to a preferred outcome. Such clients may not value the process of dealing with their attractions within their value frame, or be willing to be patient as they make adjustments and new adaptations that *may* lead to heterosexual attraction and functioning. Just as children do not actively go about willfully trying to achieve heterosexuality, one should not place too much pressure to accomplish the sexual component of sexual orientation work. The APA's guide *Answers to Your Questions about Sexual Orientation and Homosexuality* states "...many scientists share the view that sexual orientation is shaped for most people through complex interactions of biological, psychological, and social factors." Such a problem would usually require a long time to understand, manage, or overcome, so it is helpful to value the process. The therapist should seek adequate training to understand psychological and developmental problems that are often associated with SSA.

Incorrectly view therapy that addresses sexual orientation as being altogether different from therapies that address other kinds of problems. Some therapists who do this work eventually see many similarities across therapies and do not view sexual orientation work as entirely different or unique.

The successful treatments of unwanted homo-erotic attractions do not over-focus on a direct alteration of sexual attractions. Successful treatments have much similarity with treatments for depression and anxiety-related problems. Among what is emphasized is treating common psychological mistakes in engaging with a nagging problem, e.g., the more you "try" not to be depressed or anxious, the more you are; the more you try to not have homosexual urges, the more you do.

This critique should be coupled with the ethical mandate to treat within the boundaries of our competencies. Therapists who wish to work with clients toward changes in sexual attractions should follow the AAMFT Ethical Principle 3.7: *While developing new skills in specialty areas, MFT's take steps to ensure the competence of their work to protect clients from possible harm. MFT's practice in specialty areas new to them only after appropriate education, training, or supervised experience.*

The therapist may wait too long to unite with the goals of the client, due to the therapist's own ambivalence about the possibility of change. A therapist may be too skeptical about the possibility of attraction-management or increasing heterosexual feelings. This is a case of not believing that a self-determined person really can make a difference in her own sexual functioning. A client may unnecessarily lose motivation or a sense of hope with such a therapist, especially if the client and therapist share religious values and goals. A therapist who cannot join with the client with some enthusiasm and confidence, after negotiating an agreement about therapeutic goals, should take the responsibility to develop a stronger competency in this area, or refer the client to someone who has competency.

The therapist may wait too long to encourage a client to move out of contemplative ambivalence, losing opportunities to help a client experiment with new behaviors, attitudes, and adaptations. There is a difference between a client who is genuinely trying to understand and process issues, and one who is perpetually stuck in contemplation. In agreement with the ethical code to develop competency, a therapist should assess and understand problem areas, such as listed in Appendix B (Cohen, 2000), common to people struggling with SSA, to motivate and facilitate growth.

Category Three: GLB-affirming therapists. These therapists have tended to err in a different direction with regards to ethics (see for example, Perez, DeBord, & Bieschke, 2000). They may:

Present a strong pro-GLB agenda that influences the decisions of clients. Some of these clients may want to be more contemplative about the nature of same-sex attraction and homosexuality or move away from an identity based on sexuality. Therapists who

have strong agendas and who use persuasive means can be coercive and unethical in that therapy becomes an attempt to override a client's values and self-determination, and promotes the interests of the therapist over those of the client. This may be especially harmful when interacting with SSA youth, who are only beginning to consider the meaning of such attractions. This kind of therapist is acting more in the role of GLB guide and advocate than therapist, which may confuse consumers of therapy. This kind of therapy may show a blatant disregard for family and larger-system relationships which the client holds dear and unnecessarily creates conflict.

APA Ethical Principle E states: *Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making.* Affirmation therapists may err on the side of treating people as fragile as a general rule, needing to save them from unconscious internalized homophobia and an oppressive society. Such a therapist may believe that these clients cannot really self-determine a non-GLB future or establish realistic therapeutic goals for themselves, other than accepting homosexual integration.

This attitude was expressed clearly by Tozer and McClanahan (1999). "An individual's desire to change [sexual orientation] is a reflection of an oppressive and prejudicial society wherein lesbian, gay, and bisexual persons are considered deviant and inferior. Therefore, this request is not truly voluntary" (p. 731). Morrow (2000) indicated that SSA clients are always, at the beginning of therapy "already suffering from internalized homophobia and self-hatred" (p.139). APA guidelines are adamant that individuals with homosexual feelings or behaviors have no intrinsic mental illness. To believe that such individuals can be so deceived by society so as to not even be able to rationally weigh the issues involved makes no sense, and actually takes a step backward toward a pathologizing approach. To be extreme in this thinking is in violation of APA Ethical Principle E: *Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination.* A client may very well determine that a non-GLB lifestyle is more dignified and fitting of her or his values and goals.

Therapists may downplay the promiscuity that is a part of a dominant GLB culture and community. These therapists may diminish attention to health risks and problems—physical and psychological—associated with homosexuality. They may encourage youth to experiment with sexuality, even if under safe conditions. See Appendix A for a current update of some health risks.

Therapists may fail to promote an understanding of or research concerning etiology of same-gender attractions, believing that such explorations are an appendage to homo-negative attitudes. This is in violation of a principle of APA ethics stated in the preamble: *Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication.* To discount or ignore research that has demonstrated that individuals can and do manage and even make changes in their sexuality within a variety of values frameworks is misinforming.

Therapists who discount important value systems that question or oppose homosexuality, believing they are necessarily prejudicial to people. Within the AAMFT Ethical Principle 1, categories of possible discrimination include, in addition to sexual orientation, religion and culture, which may include family culture. To dismiss these significant influences out-of-hand as prejudicial and homophobic is systemically naïve, underhanded, and harmful to clients who depend on them.

Therapists who may value adolescent and adult sexual exploration and activity. What would be considered promiscuous and psychologically, interpersonally, and spiritually unhealthy by a majority of religions and people, is celebrated, encouraged, and even required by elements of the GLB culture. Bepko and Johnson (2000) detailed common rules among relationship-committed and non-monogamous gay male couples. "...rules exist such as no emotional affairs, only tricking (one-time sexual liaisons), no disclosures about outside sex (or full disclosure about it), or

mutual participation in outside sex only as a threesome or in larger groupings." (Such behavior is rarely a part of lesbian culture.) This behavior would seem to undermine the role of sexuality in the development of secure attachments. It also privileges the status of male recreational sexuality among values. Monogamy is generally regarded as an absolutely critical relational ethic among close, committed sexual partners.

Therapists who dismiss entirely the possibility of heterosexual development and the diminishing of unwanted homo-erotic attractions. In the APA's guide *Answers to Your Questions about Sexual Orientation and Homosexuality* the answer given to the question "Can therapy change sexual orientation?" is "No," and further, that engaging in such therapy is harmful and likely unethical. The authors acknowledge that sexual orientation is "extremely important to an individual's identity," yet foreclose on a person's being able to do anything about it other than acceptance. The question is worded rather deceptively in such a way as to make the answer correct: probably no one believes that "therapy changes sexual orientation." This is like saying "therapy eliminates depression." If the question was "Have people reported that therapy assisted them to diminish same-sex attraction or increase heterosexual feeling," then, according to research, the answer would be, "Yes."

The ***DSM IV*** diagnostic code 302.9 *Sexual Disorder Not Otherwise Specified* subcategory: *Other sexual orientation problems* were created in part for people who are distressed about their sexual orientation. This created clinical room for people to explore and take initiative about unwanted elements of sexual orientation. The APA, in negating a range of effective therapeutic modalities, is clearly expressing a political bias.

Numerous recent and historic studies have indicated that it is possible for some individuals to completely diminish same-sex attraction and enjoy heterosexuality (see Beckstead, 2001; Byrd & Olsen, 2001; Nicolosi, Byrd, & Potts, 2000; Spitzer, 2003 [this article contains an excellent, state-of-the-profession series of 26 peer commentaries concerning research in sexual orientation and change]; Throckmorton, 2002, Yarhouse, 1998). Perhaps a larger majority of clients who have been successful in altering sexual attractions have done so with a kind of negotiation—homosexual compulsions, intrusive thoughts, or overwhelming feelings are treated and generally resolved, yet heterosexual attractions are not as strong as homosexual ones. Sometimes, and in the course of years (*an average of two years post therapy, reported by Spitzer*), heterosexual attractions emerge more strongly, especially toward a spouse or partner in a committed, loving relationship (not usually generalized to many people of the other sex). Even so, researchers indicate that more than one-third of clients who seek a change in orientation are not successful. These people may be glad that they "at least tried"; others may be very disappointed, angry and resentful, or suffer damage to their self-esteem and sense of identity. With these clients, it is important to monitor expectations in therapy and help them achieve realistic goals.

Final Comments

These lists and considerations are not exhaustive, nor are they axioms to conclude without debate. Ethical guidelines exist to help clinicians protect themselves and their clients against harm. I encourage clinicians to consider their own values, practices, limitations, and strengths regarding this type of therapy, and seek continual training to provide competent help. I also encourage ongoing dialogue among clinicians of different faiths and belief systems, as these have important influences in our clinical work. We do not help clients when we are militant or take strong political stances *and* expect our clients to do the same. A common goal among all therapists is to reduce or eliminate harm, and help clients lead healthy lives that are congruent with their values.

Appendix A
Research Regarding Health Risks For Practicing Homosexuals

Although the American Psychiatric Association in 1973 removed homosexuality as a form of mental illness, people who report homosexuality in adulthood and adolescence, compared to people who do not, are two to four times more likely to receive mental health services (Clark & Serovich, 1997). Homosexuality has been correlated with higher incidences of suicidal thinking and attempts (Herrell, Goldberg, True,

Ramakrishnan, Lyons, Eisen, & Tsuang, 1999), self-harm (Skegg, 2003), eating disorders among male homosexuals (Cartat & Camargo, 1991), and anxiety-related problems (den Aardweg, 1985).

A standard conclusion across research articles is that gay men usually have more sexual partners within specified periods of time than heterosexual men, and that sexual monogamy across a lifetime is so rare as to be not reported (Bepko & Johnson, 2000). In a 1996 *Genre* magazine survey of 1,037 volunteer male respondents, 24% said they had 100 or more partners in their lifetime; another 16% said they had more than 40. They also report much more permeable sexual boundaries in committed gay relationships than would be expected in heterosexual relationships.

Among more conservative people with SSA, Spitzer's (2003) highly religious sample of 143 men and 57 women (N = 200; 14 people were LDS) who had undergone therapeutic or group attempts to modify sexual orientation, 13% of males and 4% of women had never engaged in consensual homosexuality; 47% of males and 94% of women one to 50 partners, and 34% of males, 2% of women said they had had over 50 partners. One-half of these males and two-thirds of the females had also had consensual heterosexual sex.

Despite large efforts to educate those who practice homosexuality, health problems and risk behaviors are on the rise. Gross (2003) reported—as predicted in 1997 by the CDC—a 14% upsurge in HIV among US homosexual men in the years 1999-2001, not including data from the gay-dense states of California or New York.

This author also reported "unprecedented outbreaks of syphilis and increasing rates of rectal gonorrhea" among homosexuals. In one report, one-third of all black homosexual men in six major U.S. cities America had HIV, the majority going a significant amount of time without knowing it.

Kauth, Hartwig, and Kalichman (2000), in the *Handbook of Counseling and Psychotherapy with Lesbian, Gay, and Bisexual Clients* published by the APA stated "…gay and bisexual men have no greater physical health problems than heterosexual men, with few exceptions."

This statement seemed to downplay what they in the chapter later acknowledged, that gay and bisexual men (compared to men who have never had sex with men) on average are sexually more active at early ages and report more lifetime partners, have more anal intercourse (a much higher health risk behavior than male/female intercourse), experience more hepatitis B, HIV and STD's and complications of physically traumatic intercourse. These authors examined research between 1991-1997 and found that approximately one-third of men surveyed in those studies had recently had unprotected anal sex, and that men under 30 commonly had unprotected sex—behavior that accounts for 47% of AIDS cases in America. Koblin, et al (2003) reported that among 4,295 HIV-negative homosexual men who had engaged in anal sex with one or more partners in previous year, "48% and 54.9% respectively reported unprotected receptive and insertive anal sex in the previous six months."

LDS youth may be particularly unlikely to use protection methods during sex, which would put them at higher risk for contracting sexually transmitted diseases. LDS youth/young adults might consider sexual planning premeditated and wrong, leading to "accidental" or impulsive, unprotected sex. It would not seem a far stretch to believe that most same-sex attracted LDS youth and young adults would also not plan for having sex, and often sexual behavior would be unprotected in new relationships.

Clearly, the decision to enter a homosexual relationship is not benign as to health risks. Part of informed consent is to non-coercively help clients have at least a reasonable understanding of health and safety risks associated with choices in behavior.

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College Newspapers Using NARTH As Research Source

An editorialist in the April 20, 2006 issue of San Jose State University's *Daily Spartan* quoted Dr. A. Dean Byrd's research paper on gender complementarity in arguing against gay adoption. Dr. Byrd's online paper is being widely quoted in media sources. The author, Jill Rae Seib, admitted that she had never thought there might be a problem with gay adoption until she read Dr. Byrd's article.

NARTH's web site had 122,000 visitors in March 2006 and hundreds of NARTH's research papers are being downloaded and distributed. NARTH's web site is becoming a significant presence on the Internet as a reliable resource of information on sexual orientation issues.

APA Members Invited To Sign Petition To The President Of The American Psychological Association

NOTE: If you are a member of the American Psychological Association (APA), you are invited to sign the petition in support of a client's right to choose. Simply forward an email to Kim Niquette at kniquette@cfl.rr.com to give us permission to include your name.

PETITION

We, the undersigned members of the American Psychological Association (APA) petition the President and Governance of APA to acknowledge, affirm and promote client autonomy, self-determination and diversity in matters relating to human sexual adaptation.

Further, we petition APA to support the individual's inalienable right to either claim a homosexual identity or to pursue change in sexual adaptation in accordance with the ethical principles of APA and consistent with an individual's expressed value system.

Finally, we petition APA to recognize, accept and provide opportunities for both gay affirming therapists and re-orientation therapists to express views and announce programs in The Monitor and otherwise under APA's purview.

UPDATE FOR NARTH CLINICAL MEMBERS LIST

By Marc Dillworth, Ph.D., Clinical Member Facilitator

The NARTH Clinical Members Discussion List welcomed a special guest in April: Dr. Rogers Wright, the co-author of *Destructive Trends in Mental Health.* We were honored to have him take the time from his busy schedule to join us online. The discussion just started at the end of March. So if you are interested in joining quickly, you may be able to view the conversation.

In this discussion, NARTH members are asking the questions and Dr. Wright is responding to them. During this session, he has told us how he keeps himself going when he is facing harassment about the contents of his book. It has been helpful to me to see his fighting spirit in the face of political correctness and intimidation. He is an example to all of us who stand for free choice in the treatment of homosexuality.

As in past discussions, the debate had gotten heated. Some clinical members have challenged the validity of parts of the book. Dr. Wright has done an excellent job of defending his positions. Debate and heated discussion is part of the clinical members discussion list. I believe it is a good thing because it sharpens one's cognitive abilities and skills as psychotherapists. Members include leaders in the field of homosexuality, experienced mental health professionals and professionals wanting to learn about the field. Join us and get connected with other mental health professionals in the field of treating unwanted same sex attraction. All licensed mental health professionals are invited to join the ongoing conversation.

Recent topics have included a heated debate on "Why Psychology Must Change" by David Blakeslee, Ph.D. Another more clinically-related discussion was about a research study done by former NARTH Sigmund Freud award winner Warren Throckmorton, Ph.D. The title of the study was "Counseling practices as they relate to ratings of helpfulness by consumers of sexual reorientation therapy." The last topic was led by Joseph Nicolosi, Ph.D., president of NARTH and Dean Byrd, Ph.D., former vice president of NARTH, who answered some questions given to them by the clinical members. This has sparked a lively debate. Some of the questions were: Can a former struggler of homosexuality be an effective psychotherapist? Is it possible to emotionally re-engage the classic, "disengaged father"? We expect more lively debate in future online discussions.

States To Grapple With Gay Adoption Bans

Bans on gay adoption are being promoted in 16 states through grassroots initiative campaigns. Ohio, Georgia and Kentucky approved constitutional amendments in 2004 that define marriage as a union of one man and one woman.

According to Greg Quinlan of Ohio's Pro-Family Network, it's now time for a ban on gay adoption. "Now that we've defined what marriage is, we need to take that further and say children deserve to be in that relationship," said Quinlan.

Florida has banned gay adoption since 1977 although gays can be foster parents. Mississippi bans gay couples from adopting, but gay singles can adopt. Utah bans all unmarried couples from adopting.

Two NARTH leaders have published papers on the importance of children being reared in families with a mother and a father. A third leader has published a paper on the questionable research of Charlotte Patterson, a lesbian who heads the APA's Division 44 on gay and lesbian issues. Patterson's research on gay families has come into question for a number of reasons. Current research shows that children brought up in homes headed by same-sex couples are harmed by the experience in a variety of ways.

NARTH Resources On The Web:

"Gender Complementarity and Child-rearing: Where Tradition and Science Agree,"
by A. Dean Byrd, Ph.D. MBA, MPH*

"Review Of Research On Homosexual Parenting, Adoption, And Foster Parenting"
by George A. Rekers, Ph.D.

"The Research Of Charlotte J. Patterson" (Updated, December 2005),
by Gerald Schoenewolf, Ph.D.

"When Activism Masquerades as Science: Potential Consequences of Recent APA Resolutions",
by A. Dean Byrd, Ph. D., MBA, MPH

HIV Rates Rising Dramatically In Asia Among Gays/Bisexuals

The Associated Press reported on March 22, 2006 that HIV infections are on a steep increase throughout Asia. The data comes from a U.N.-funded surveillance program that is monitoring the worldwide AIDS pandemic. In Bangkok, Thailand, HIV rates among gay and bisexual men increased from 17% in 2003 to 28% in 2005, according to a Thai study and the Centers for Disease Control (CDC).

Phucid Junsaengsook with the gay-affirmative Rainbow Sky Association expressed concern about gays and bisexuals seeking out unsafe sex in bathhouses. He observed: "For those who go to a bathhouse, they want to have fun. Sometime when they meet people, they are living in the moment and don't worry about a condom. This really worries me. It's not about only one person's health. It's about everyone around them. I have a lot of friends who contracted HIV just because they had unprotected sex once."

Similar trends were discovered by the U.N. surveillance program in Mumbai, India (18%) and 12.8% in Phnom Penh, Cambodia.

More information on HIV and other STDs in gay and bisexual populations is available on NARTH's web site under "Medical Issues."

Transvestic Fetishism: Alternate Life-Style or Narcissistic Disturbance? An Exploration

By Brian Leggiere, Ph.D.

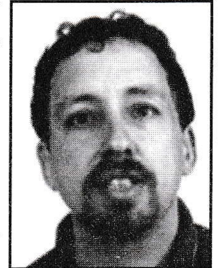
Introduction

I first confronted the issue of paraphilias in general, and transvestism in particular, when I was the Coordinator of a Sexual Abuse Treatment program which serviced the Orthodox Jewish community in Brooklyn and other areas. I had occasion to treat many different forms of sexual behavior disorders such as pedophilia, exhibitionism, voyeurism, masochism, ego-dystonic homosexuality as well as cross-dressing. I continue to specialize in this area.

I was confronted firsthand with sexual varieties which gave people pleasure but were also dyscongruent with their moral and religious principles (or at least those of their spouse or significant others). Because a particular form of sexual expression results in pleasure does not necessarily mean that it is healthy, desirable or even legally allowed. At the same time, I realized the difficulty in helping people free themselves of their compulsions. As Freud (1919) once noted, "Hardly anything is harder for a man than to give up a pleasure which he has once experienced" (p. 145).

I would like to speak about transvestic fetishism, or cross-dressing as it is commonly termed. I will make reference to psychodynamic theories, object relational theories and other relevant explorations.

One may rightly wonder why such a seemingly innocent behavior should give rise to such passion and angst. Certainly there are other more relevant topics to address. In my experience, many of my cross-dressers have become obsessed with their self- feminization to the point of where it has become an addictive process. They often become unhappy and enter the throes of withdrawal when prevented from dressing in female clothes. It can certainly become detrimental to their overall well being as well as that of their significant others, particularly if they are married or involved. Cross-dressing is not an ideal state. It represents a misdirection of sexual energies from their original purposes. It risks violating the organic unity of the male. Part of him is committed to women and to finding higher fulfillment through his love of women, and cross-dressing diverts energy from this. Besides my identity as a psychologist, I am guided by the Jewish tradition.


Brian Leggiere, Ph.D.

A Jewish Perspective

The Jewish Bible contains many proscriptions against particular sexual acts. Of these acts, most are connected to the maintenance of social cohesion and order and make intuitive sense such as adultery, incest, etc. A limited number are not connected to social cohesion and their inclusion appears mysterious and unnecessary. These include homosexuality, masturbation and transvestism. Of transvestism it is said, "A man shall not wear a woman's garments." It is well known that acts in the Bible are not routinely forbidden unless there is an acknowledgment of their widespread appeal and temptation. Certain commentators have said that these restrictions are in place to insure procreation and fertility and to greatly discourage forms of sexuality which are non-procreative. While fertility was certainly an important concept in the Torah, I would like to suggest that these three sexual forms are proscribed concomitantly because of the issue of narcissism.

These actions, if engaged in excessively, result in a turning inward and finding satisfaction in a distinctly

intra-personal way. The present paper will focus on these social factors and narcissism in this one particular paraphilia, namely transvestic fetishism.

Paraphilias

Paraphilias are a class of sexual behavior disorders which were formerly termed perversions. They describe sexual practices which accent non-normative expressions of sexuality. Paraphilias, according to the DSM-IV (1994) are characterized by recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Transvestic Fetishism

Transvestic fetishism refers to a condition whereby a male becomes sexually aroused by wearing female clothing. The DSM-IV describes it as follows: Over a period of at least 6 months, in a heterosexual male, recurrent intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing are engaged in which again cause clinically significant distress or impairment. Impairment may not be consciously felt, but may represent the fact that transvestism generally competes with heterosexual attraction. It also may impair the ability to form intimate bonds with others, particularly sexual relationships, because the source of erotic excitement is directed more to the self than the other. The DSM asks that the clinician specify whether or not the man has discomfort with gender role or identity. Often the cross-dressing results in collecting female clothing and while cross-dressed masturbating and imagining himself to be both the male subject as well as the female object of his sexuality.

This is often confused with a similar disorder known formerly as transsexualism, now referred to as a Gender Identity Disorder. This is inaccurate. In Gender Identity Disorder the person may certainly dress in women's clothing, but with a different motive. In the transsexual, it is for the purpose of reflecting what they feel is their true gender identity, namely female. The transvestite, on the other hand, feels himself to be male and in the great majority of cases is heterosexually identified. There may be a relationship between the two syndromes, however, with transvestism being the entry point in a disturbance of gender identity and transsexualism being the end point of this process. Lukianowicz (1959) has argued that transsexualism and transvestism exist on a continuum differing only in the degree to alter one's sexual anatomy. Buhrich and McConaghy (1977) have attempted to study these differences in a degree which can be important clinically. They find that transsexuals more often cross-dress in public, attempt to pass as female, have greater conviction that they are the opposite gender, and have fewer heterosexual experiences and more frequent homosexual encounters.

Classical Freudian Views on Perversion & Transvestism

Different aspects of Freud's theories have been used to explain perversions such as transvestism. These include genetic disposition, over-closeness to the mother, Oedipal fears, the incest taboo, the ambivalence of the mother to the boy, the ambivalence of the boy towards the mother and subsequently all women. Freud had early on (1905) argued that perversions were basically infantile sexuality being expressed without repression and conflict as occurs in a neurosis. Perversions were the negation of neurosis and neurotic symptoms were disguised perverse acts. According to Fenichel (1945) in perversion, sexuality is replaced by one of the components of infantile sexuality. As he writes, "He regresses to that component of his infantile sexuality which once in childhood had given him a feeling of security or at least reassurance against fear" (p. 327). Perverts are persons with a more infantile as opposed to adult sexual function. This may be due to either arrested development and fixation or regression due to stress in the person's present life.

One form of perversion which Freud studied intensely was fetishism where a person fixates on a particular body part or item to the exclusion of normal sexuality. According to Freud (1927) in his paper on fetishism, the fetish item stands for the "lost" phallus of the mother with the boy refusing to "admit" and acknowledge her castration. The boy fantasizes that the woman possesses a penis, which then allays the castration complex anxieties. Concomitantly, the boy identifies with this "phallic" mother. This, of course, refers to

his theory of penis envy and male castration fears which will be discussed later.

Interestingly, Freud (1927) writes that, "the fetish spares the fetishist from becoming a homosexual." In this theory, the homosexual man replaces love for the mother by identification with her, while the fetishist refuses to acknowledge that a woman has no penis and is able to maintain his potency accordingly. The perversion functions as necessary preserver of potency. The transvestite fetishist actually assumes both attitudes simultaneously. He creates a "phallic" mother he can then identify with and in so doing, achieve sexual success with a female. The paradoxical script becomes that when he most disguises his masculinity, he attains its height, i.e., erection. According to Fenichel (1945), the transvestite overcomes castration anxiety through identifying with the threatening mother as well as unconsciously refusing to acknowledge that she has no penis. The transvestic identification is established not by imitating her object choice (as in the homosexual), but rather by "her being a woman." The transvestite identifies with being the phallic woman.

The Freudian View: Heterosexuality As The Natural State

In exploring the underlying dynamics of transvestic fetishism, there are many issues of a similar nature to homosexual object choice which will now be discussed. Both share similarities in the underlying gender identity dynamics.

In the Freudian view, heterosexuality is a given. It represents the natural state for a boy. The male begins life with "superior genitals" as Freud would call the male phallus and with his mother as the natural object of his love and affection. Sexuality is seen from the masculine point of view. In a late mature paper (1938) Freud actually argued that in analysis something must go wrong to cause a reversal of this state of affairs to cause homosexuality.

In the Freudian view as expounded in a late mature paper (1938), Freud argued that analysis is really interminable because one eventually hits the "bedrock" of analysis when one is confronted with the repudiation of femininity, which is expressed in the woman's desire for a penis and the male's fear of being castrated by the father for the boys' interest in the mother.

Fear Of The Mother

Many have commented upon Freud's possible "reaction formation." Freud assumed an unambivalent desirable female figure who was safely yearned for by the son and only kept from by the threatening "Oedipal" father who frightens him into submission. The boy ultimately identifies with this father figure and renounces his claims for the mother. This "Oedipal" mother was intensely desired and yearned for without hesitation or fear. All of the deeper fears were attached to this threatening father figure. Fromm (1970) writes that, "Freud could not conceive that the woman could be the main cause of fear. But clinical observation amply demonstrates that the most intense and pathogenic fears are indeed related to the mother; by comparison, the dread of the father is insignificant."

Freud, in short, never having been analyzed or fully confronted his relationship to his mother in all of its complexity and ambivalence developed a theory (penis envy) which can be envisioned as an elaborate attempt to deny these deeper fears and envy.

The Oedipal period is preceded by a "pre-Oedipal" drama which is more mysterious, ambivalent. This is the realm of the Great Mother individually and collectively (Neumann). This mother may possess the magical qualities which the boy is drawn to, but also contains a darker, more frightening side. Whether the darker side is an accurate portrayal of her true qualities (Neumann), a result of early pre-Oedipal experiences of a traumatic nature (Dinnerstein, 1977) or partly created by the emerging ego as a method of not getting merged and dissolved via regression will be addressed.

Disidentifying From The Feminine

For our purposes, the fact remains that the boy's first and primary identification is with the mother. She represents a reassuring and magical figure which the boy enjoys, but also must give up if he is to individuate. The Great Mother exerts a fascinating pull. This pull, however, must be loosened if the male is to ever obtain

a full sense of gender identity. He must move away to some extent from this blissful, yet dangerous and forever remembered and yearned for mother-infant symbiosis. Stoller (1975) has termed this symbiosis anxiety." This refers to the fear that one will not be able to remain separate from the mother and that the ego will remain undifferentiated from the unconscious. The personality erects defenses against this pull for merger. In regards to transvestism, Stoller argues that the unconscious woman with a phallus fantasy denies women's superiority. It replaces for males a fear of the mystery of female generative capacity's inner hidden power, as in procreation or life-and-death omnipotence over their infant—with the familiar penis. He sees the transvestic situation as basically a counterphobic one. No boy ever grows into manhood without being disloyal to his mother on some level. As it states at the beginning of the Hebrew Bible, "And a man shall leave his mother and cleave to his wife."

According to Freud (1917), there exists in the unconscious of man a fear of women, a sense that the females' genitals are "uncanny." As they are the entrance to the original home of mankind, the abode where every one of us was originally at home, Freud writes that, "women's genitals may be a prototype of the uncanny."

One finds the female and her body as both a feared for and yet yearned for object. Unconsciously, one was first bonded with and identified with the feminine. Indeed, one can go further. On a biological, cellular level, we all once were female. Where Freud originally argued that we originally are bi-sexual, biology now tells us that the fetus begins life as a female. To become male, something must happen. I will argue that this is the case psychologically as well. This biology may unconsciously pull us to regression we hope for and dread.

Retaining The Life-Giving Feminine

It is important to emphasize that masculine and feminine development are not such opposites and are only perceived as such by the growing ego in search of gender identity. Males need and desire some of the life giving feminine qualities in their life and their psyche. As the Zohar says, "It is incumbent upon man that he be male and female always." Obviously, given Jewish Halakhah, which emphasizes separations, this is meant metaphorically and may be taken too literally by the transvestite. This seems to be the path of androgyny as set forth by Jungian psychology as well (Singer, 1971).

Freud's case history of Schreber (1911) has been seen as a regression to the dread of homosexuality, which Freud believed existed in the unconscious of the male. However, a carefully reading of the text reveals that what Schreber was most terrified of while in his psychotic state was the "dread of transsexualism." His delusion was that he was turning into a woman. This may be a prototypical fear in the male psyche.

Heterosexuality Is An Attainment

What is the relevance of this to our topic? As Stoller (1975) writes, "the fright makes of some a homosexual, others fend off by means of a fetish and the vast majority of men get over [it]." Rather than heterosexuality being the norm for a male and homosexuality being the norm for female development (given their original object choice—the mother) and males developing homosexual fixation because of a turn of events, it appears that the converse may be more true. Heterosexuality is not simply a given a priori, but an attainment for the male who moves from his state of identification with the female and must at least partially create a firm male gender role. Same-sex object choice as well as transvestic fetishism may represent difficulty with this development task.

If I seem to minimize the role of the father, I hope to show that this is not the case. In situations where the boy remains overly tied or frightened of the matriarch and the unconscious and does not develop a firm enough ego structure or male gender role, the father's role is crucial to understand as the role of matriarchal dominance and masculine abdication are complementary. In other words, a weak or absent father does not become an adequate model for the son to identify with, the son develops a weakened sense of self, is more at the mercy of the Great Mother and succumbs more easily.

Different Cultural Perspectives

Most cultures, particularly those of a more patriarchal

bent have initiation rights. These are designed to help a boy break his tie to his mother as well as gain mastery over his primal fears of the mother, the matriarch and femininity and be "re-born" into the community of males.

A flood of uncontrollable fear of the "castrating maternal deities" pervades the anthropological literature. There is no doubt that the mother goddesses required emasculation as the price to be in her graces. Ritual castration was exacted by maternal figures as a sign of devotion and submission on the part of male figures. There appears to be an archetypal link to transvestism as connected to symbiosis with the matriarch. According to Neumann (1952), "Devotees of the Great Mother were castrated; their genitals and masculine clothing were carved in the bridal chamber of Cybele. Thereafter, they only wore women's clothing, were anointed and wore their hair long. They were then spoken of only in the feminine gender." (p. 92).

Frazier (1922) reports on many myths world wide where after circumcision, boys are dressed as females and continue this mode of dress until their wounds heal at which point they are shaved and thereafter assume the dress of warriors. According to Bettleheim (1952) initiation rites and circumcision may represent the male's attempt to master envy of the female sex and her magic feminine qualities.

Many cultural myths speak to the dread of being affected, controlled and ultimately destroyed by the woman either in her positive aspects (Loreli, Sirens) or her negative incarnations (Eve, Pandora, Medusa, Diana). We can recall the story of Actaeon who comes across the goddess Diana as she is bathing in a pool. Stunned by her beauty and transfixed, he is turned into an animal. This echoes the primordial male fear of women's beauty being a trap, that it will turn him into his animal nature and kill him (or remind him of his mortality which is often associated with mother earth). This archetypal theme is, of course, found in the Eve story. She brings death into the world and the man is found to be powerless to cope with her allure. Pandora's Box (a Freudian symbol for the vagina/womb if ever there were one) brings chaos and destruction to the world. Likewise, Medusa's head is explained by Freud as the male terror of perceiving the female genitals.

Stoller (1975) has written eloquently about how many of these themes will find their way into pornography, which he considers a form of modern cultural mythology. One can perceive these unconscious concerns in the males who consume pornography, and in its attempt to allay them. Thus, one often perceives the archetypal theme of a virgin woman who appears virginal, but is turned into a whore or even an animal. She is kidnapped, tied up, held captive or raped until her "true" animal nature is released. It is archetypal theme in pornography for women to be associated with animals.

Pornography And Transvestism As 'Revenge'

Pornography with transvestic scenes can also be envisioned as an attempt to find revenge, restitution and potency. These themes almost always portray a helpless male who is forced to dress as a female, but ultimately finds "revenge" in his ability to get an erection and prove his maleness. He succeeds with women where he was expected to fail. The issue of anger and restitution are important in transvestism. LaTorre (1990) conducted an interesting experiment which sheds some light upon the etiology of transvestism. In this study, men who were informed that they had been rejected for a potential date by an attractive unknown female reported less sexual attraction and other positive feelings to pictures of attractive women than did men who were accepted for dates. The rejected men were found to judge pictures of women's panties as more sexually attractive and arousing than pictures of attractive women.

Narcissism

The character of Narcissus was often portrayed as a somewhat androgynous male, who the story tells us, became so infatuated with his reflection in a lake that he attempted to hug himself and in so doing fell into the water and drowned. Doubtless, this was the Greeks' moral instruction against too great a sense of hubris and self-obsession. Cross-dressing itself is an activity which thrives upon mirrors and photographs. How often I have been able to reduce its compulsive force simply by telling the client to disavow the use of mirrors. Transvestism can be viewed as a carryover from early narcissism (Brok). Gender is among the earliest recognition of our self identity. In normal

development, children quickly identify themselves based upon gender and quickly learn gender roles. It is true that in development there is an early dichotomy set up which is immature and which we may later revisit and modify. It remains pertinent, however, that gender identity first be learned even if in a rigid fashion before we can flexibly shift our boundaries.

A Refusal To Disidentify From The Mother

Transvestism may represent a refusal to accept limitations. It may represent a vestige of "infantile omnipotence" where a person refuses to give up any choices and wants everything. There may be corresponding rage at having to give up the earliest identification. According to Bettleheim (1962) in his cross-cultural study of initiation rites, transvestism seems to be an indication of the pervading desire of both men and women to share the sexual functions and roles of the other sex. It also seeks to assure the child that with the reaching of sexual maturity not all desires to share the prerogatives and pleasures of the other sex need be given up once and for all. It seems to emphasize that from time to time this will be permitted. These desires seem to reveal not only the infantile refusal to commit themselves to any definite sexual role, but their envy of anyone who can do so.

In transvestism, what often occurs is that the man chooses to display the attractive features of women and to enjoy these rather than to enjoy these features as present in an actual woman.

Transvestites Likely To Be Firstborn

Transvestites, we have seen, are over represented in first-born males or only children. One may speculate that they received a great deal of their mother's emotional involvement. It is important to discuss interpersonal factors as opposed to only intra- subjective ones in the genesis of transvestism. It has become accepted in psychodynamic approaches that perversions can no longer be seen simply as a question of egosyntonic regression to pre-genital modes of instinctual gratification. While Freud emphasized the role of auto-erotic experiences, intimacy is not simply a regression to ego-syntonic repetition of infantile auto-eroticism According to Anna Freud (1952), there is a crucial lack of object relations in terms of an incapacity or difficulty with love and a dread or terror of emotional surrender. This view makes great sense and is crucial for enlarging our understanding of the phenomena.

Perversion As 'Defective Object Relationship'

In any perversion, including transvestism, there is a fixation not on a person, but generally on an activity. Devereux (1950) goes so far as to state that, "All sexual relationships in which the behavior is for all practical purposes normal, but the object relationship defective is essentially perverted." According to Schmidberg (1956), "Structurally, perversions are similar to acting out in analysis." In perversion there is a sense of revenge and interpersonal restitution (Stoller, 1975). In transvestism, the revenge may be in separating from the mother's clutches and obtaining an erection. In transvestism, one cannot bear another's totality, but rather seeks to fragment, split and to some extent dehumanize. The garments become split off from the human being or the "whole object" as the object relational theorists would posit. Intimacy with a real live woman is desirable, but dangerous. There is a substitution of inert clothes for living skin.

According to Bak (1968), "Fetishism is the model for all perversions. The pervert is one who cannot bear another totally and will need to fragment, split and dehumanize." There is an early disturbance in the mother-infant relationship. Identification with the phallic mother is a way of mastering her threatening qualities.

Perversion As An Attempt To Preserve Masculine Potency

One can, at the same time, envision the transvestic ritual as an attempt at healing gone astray. These rituals function concomitantly as an attempt to undo separation, but at the same time promote it. This is another way of expressing that the perversion is an attempt to preserve masculinity and potency. One can envision the female garments as transitional objects between the mother and full separation from her. This is the point of view of Welldon (1980) who argues that anxiety about separation from the mother is the most important element in perversion formation rather than "castration anxiety."

In connecting this to our previous discussion, one can argue that the male needs to separate enough from the mother and the primary feminine identification, but does this in an interpersonal context. In healthy development the mother must encourage and allow the separation in a dosed fashion or run the risk of attenuating the primary feminine identification.

Although I am not particularly cognitive/ behavioral in my orientation, its insights can be useful clinically. They can concomitantly be seen as exploring the same dynamics as psychoanalytic approaches. Cross-dressing may begin via accidental pairing of the unconditioned stimulus with the conditioned stimulus. Additionally, it may prove to be a negative reinforcer in operant terms given its ability to be soothing when it first occurs. It has negative reinforcement properties by its ability to decrease anxiety. It takes on positive reinforcement properties by its added reward component of excitement, masturbation and orgasm. Cross-dressing may become self-perpetuating because of the pleasure associated with it.

Although it is beyond the aims of this paper, treatment components based on extinction, aversion and cognitive restructuring may prove useful.

Cross-Dressing: The Case of Dovid

I would like to describe a case history which elucidates many of these themes: Dovid was a 22-year-old college student. Intensely Orthodox in an unyielding fashion, he recognized the lack of congruity of his symptom. He had cross-dressed for as long as he could remember. He used to sneak and put on his mother's bathing suit or underwear as well as dresses when his parents would go out. He was the oldest child in the family of six. Dovid's personality was very rational and "Apollonian." He utilized logic to an impressive degree. He denied any conscious sexual feelings. He tended to control his feelings deeply. A Jungian perspective, of which there was some evidence, would argue that his cross-dressing represented a "return of the repressed." He had so neglected the more feminine traits of yin, yielding and spontaneity that his personality was too out of balance. He loved music, but described himself as "artistically" challenged. He had no visual sense at all (except where he cross-dressed). He termed his paradoxical trends as "controlled chaos."

Interestingly enough, he claimed that gender, which is quite central in Orthodox Judaism, was not really salient to him. He was the first to have remarked to me that he could sometimes not notice or remember whether someone he had met was a male or female. I have since heard this remark from other transvestites.

Dovid was somewhat unsure of his sense of gender identity. He had no desire to change his sex. He never even countenanced such an idea. At the same time, he expressed conscious envy of females and their procreative abilities. He had a recurrent fantasy that he would like to cross-dress in public and pass for a female. He was turned on by the thought of being female although he denied any sexual arousal in his fantasies or behaviors.

A Symbiotic Mother-Son Relationship

Dovid's parents seemed to fall into the typical patterns of transvestic behaviors. The father was a very distant and unavailable person. He was a lawyer who worked long hours. While he loved his son, he was not really there for him in any practical sense. The mother was a very warm and supportive person on the surface. In certain sessions where there was family work, she presented as somewhat overly close. One might be tempted to call her behavior "seductive," but I saw it differently. The entire "Oedipal" scenario was characterized by a lack of real conflict and dynamic tension. Dovid had basked in her presence and magic and never really developed what can be called a heterosexual relationship with her. There was no real Oedipal conflict. No sexual tension was discernable. He never desired her as a separate person; the two of them became as "one." At the same time, this symbiosis was threatening to his developing ego. He recalled dreams of being smothered, of drowning or being annihilated.

Dovid's father took an active interest in him when his cross-dressing proclivities became known. One can look at this as one of its motivations. This insight was further supported when Dovid became involved with a non-Jewish divorced teacher. He had to admit that although it appeared coincidental, these were the two unpardonable acts he could engage in.

An important event occurred with this teacher. He would cross-dress with her and engage in petting. He experienced his first orgasm with her. He began to engage in this behavior periodically despite my recommendations to the contrary. He was somewhat resistant to any exploration of his relationship with his mother and father. He did express rage towards his father's new found control. He expressed positive feelings towards his mother and at least considered my reconstruction about his cross-dressing as connected to his feelings about separation from her (a transitional object like Linus's blanket). We explored his narcissism and this resulted in a great deal of resistance. He perceived himself as a selfless, giving person. While it is true that he did possess compassionate qualities, it was necessary for him to own the extent of how his system controlled his parents and procured him great attention and energy.

Setting Boundaries Against The Intrusive Mother

One of the major issues, which was connected to the concept of symbiosis anxiety, was the question of boundaries. His parents, particularly his mother, had a very difficult time accepting him as a separate person with his own boundaries. Much of my therapeutic work centered on trying to set proper boundaries for an adult with his parents and managing the upheavals of their intrusions. He slowly became able to begin to set his own boundaries and give up some of the secondary gains he received by playing along with this script. It was hard for his mother to contain herself, but her love for him proved stronger than her neurotic need to engulf him.

Management Of The Symptoms

The behavioral technique of olfactory aversive conditioning was integrated to the psychodynamic treatment. At first he greatly resisted and expressed that he was "freaked out" that this technique might mess around with his brain and its sexual arousal centers. We explored anew the issue of control and domination and how it was connected to the transference. He agreed to try this technique. He reported that it did help him control his urges.

Dovid met a Jewish woman he felt he could settle down with. He reported continued intrusions of the urges, but he was able to control them with the support of therapy. We continued to explore his patterns of intimacy and his fear of contact and tendency to "run off" metaphorically, which the symptom partially represented. I tried to help him to face his terror of intimacy and he was able to handle his anxiety to the point where he married. We explored his sexual arousal and the circumstances when the transvestism recurred with a vengeance. He was able to identify a pattern rather than seeing the symptom as simply an arbitrary occurrence not connected with any external or internal factors.

Dovid moved away after their second child was born. He continues to contact me periodically. The urges have never fully left him, but he has been able to greatly increase his ability for pleasure in sexuality and intimacy. He continues to deal with this issue. He understands that he might always have some imprint of this symptom to deal with, but feels that his life has been returned.

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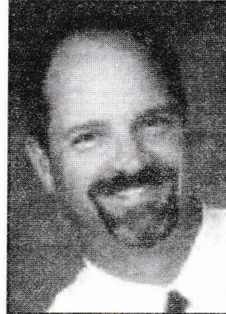
Boys With Gender Identity Disorder Raised By Single Mothers

By S. Scott Sutherland, M.A.

Introduction

Historically, there has been a great deal of focus on the treatment of adult men struggling to overcome unwanted homosexual feelings. However, preventing homosexuality is vital, too. Since 75% of children diagnosed with Gender Identity Disorder (GID) will report a homosexual or bisexual orientation as an adult, I consider GID to be a pre-homosexual condition; one which demands our attention. Although not all pre-homosexual boys develop GID, treating GID in the early stages of its development would prevent a great deal of pain and suffering.



S. Scott Sutherland M.A.

Since the origins of GID have a great deal to do with overly distant relationships with fathers and overly close relationships with mothers, boys being raised by single mothers may be at a higher risk of developing GID. As such, this presentation will focus on those aspects of the origin and treatment of GID relative to single mother-headed households. But let me be perfectly clear. The vast majority of boys raised by single mothers grow into well adjusted young men who never manifest any GID traits.

The scope of this situation is significant. The overwhelming majority of single parent households are headed by single mothers. First, we have a divorce rate in excess of 50% and in over 85% of these divorces, mothers are given sole custody of their children. To make matters worse, fully half of the fathers discontinue all visitations with their children within three years of divorce. Also, according to the National Center for Health Statistics Report on Births to Unmarried Mothers, one out of every three births in America is to an unmarried mother and from 1980 to 1992 the annual rate of births to unmarried mothers almost doubled to 1.2 million.

Clearly, millions of children are growing up with little or no contact with their fathers and the potential impact must be examined.

Basic Terminology

Sex and gender are terms that are often used interchangeably. However, these terms have very different meanings that are important for a clear understanding of this topic. Sex refers to our biological femaleness or maleness. There are two aspects of biological sex: genetic sex and anatomical sex. Genetic sex is determined by sex chromosomes and anatomical sex consists of the uniquely physical aspects of males and females. Gender is a psychosocial concept of masculinity and femininity. Although the concepts of "masculinity and femininity" are largely defined by culture, congruent sex-gender identity begins with biology. The anatomical design and physiological functions of the reproductive system make humans predisposed toward gender identification that is congruent with their given sex. When gender identification is incongruent with a child's given sex, there is a reason.

What Is Gender Identity Disorder?

I have spoken with scores of parents who initially did not know how to respond or even if they should respond to their son's gender confused behavior. Should they be worried that their son only plays with girls and avoids rough and tumble play with boys? Was their son's preoccupation with traditionally feminine activities such as dressing in female clothing, playing traditionally female games, and consistently portraying female characters in their fantasy play, just a phase? And should a parent do anything when their son expresses a wish to be a girl and pretends not to have a penis by pushing it between his legs? The majority of these parents received well intentioned but misguided counsel by teachers, family doctors, pastors, and even mental health professionals. They were often told this was just a phase, or worse, that these behaviors were just a reflection of their son's "inner self" and that as loving parents they should accept this.

So, just what is GID? Technically speaking, a diagnosis of Gender Identity Disorder requires strong and persistent cross-gender identification; there must be evidence of ongoing discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex; there must also be a significant degree of clinical distress or impairment in social, academic, or other important areas of functioning.

Etiology Of Gender Identity Disorder

I've broken down the primary issues regarding the development of GID into four categories. As always, categories are oversimplifications of complex dynamics; however, they can be useful in helping us to understand and address behavioral and emotional problems. These categories are: identification with the feminine, failure to identify with the masculine, temperament, and development of a false self.

Identification With The Feminine

Mother

A boy may develop an overly close relationship with his mother for many reasons; but when his father is not available, or desirable, a boy may have little choice but to identify with his mother. Regardless of her personality, she dominates his life. The boy may be companion, confidante, and even play the rescuer role if he perceives his mother to be a victim.

It's easy for him to identify with his mother because she is familiar, comfortable, and safe. As he feels increasingly familiar, comfortable, and safe with females, he feels increasingly unfamiliar, uncomfortable, and unsafe with males.

Sister

Sisters don't cause GID, but they can exacerbate underlying dynamics thereby contributing to their brother's identification with the feminine. It's normal for brothers and sisters to play together; however, for boys struggling with their gender identity, too much interaction can be detrimental. Often times, after a boy has experienced some sort of trauma, an older sister becomes an oasis of comfort and safety. Many GID boys have idealized an older sister.

Disidentification From The Masculine

Father

Gender identification requires time and contact in order to develop. Non-custodial fathers face an uphill battle building close relationships with their children. Dr. William Pollock, author of *Real Boys*, states that divorce is difficult for children of both sexes but is devastating for boys. He says the basic problem is the lack of discipline and supervision in the father's absence and his unavailability to teach what it means to be a man.

Brother

An older brother-younger brother relationship can be extremely helpful for a young boy when his father is not sufficiently available. However, an older brother-younger brother relationship can also be equally negative as well. Again, sibling relationships don't cause GID, but they can exacerbate the pertinent underlying dynamics between child and parents.

Male Peers

Boys generally long to have male friends and to be accepted by them. This is normal and healthy. But when a boy struggles in his relationship with his father, he often struggles in his relationships with his male peers. It doesn't take too long before the other boys realize that he doesn't play sports, doesn't play with them, that he hangs out with the girls and maybe possesses some feminine mannerisms. Teasing ensues. Being the object of teasing is difficult for any child, but can be particularly damaging for sensitive children (I'll discuss the sensitive boy later). For the boy already struggling with his gender identity, teasing can confirm his worst fear, that he is different from other boys, that he is not "one of the guys" and never will be. While feeling increasingly disenfranchised, he feels increasingly inadequate and his social alienation from boys grows. Feeling increasingly rejected by peers, he may react by rejecting them and their "male-ness."

Gender Condemnation

According to Dr. Judith Wallerstein, author of *The Unexpected Legacy of Divorce: A 25 Year Landmark*

Study, post divorce anger is very damaging for boys. It is probably not surprising that over 80% of women expressed intense anger regarding their failed marriage and divorce and that the most common form of expression of post divorce anger was denigration of their former spouse. Furthermore, over 50% of the mothers were extremely critical in their comments about the other parent.

Over-Protection

Some mothers, with their natural tendency toward caring and nurturing, try to protect their son from getting hurt. Guilt over a divorce can exacerbate the desire to protect their child. This can result in mothers not allowing their sons to play rough and tumble games because they might get hurt. Some mothers will overly attend to a child who is hurt such that the boy gets the message that physical pain and discomfort is bad and to be avoided at all costs. These boys will often over react to normal bumps and bruises, cuts, and scrapes. Boys thus avoiding physical games make it more difficult to connect with male peers and are set-up to endure teasing.

Temperament
It has been my clinical observation that "sensitive" boys are more vulnerable to developing GID. They are frequently emotionally intense, physically unaggressive, and avoidant of rough and tumble play. According to Dr. Elaine Aron in her book, *The Highly Sensitive Child:*

> Highly sensitive individuals are those born with a tendency to notice more in their environment and deeply reflect on everything before acting, as compared to those who notice less and act quickly and impulsively. As a result, sensitive people tend to be empathic, smart, intuitive, creative, careful, and conscientious. They are also more easily overwhelmed by high volume or large quantities of input arriving at once.
>
> They try to avoid this, and thus seem to be shy or timid or party poopers. When they cannot avoid over stimulation, they seem easily upset and too sensitive.

Classic Family Triad

The classic family triad usually begins with a strained relationship between mother and father. The mother's lack of emotional fulfillment from her husband sometimes results in her unconsciously seeking fulfillment of some of these needs from her son. The sensitive boy is more emotionally attuned and will often side with his mother in an unspoken alliance with her against his father. This dynamic provides the foundation for the GID boy's disconnection from his father and concurrent enmeshment with his mother. Because the father is not physically present in the single mother headed household, the family is prone to the emotional dynamics of the Classic Family Triad. However, the single mother headed household does not have to succumb to the dysfunctional emotional dynamics of the Classic Family Triad.

Treatment

I am restricting the scope of this paper to prepubescent boys because the onset of puberty qualitatively changes the issues involved with GID and therefore the treatment. With physiological, mental, and emotional changes that occur in boys' passing through puberty, boys previously displaying symptoms of GID often begin to eroticize their unmet needs for healthy connection with males. The onset of same sex attraction requires the intervention of direct, individual psychotherapy.

Since the origins of GID have to do with family dynamics and a sensitive temperament, treatment focuses on altering family dynamics and learning how to work with the boy's sensitive nature. I do not work with the boys directly; instead, I work directly with the mothers and, if possible, the fathers. Parent-only counseling is desirable because this avoids unnecessary stigmatization of the boys. Generally speaking, it is not in the boys' best interest that they believe that there is something "wrong" with them. Ideally, the boys will never know that their parent(s) are working with a mental health professional.

Resistance
There are typically two types of resistance. There is the resistance of the child and the resistance of the parent(s). Even though the boy is usually unaware of

the involvement of a mental health professional in his life, he frequently will become aware that his parents are behaving differently or are treating him differently. Many of the changes he'll enjoy, but some changes he will dislike because he is being nudged out of his comfort zone. Effectively dealing with a child's resistance requires a skillful working alliance between the parent(s) and therapist. Trouble-shooting and brain-storming are often required to find the interventions that will be effective for each child and their unique combination of personality and family dynamics.

It is important to reassure the parent(s) that most people are not aware of the origins of this condition and are therefore ill equipped to effectively handle this issue without professional guidance. Little information is available regarding GID and even less about treatment. Furthermore, the majority of physicians, educators, mental health professionals, and clergy are misinformed about this condition and therefore give out misleading advice to parents.

Identification With The Feminine

Mother

Single mothers should be careful not to develop an inappropriately close relationship with their sons. It is all too easy for newly singled mothers to let some of their hurt and anger toward their former spouse spill out onto their children. Some mothers inadvertently turn one of their children into their confidant. This is usually a sensitive child who then becomes mother's rescuer, assuming a disproportionate level of responsibility for his mother's well-being. Some parents justify their behavior by saying "I'm just telling them the truth."

It is particularly important that single mothers have same-sex friendships in order to have a healthy place to vent their worries and frustrations regarding the pain of divorce, the challenges of single parenting as well as other life issues. The best way to prevent an overly close relationship with their children is for mothers to get their emotional needs met by other adults.

Single mothers can meet some of their needs for male companionship through healthy relationships with male family members and friends. Dating should only be undertaken when sufficiently healed from the marital loss. Also, many churches have ministries that specifically address the needs of single parents and their children.

Sisters

If a boy has an overly close relationship with an older sister, her cooperation can be enlisted. Depending on her age and maturity, be prudent about the amount of information you give her about her brother because even good kids can misuse sensitive information when upset. Encourage her not to do "girl things" with him like play with dolls or dress him like a girl; but rather, play games where they assume traditional gender roles.

Disidentification From Masculinity

Father

The father-son relationship is the foundation of a boy's masculine identity. Even a non-custodial father has a profound impact on his son; he will always have a special place in his son's heart. Unless a father is actually abusive to his son, a mother should do everything in her power to facilitate a healthy relationship between her son and his father. This includes being flexible and generous with visitation even when she has the legal right to do otherwise. I have worked with single mothers who were so angry at their former spouse that they wanted nothing to do with him and they wanted their children to have nothing to do with him. For these mothers, it is a bitter pill to swallow to foster a relationship between her children and her adversary. But it needs to be done. Remember, "Mothers make boys, fathers make men."

A positive male image is still important even when the father is permanently absent. Father's don't have to be viewed as perfect by their sons, but particularly in the early years it is helpful to a boy's development that his father be viewed as someone he would like to grow up to be like.

Mentors

When a father is unable to fulfill his child-rearing responsibilities, other men must be found to pick up the slack. By establishing a mentor relationship, a boy can receive valuable affirmation, emotional connec-

tion, fatherly guidance, and a same sex role model to emulate. Family members such as grandfathers, uncles, or older brothers are generally more committed and more likely to stick with the relationship. A mentoring relationship that starts and then fades can backfire causing further distrust of males. However, in our mobile society suitable family members are often not available and other sources must be pursued such as family friends, church members, or a youth pastor.

Organizations exist that provide mentors such as The National Mentoring Partnership, Young Life, Youth For Christ, Youth Builders, One Kid At A Time, and Boys to Men with City Impact. Big Brothers and Big Sisters of America is the largest mentoring organization in the nation; however, they allow gay-identified individuals to be mentors and gender confused boys need mentors with strong gender identification themselves.

Brothers
It's important to monitor sibling relationships. Parents must intervene to stem adversarial relationships between brothers, particularly between an aggressive older brother and a gender confused younger brother. Conversely, helping brothers to build a positive relationship can be very beneficial for a gender confused boy. Enlist the older brother's help, but again, depending on his age and maturity, don't give him all the details.

Friendships
Foster male friendships. Friendships with male peers are almost as important as relationships with fathers. Boys in groups have the unique power to bring out the masculine potential in each other. The natural ebb and flow of good-natured teasing and joking, shoving and wrestling, insulting and encouraging each other, is part of the process of bonding with peers, developing a particular kind of toughness (a "thick skinnedness"), and molding of the male identity.

Males tend to bond through the joint experience of activities, the more intense the better. Military service, sports, and challenging work are prime examples where men typically bond. For young boys, sports may be an available avenue to bond with their peers. If the boy has an aptitude for sports, encourage his involvement. Team sports in particular foster comradeship and mutual dependence. But let me be very clear, these bonding activities don't have to be sports. If he doesn't like sports, then don't force him. This would only set him up for failure and confirm in his own mind his inferiority to other boys. The opportunity to get to know other guys, to de-mystify them, to get comfortable with them, and to eventually bond with them is infinitely more important than the nature of the activity. Organizations such as the Boy Scouts or the YMCA Indian Guides provide boys with non-competitive, activity-based environments within which to connect with male peers.

Affirm Masculine Identity

Single mothers need to make a conscious effort to encourage and affirm their son's masculinity by clearly differentiating between their femininity and their son's masculinity and making it clear that these differences are good. They should treat their sons differently from their daughters. This is a time to be a little politically incorrect by assigning different household duties that reflect traditional gender roles and explaining the importance of being a gentleman and teaching him how to treat girls differently than boys. Stroke his budding male ego by complimenting him on how big and strong he is and congratulating him on his accomplishments.

Conclusion

In summary, good treatment for boys suffering with Gender Identity Disorder really means good parenting. This is not brain surgery, but it does require effort and persistence.Help him to build healthy relationships with male peers. Help him to separate and individuate from his mother and other females.

Encourage the mother to address her issues so that she can be a better parent. Allow the boy to be a child and attend to his own needs. Allow him to be "one of the guys."And finally, listen to him and encourage him to appropriately express his needs, wants, thoughts, and feelings.

Scott Sutherland is a psychological assistant to Dr. Joseph Nicolosi, at the Thomas Aquinas Clinic in Encino, California.

'Brokeback Mountain': A Woman's View Of The Life Of Gay Men

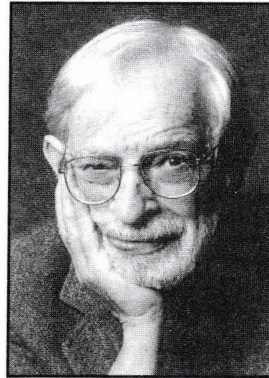
By Louis A. Berman, Professor of Psychology (retired), University of Illinois at Chicago

Given the lavish praise it won from the film critics across the country, "Brokeback Mountain" was a sure bet to be named Best Picture of the Year at this year's Academy Award ceremony. One particularly lavish endorsement appeared in *Rolling Stone*, and included the words: "Unmissable and unforgettable! . . . A classic in the making! . . . A landmark film . . . an acting miracle. . . .The unerring script . . . a model of literary adaptation." The publication *Entertainment* lauded "Brokeback Mountain" as "a film in which love feels almost as if it were being invented. Revolutionary."

The Human Rights Campaign, the largest national gay rights group, prepared to make the most of the virtual certainty that this romantic story of faithful gay love, based on a short story by Annie Proulx, would be named "The Best Picture of the Year" by the Motion Picture Academy. A month before Oscar night, the Human Rights Campaign held a gala in New York City at which a pair of jackets worn in the movie by the gay lovers, was auctioned off for $42,000. The *Chicago Tribune* quoted Human Rights Campaign spokesperson Susanne Salkind as saying that recognition of "Brokeback" will be an opportunity to raise gay issues "to another level of American culture. . . . We want to transform this . . . occasion into something much more important."

An Associated Press article (published in the Feb. 15, 2006 *Chicago Tribune*) quotes gay men who agree that the film "tells the story of [their] own gay life and struggles in a strikingly personal way," and that such movies "have given millions of Americans a greater understanding of who we are." Speaking on Hong Kong television, according to Chicago's *Windy City Times* of March 15, "Brokeback Mountain" director Ang Lee said, "This is the way gays are. It's just that they have been distorted. When two people are in love and are scared, that's the way they are."

Nobody asks that fictional characters be typical of persons of his group. Was Zorba a typical Greek? Was Capote a typical gay writer? But when it is claimed of



Professor Louis A. Berman

"Brokeback Mountain" that "this is the way gays are," that calls for a closer look at the film, at the story on which the film is based, and how the events of the story compare with what is actually known about the lives of gay men. There is, after all, a considerable literature about the lives of gay men, including autobiographical writings, clinical studies, surveys, research studies and field observations of all sorts.

Romanticized Or Reality?

Suppose we compare what we know about the lives of gay men, with what the story tells us. Is the story an educational (as well as an artistic) experience? Does the film sharpen our image of the gay man, or does it actually becloud it, romanticize it, elevating political correctness to a dazzling new level. How much does the story tell us about the social and inner life of gay men? For our answer, I will be guided mainly by Proulx's short story, rather than try to recall every detail of the movie adaptation. What contrasts so boldly between this pair's behavior and what is known to be so much more typical of gay men, is the secret lovers' uncompromised faithfulness, through 20 frustrating years. Jack is depicted as the faithful lover who pines away for his absent love. (A feminine conception of gay sensibility?) This makes a believable story for straight folks to behold, and gives the movie a very romantic touch, but this does not recognize the importance of cruising in the life of a typical young gay man.

The survey findings of the University of Chicago's Prof. Edward Laumann contrasts the average number of sexual partnerships claimed by typical straight and gay men. In a study reported in 2004, 80% of gay men claimed to have had 16 or more sex partners. In a 1992 study of heterosexual married adults, by contrast,

Laumann reported that a majority of 1,660 respondents claimed to have had only one sexual partner after the age of 18, and only 15 per cent more than ten.

"Cruising" is the word gay men use to describe this activity. Researchers use the term "multiple partnerships" and avoid the word "promiscuity," which is old-fashioned and pejorative. Multiple partnerships are far, far more common in gay populations than is the uncompromised faithfulness depicted in "Brokeback Mountain."

A gay man has always had to be careful where he worked or lived. Life in the rural West could be rather dangerous, as the following quote from Proulx's story (Ennis speaking) indicates: *". . . There was these two old guys ranched together down home, Earl and Rich. . . . They was a joke even though they was pretty tough old birds. I was what, nine years old and they found Earl dead in a irrigation ditch. They's took a tire iron to him, spurred him up, drug him around by his dick until it pulled off, just bloody pulp. . . . Dad made sure I seen it. Took me to see it. . . . Dad laughed about it. Hell, for all I know he done the job."*

The Earmarks Of A Woman's Imagination

Jack and Ennis are portrayed as faithful lovers who pine away for each other in-between their infrequent reunions. Both men claim a powerful craving for each other, and indicate no sexual attraction to other men. However, this powerfully-drawn theme of endlessly patient and faithful love, has the earmarks of a feminine imagination. In the real life of most gay men, the world is too big and abundant, and one's physical cravings are much too urgent to spend months pining away for an absent partner. If "Brokeback Mountain" were written by a gay man, it would tell a rather different story, and it might not be so readily adopted by Hollywood.

Professor Berman is the author of *The Puzzle: Exploring the Evolutionary Puzzle of Male Homosexuality* (Godot Press, 2003).

Events And Announcements

New Supervision Opportunity

Do you want learn how to treat homosexuality or improve your clinical skills? NARTH President Dr. Joseph Nicolosi, clinical psychologist and author, is now offering group supervision. All licensed mental health professionals are eligible. The supervision will be two times each month, live over the telephone. The cost will be $40.00 per session, and the time to be determined later. We only have two or three openings for the group so act quickly. Please contact Marc S. Dillworth, Ph.D. at mdillwor@tampabay.rr.com if you are interested.

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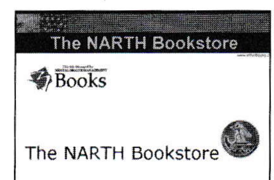

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The Condition Of Male Homosexuality CD by Dr. Joseph Nicolosi for $8.

NARTH professionals should plan now if they wish present papers at the NARTH Conference for 2006 to be held in Orlando, Florida. The conference will be held November 10-12.

Those wishing to speak and present papers at this conference should fill out our online form and submit it by email.

Boston Globe' Columnist Concerned Over Freedom Of Conscience And Gay Adoption

Boston Globe columnist Jeff Jacoby has recently penned a sobering commentary on gay adoptions and the Catholic Church. His column was reprinted in the *Jewish World Review* as "Adoption, kids, and the gay agenda."

Jacoby describes the current situation in Massachusetts with the Archdiocese of Massachusetts shutting down its adoption agency in order to avoid state-imposed adoptions of children by gay couples.

Jacoby noted that the Human Rights Campaign spun the story with a headline that read: "Boston Catholic Charities Puts Ugly Political Agenda Before Child Welfare."

According to Jacoby, the move by the Catholic Church isn't politically motivated. It is motivated by adherence to Catholic doctrine on homosexuality and the best interests of the child. "Catholic Charities excels at arranging adoptions for children in foster care, particularly those who are older or handicapped, or who bear the scars of abuse or addiction. Yet the Human Rights Campaign and its friends would rather see this invaluable work come to an end than allow Catholic Charities to decline gay adoptions," said Jacoby.

He asks the question: "Is this a sign of things to come? In the name of nondiscrimination, will more states force religious organizations to swallow their principles or go out of business?"

Jacoby quotes Harvard Law Professor Mary Ann Glendon who wrote in 2004 that once same-sex marriage becomes legal in a state, "the experiences in other countries reveal that once these arrangements become law, there will be no live-and-let live policy for those who differ. Gay-marriage proponents use the language of openness, tolerance, and diversity, yet one foreseeable effect of their success will be to usher in an era of intolerance and discrimination. ... Every person and every religion that disagrees will be labeled as bigoted and openly discriminated against. The ax will fall most heavily on religious persons and groups that don't go along. Religious institutions will be hit with lawsuits if they refuse to compromise their principles."

The Archdiocese of San Francisco is facing the same dilemma that faced the Boston Church. It, too, may be forced by anti-discrimination policies to shut down or be forced by the city to place children in gay households.

Catholic Charities Of San Francisco Will Stop Placing Children In Gay Homes

The San Francisco Catholic Archdiocese is currently under fire for a decision to enforce Catholic doctrine, which prohibits the placement of children in homosexual homes. The new Archbishop of San Francisco is George Niederauer, who has admitted that the Catholic Charities adoption agency has placed children in the homes of homosexuals before, but will now stop the practice.

According to Pope Benedict XVI, placing children in such homes means "doing violence to these children, in the sense that their condition of dependency would be used to place them in an environment that is not conducive to their full human development."

Archbishop Niederauer said: "We fully accept and faithfully teach what the Catholic Church teaches on marriage and family life. In light of these convictions, we currently are reviewing our adoption programs to determine concretely how we can continue to best serve children who are so much in need of a home."

A lesbian rights organization is threatening to file an anti-discrimination lawsuit against the Church over this new policy.