Possible Factors in the Development of Same-Sex Attraction (SSA)[1]

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[1] This paper is a revision of "Who Am I? Psychological Issues in Gender Identity and Same-Sex Attraction," pp. 70–98, in H. Watt (Ed.), *Fertility & Gender: Issues in Reproductive and Sexual Ethics* (Oxford: Anscombe Bioethics Centre, 2011). The original paper was based on a presentation given at the Linacre Centre for Healthcare Ethics—now Anscombe Bioethics Centre—International Conference on Fertility, Infertility and Gender in Maynooth, Ireland (June, 2010). A copy of this published paper along with the other conference proceedings may be obtained at http://bioethics.org.uk/index.php/.

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Abstract

Each human being, including one who experiences same-sex attraction (SSA), possesses a nature and existence that in some ways is universal, in some ways is pluralistic, and in some ways is unique. Genetic and biological factors may influence, but do not (pre-) determine, the development of gender identity in general or SSA in particular. Certain early life experiences influence the development of gender identity, depending on how these influences are perceived and internalized by the individual. Perceived disaffirmation from and other experiences with parents, siblings, peers, and/or others may predispose to, but do not predetermine, the development of SSA. Same-sex attractions have meaning beyond the simple desire for sexual gratification. These may include: 1) Unmet needs and unrealized growth and maturation; 2) unresolved feelings, unhealed hurts, and unreconciled relationships; 3) unrealistic hopes, fears, and expectations for self and others, and unfulfilling—and inauthentic—self-image/identity; and 4) unmanaged co-occurring compulsions and addictions (among them addiction to sex, alcohol and other drugs, and food) as well as disorders of mood (anxiety, depression) and personality. To be helpful, medical and mental health care for unwanted homosexuality—like all professional care for any presenting concern—must be given personally, one client at a time, to those who freely seek it.

Homosexual feelings and behavior are not innate or immutable, and homosexual behavior is not without significant risk to medical, psychological, and relational health. Understanding the psychological issues involved—including the risk factors and bio-psycho-social realities that those who experience unwanted SSA may face—may help such persons manage and resolve the issues involved as well as the unwanted SSA. Some state, national, and international legislatures and professional organizations are working to stifle, instead of to facilitate, the right of persons to receive—and professionals to give—assistance for dealing with unwanted SSA. Men, women, and children can hardly

be adequately described by a reductionist reference to their *sexual orientation*—in other words, their being *a* "heterosexual" or *a* "homosexual." Human beings have a much more fundamental identity.

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Introduction

On May 16, 2013, the Gallup Poll headlines read: "More Americans See Gay, Lesbian Orientation as Birth Factor—By 47% to 33%, Americans say it is inherent rather than product of environment" (Jones, 2013). A random sample of 1,535 adults was asked in a telephone interview: "In your view, is being gay or lesbian something a person is born with, (or) due to factors such as upbringing and environment?" According to the interview:

> Currently, 47% of Americans view being gay or lesbian as a sexual orientation (which) individuals are born with, while 33% instead believe it is due to external factors such as upbringing or environment. That 14-percentage-point gap in favor of "nature" over "nurture" is the largest Gallup has measured to date. As recently as two years ago (2011), the public was evenly divided. (Jones, 2013)

According to the graph accompanying the report, only 13% of respondents in 1978 viewed being gay or lesbian as "something a person is born with," while 56% viewed it as "due to upbringing/environment." This gap gradually narrowed until 2000/2001, after which the public has remained more or less evenly divided on this question for a decade—until now (Jones, 2013).

It is beyond the scope of this paper to discuss the factors that have led increasingly more people to believe that "being gay or lesbian" is due *more* to nature (something a person was born with) *than* nurture (external factors such as upbringing or environment). It is interesting to note, however, that the general public's views are not shared by the American Psychological Association (APA).

As early as 1998, the APA answered the question *What causes a person to have a particular sexual orientation?* as follows: "[M]any scientists share the view that sexual orientation is shaped for most people at an early age through complex interactions of biological, psychological and social factors" (APA, 1998).[3] Ten years later, the APA took a similar position. In 2008, while acknowledging that research has studied "possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation," the APA concluded: "There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation........ Many think that nature and nurture both play complex roles" (APA, 2008). While the APA's views contradict the general public's growing belief that "being gay or lesbian [is] something a person is born with" (Jones, 2013), the APA unfortunately offers no evidence or suggestions to explain *how* sexual orientation *does* develop, either for specific persons or in general.

This paper reviews what a number of mental health professionals who have served clients with unwanted same-sex attraction (SSA), as well as what a few researchers and theorists, have observed about the possible causes of their clients' development of same-sex attractions, thoughts, and behavior, and how these professionals have interpreted these influences on their clients' experiences. The voices of these professionals are not the only ones that need to be heard, but they do offer invaluable insights about the experiences of some persons with SSA and

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[3] "How a particular sexual orientation develops in any individual is not well understood by scientists. Various theories have proposed differing sources for sexual orientation, including genetic or inborn hormonal factors and life experiences during early childhood. However, many scientists share the view that sexual orientation is shaped for most people at an early age through complex interactions of biological, psychological and social factors" (APA, 1998).

guidance about the needs that some with SSA may have should they seek professional assistance.[4]

I. Each human being, including one who experiences same-sex attraction (SSA), possesses a nature and existence that in some ways is universal, in some ways is pluralistic, and in some ways is unique.

When discussing psychological issues that *may* be relevant for understanding gender identity development in persons who experience SSA, it is important to remember how unique each person is. I am mindful of learning more than 35years ago in a college undergraduate elective class in business management that "in some ways, all people are alike. In some ways, some people are alike. And in some ways, each person is unique." A similar idea was expressed recently in an interview given by biographer Joseph Pearce (2004):

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

Psychiatrist Jeffrey Satinover (1996) observes that "in reality, every person's 'road' to sexual expression is individual, however many common lengths it may share with those of others" (p. 221). Satinover emphasizes that even though many men

[4] I have tried to offer a representative sampling of professionals whose work is fairly contemporary. The intent of the original presentation on which the original paper and this present paper are based was to offer a fair introduction, citing sources that were reasonably accessible to members of the audience, most of whom were not mental health professionals or researchers. I also tried to offer a sampling of observations about women, mindful that more is written about men who experience SSA by the male professionals who serve men than about women with SSA by the commonly female professionals who serve primarily or only women. I hope that readers find that the present paper does offer both ideas and sources of further information to those seeking either or both.

and women who develop SSA may share one or more characteristics or similar life experiences, none of these factors or experiences, either singly or in combination, themselves *determined* that the person would develop SSA.

Hallman (2008) offers a similar and profound overview of how many and varied factors interact in the lives of all women, leading some women to develop SSA, while other women with the same experiences do not. Hallman writes:

> All that is human, including sexuality, involves a mysterious weaving of our biological blueprint with our experiences, perceptions, cognitions, emotions, reactions and choices. Our genetically or biologically based qualities and traits . . . *directly [affect] how we perceive and process our worlds*. How we perceive and process our worlds in turn affects who we become. . . . . . All that is human, then, is extremely complex, categorically mysterious and potentially in flux. (pp. 51–52; emphasis in original)

Whether one is a professional engaged in the medical or mental health arts and sciences; a person engaged in public policy, legislative, or other political concerns; a pastor or active member of a religious denomination; or a private citizen, including a family member or friend, it is important to remember that each person is an individual—that he or she has his or her own story with experiences, responses, and choices that are unique to him or her. This includes those who experience SSA, as various mental health professionals who provide psychological care for unwanted SSA have reported. As psychologist Dean Byrd (2009) observes, “There are many differences among those who struggle with unwanted homosexuality” (p. 84).

Janelle Hallman (2009), a therapist who serves only women, remarks similarly:

> While these women often share common themes in their stories, similar strengths and, therefore, similar survival strategies, women with same-

> sex attractions and dependencies should never be stereotyped or squeezed into a 'box.' Like everyone else, they want to be known for who they truly are, apart from their sexuality or confusions or conflicts. Every woman who has or has had same-sex attractions is also wonderfully unique and special. They have various backgrounds, families of origin, experiences, personalities, character traits, relational styles, professions, appearances, marital status, developmental needs, abuse histories, religious upbringings, and talents and giftings. (p. 137–138)

Whether similar to or different from the stories of those who do *not* develop SSA, frustrations of certain longings for love and affirmation are commonly reported by those who do develop SSA. Yet, as Hallman (2008) writes, those who help persons attempt to resolve unwanted SSA find that no "*single factor individually determines or directly causes female SSA*" (p. 54, emphasis in original).

The same may be said for male SSA. Neil and Briar Whitehead (2013) reviewed more than 460 papers and books from the biological, psychological, sociological, and anthropological literature to try to understand what is and is not known about the causes of homosexuality, heterosexuality, and human behavior generally. The Whiteheads answer the question "What is the cause of SSA?" as follows: "There is no one cause. No single genetic, hormonal, social, or environmental factor is predominant. There are similar themes, childhood gender nonconformity, sexual abuse, peer and family dynamics, sexual history, but the mix varies with individuals making individualistic responses the single overriding factor" (pp. 271–272). A given person who experiences gender nonconformity, sexual abuse, particular peer and family dynamics, a certain sexual history, and/or other factors *may* develop SSA, but many persons with the same experiences or factors in their lives will not.

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

While there is no one-size-fits-all developmental blueprint for the origins of SSA, this and the following sections describe a number of factors commonly observed by clinicians and researchers, as well as reported by persons with SSA concerning their unique and common developmental experiences. Neil and Briar Whitehead (2013) explain that whatever may influence *any* and *all* of our human behaviors, including SSA, "genes don't make you do it. There is no genetic determinism, and genetic influence at most is minor. Individualistic reactions to random factors are very important. ......The fact is that nothing *makes* us do anything—neither our genes nor our environment" (pp. 270, 271; emphasis in original).

While those who promote the normalization of SSA may publicly argue that people are "born that way," there clearly is no scientific evidence to support the view that SSA is genetically or biologically predetermined. The few studies that have been misreported in the media as offering support for such predetermination either have been discredited or were not supported in subsequent, higher-quality research (Whitehead & Whitehead, 2013 pp. 128–139, 150–157, 168–172, 174–206). As discussed above, the APA (1998, 2008) also concludes that SSA is *not* genetically or biologically predetermined.

Although genetic and biological factors do not predetermine the development of gender identity and/or SSA, they *may* be relevant. For example, Patton (2009) lists the following common personality traits observed among women who seek therapy for unwanted SSA: "Above average intelligence, strong sensitivity, creativity, analytic ability, curiosity, a strong sense of justice, and natural abilities and interests outside of stereotypical female interests and talents, such as being active or athletic" (p. 99; cf. Hallman, 2008, pp. 54–55).

Both similarly and conversely, Nicolosi (2009a) notes that "among SSA men we often see a temperament that is sensitive, emotional, relational and more aesthetically

oriented than the gender-typical male" (p. 36). Nicolosi explains further that while such sensitivity, abilities, and interests are great gifts, such attributes also leave boys more vulnerable to being and feeling hurt emotionally. In response to distressing, isolating experiences in their families and among peers, such gifts may lead some boys to avoid interaction with other persons and to seek relief through fantasy or impersonal relationships in which they may feel safe(r) and over which they experience (more) control.

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

Pediatrician Michelle Cretella, MD (2012), offers an interesting perspective on the development of SSA:

> It is a well-accepted scientific fact that complex behavior traits regularly involve the interaction of multiple genes with multiple environmental factors, plus *free-will choices*. Why would SSA and its associated behaviors be different? In fact they are not. That is why it is accurate to say both that sexual attractions are generally not chosen, but that responses to those attractions do involve choice. Unbidden attractions may come because of situational factors and prior sexual experiences. There may be a biological predisposition that makes such attractions more likely than not. However, these attractions may be increased or decreased by the choices that people make. The medical term for this

dynamic is a "biopsychosocial model mediated by choice." (p. 132; cf. Abbott & Byrd, 2009, pp. 35–46)

III. Certain early life experiences influence the development of gender identity, depending on how these influences are perceived and internalized.

Experiences throughout one's life influence the development and maintenance of a person's gender identity.[5] Especially in one's infancy and early childhood, one's gender and identity is both "caught" and "taught," as a result of how one perceives others living as gendered beings; how one is related to by others as a gendered being; how "good"

[5] This section is the fruit of a myriad of experiences—personal, clinical, and professional—as well as professional and scientific study. That all facets of our experience as human beings—including psychosexual, socioemotional, cognitive, and biological—may and commonly do develop over the course of a person's lifespan is a mainstream understanding of the social and behavioral sciences (Santrock, 2012). Clinical approaches emphasizing brain "neuroplasticity," i.e., the ability of the brain itself to change over the lifespan, and specifically each person's potential for engendering such change—with and/or without professional assistance—in order to influence how one behaves, likewise is a commonly accepted position in contemporary medical and mental health practice (Doidge, 2007; Schwartz & Begley, 2003; Schwartz & Gladding, 2011).That changing one's behavior and thoughts—including one's gender identity—and the brain biology that facilitates or inhibits how one aspires to live is *possible,* even for gender identity, does not mean either that it is advisable that a given person try to change, nor to what extent a given person's efforts may be successful in changing how she or he may think or act at a given time. While this paper mentions "gender identity" because this is a dimension of every human being's life, including those who experience SSA, there is neither the time nor space for even a brief overview of clinical issues such as gender identity disorder, gender dysphoria, and transgenderism. That said, it is worth noting that the APA (2011) answers the question "Why are some people transgender?" as follows: "There is no single explanation for why some people are transgender. The diversity of transgender expression and experiences argues against any simple or unitary explanation. Many experts believe that biological factors such as genetic influences and prenatal hormone levels, early experiences, and *experiences later in adolescence or adulthood may all contribute to the development of transgender identities.* (p. 2; emphasis added) This answer sounds remarkably similar to how the APA (1998, 2008) answers the question "What causes a person to have a particular sexual orientation?" that is mentioned in the introduction. Implicitly, the APA asserts that "gender identity," like "sexual orientation," is *not* simply an innate, biological "given."

one evaluates living, now and in the future, as one's biological sex; and how thoroughly one internalizes and externalizes these "lessons" in one's interactions first within and eventually outside of one's family.

Personal and sexual identity is the result of both "seeing and hearing"—in other words, experiencing, often outside of conscious awareness, the "answers" to a number of questions. These include:

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

What is a boy or a girl?

Am *I* a boy or a girl? Is that good?

Am *I* good enough as I am?

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

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

How does Mom treat Dad, and other boys or men—including my brothers? Compared with *me*? Is it good?

What does that say about me and *my* goodness, especially as a "boy" or "girl"?

How does Dad treat Mom, other girls or women—including his mother? His and my sisters? Compared with *me*? Is it good?

What does that say about *me* and *my* goodness, especially as a "girl" or "boy"?

In early childhood and throughout one's transition to adulthood, one begins to more formally ask, or at least enact, implicitly answered questions about living as an adult:

What does it mean to be a male or a female person, a man or a woman?

What do men/women do? How do they act? How am *I* supposed to act when I grow up? What is *my* gender identity?

Given that identity: How may—and must—any man or woman live so as to flourish?

How may—and will—*I* live well as the man—or woman—that *I* am?

Answers to such questions profoundly influence one's ability to flourish as the boy or girl, and later as the man or woman, the male or female person, that one is intrinsically and becomes over time.

IV. Perceived lack of or disaffirmation from and other experiences with parents, siblings, peers, and/or others *may predispose* to, but *do not predetermine*, the development of SSA.

In words that in large part also describe the phenomena of male homosexuality, Hallman (2008) explains the "extremely complex, categorically mysterious and potentially in flux" nature of female SSA[6] as follows:

> [F]emale homosexuality is a multidimensional infrastructure, intricately linked to a woman's biology, experiences, cognitions, emotionality, relational networks, concept of self and inherent design as a female made for relationship and meaning. In light of this complexity, . . . female SSA cannot be explained by a single clinical picture with common underlying dynamics. (p. 52)

In spite of there being no "single clinical picture with common underlying dynamics" for explaining female—or male—SSA, there nonetheless are common

[6] The "flux" of SSA is to some degree general for all persons and to another degree more common among women. On the one hand, as the APA (2009) concludes, "Recent research on sexual orientation identity diversity illustrates that sexual behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways, some of which are fluid" (p. 14). On the other, the APA also mentions the particular "experiences of fluidity and variation in sexuality and relationships" among women (p. 63). Diamond (2008) has written extensively about the fluidity, flux, or changeability—unassisted by professional or other efforts—of female sexuality and SSA.

dynamics worth considering. For example, whether one is a male or female child, one enters life needing to be loved. Reflecting on the women with unwanted SSA whom she has served, Hallman (2009) remarks: "They were little girls at one point. They innocently looked up into the eyes of their mother and father longing for love, comfort, attention, hugs, patience and understanding. Many of their stories are not so different than many of ours" (p. 138).

Certain life experiences, including particular intra- as well as interpersonal influences and environments, commonly *are* associated with (in other words, appear to contribute to) the development of SSA in some persons. While many risk factors may be common among persons who experience SSA, typically many more persons with the same attributes and/or experiences do *not* develop them (Whitehead & Whitehead, 2013 pp. 16, 26, 270–271, and Chapters 10 and 11). Nevertheless, a *risk factor model* is helpful for understanding the development of SSA. Such a model recognizes that certain experiences *may predispose* a person to develop a particular way of thinking, feeling, or behaving, but *do not (pre-) determine* this development or compel a person to think, feel, or act in this way.

Some of the risk factor experiences associated with SSA may occur early in life, indeed even during infancy and toddler-hood. Common risk factors associated with the development of SSA feelings and behaviors include: 1) Gender atypical characteristics: temperament, abilities, interests, and/or physical appearance. 2) Gender incongruity or distortion associated with disruptions in one's intrapersonal (i.e., internal) experience of masculinity or femininity. 3) Same-sex disaffiliation associated with disruptions in interpersonal experience with older members and/or peers of one's own sex, especially parents, siblings, and classmates. 4) Opposite-sex relational wounds associated with older members and/or peers of the opposite sex, including parents, siblings, friends, and classmates. 5) Sexual abuse from members of the same or opposite sex. 6) Habits of

gratification, which—especially if they represent ways of compensating for intolerable, recurrent feelings—may become compulsions or addictions.

While each person who experiences SSA is unique, common *themes* or *issues* have been found in the life experiences of many who develop SSA. For example, Byrd (2009) explains that "along with one's biological 'givens,' non-conforming children are vulnerable to a number of difficulties, including those associated with homosexuality" (p. 60). Byrd reports further:

> Dean Hamer, the self-identified gay researcher [who was touted incorrectly by the popular press as having found 'the gay gene'], noted that *gender nonconformity* is the single most common observable factor associated with homosexuality and concluded that "In fact, it may be the most consistent, well-documented, and significant finding in the entire field of sexual orientation research and perhaps in all human psychology" (Hamer & Copeland, 1994, p. 166). (p. 60; emphasis added)

From childhood through adolescence, perceived and actual difficulties with having one's gender and gender identity affirmed by one's family and peers may leave a young person vulnerable for developing SSA. As psychologist Maria Valdes (1996) writes:

> In homosexuality there is a *disidentification with self*, with the person one is. The person is body and soul at once with a specific physiological sex, either male or female. If the gender (identity) is not developed and integrated with the physical sex, a basic unmet need is established in the individual for which he is not responsible at all. This *need for gender identity* will remain until it is met. (p. 363; emphasis added)

Mettler and van den Aardweg (2010) conclude similarly that

> upon examining the psychological and psychiatric observations and research evidence of recent decades, there is a steadily growing consensus that same-sex attractions somehow spring from *failed "gender identification"* ("gender nonconformity" and the like) during childhood and adolescence, due to imbalanced parent-child interactions and peer-group maladaptation. (p. 5; emphasis added)

Same-sex attractions are understood as arising from "feelings of inadequacy with respect to one's gender identity." In effect, SSA involves "compensatory reactions to inferiority feelings with respect to one's masculinity or femininity" (p. 5).

Reflecting on his experience of serving hundreds of men with unwanted SSA, Nicolosi (2009a) likewise observes that certain patterns of experience are common among his clients. He describes two basic patterns: 1) *pregender* and 2) *postgender* homosexuality (pp. 81–85). Using the constructs of psychodynamic theory, *pregender* SSA involves "a failure to negotiate the gender-identity acquisition phase of one-and-a-half to three years old" (p. 82). When this phase is negotiated successfully, a boy disidentifies with his mother and identifies securely with his father. When this effort is unsuccessful, several experiences are commonly observed. A boy may have experienced insufficient maternal nurturing, which leads to his being poorly attached to the mother. "Insecure attachment" commonly is associated with the development of a "self-deficit"—in other words, a lack of a clear sense of self. Such effects are magnified should there also be "a failure to bond with the father." A boy's inability to perceive and experience his father as "salient and benevolent" commonly leads to a "gender-identity deficit" (p. 81).

By contrast, a man who experiences the *postgender* type of SSA commonly has "successfully completed the gender identity phase (of male human development) but later experienced another form of trauma for which homoerotic desire became conditioned as an affect regulator" (p. 82). Rather than desiring the attention and qualities of an "idealized masculine type" of man, a person with postgender SSA commonly "looks for masculine affirmation"—in other words, for "the anxiety-reducing reassurance of male support and comfort against his inner insecurity." Possible sources of the trauma contributing to such masculine insecurity include "an abusive older brother; cruel, teasing peers at school; a disorganizing, destabilizing mother," along with a father who may have been experienced as too "weak or ineffectual" to defend the boy against such repeated traumas (p. 83). Nicolosi notes that a postgender-type client often may have "distinct sexual attractions to women but little or no interest in female friendship" (p. 83).

In a chapter entitled "Putting the Pieces Together," Jeffrey Satinover (1996) describes "just one of the developmental pathways that can lead to homosexuality, though a common one" (p. 221). This pathway shares many features with those described above by Byrd (2009), Mettler and van den Aardweg (2010), Nicolosi (2009a, 2009b), and Valdes (1996).

Although the preceding explanations are the results of clinical experiences serving primarily male clients seeking to resolve unwanted SSA, similar observations may be made about women. As mentioned above, Hallman (2008) emphasizes that no single clinical picture or set of underlying dynamics adequately explains why a given woman may develop SSA. But Hallman has also observed and described some life events, traits, and characteristics that women who experience SSA may share.

For example, while realizing that each woman she meets is "wonderfully unique and special," Hallman has noted that many—but not all—women who experience SSA have experienced "interferences, stressors or failures in their most

primal attachment"—their mothers. Such "perceived or actual disruptions" of bonding may have occurred in the context of "prenatal, birth and postnatal complications"; "accidental or uncontrollable separations from their mother" due to a variety of circumstances; "maternal deficits or weaknesses" stemming from their mothers' own personal histories; and, at times, "actual maternal abuse or abandonment" (pp. 57–58; cf. Hallman, 2008, pp. 58–65). For some clients, "the shock of puberty" and the often corresponding experience of a "disparaging self and body image" are distressing factors associated the development of SSA (pp. 90–93).

Many women with SSA have lacked an engaged and affirming father and/or grew up in a family with gender roles or other relational dynamics that were dysfunctional (pp. 67–72). Other factors such as sexual abuse (pp. 82–85), disappointing or negative experiences with boys or young men (pp. 92–93), too few childhood girlfriends (pp. 85–87), and/or a particularly satisfying relationship with a young woman in adolescence or young adulthood (pp. 93–96) may have contributed uniquely to a woman's development of SSA. Of course, even when such experiences do not lead to a woman developing SSA, she is likely to experience other *intra*- and *inter*personal difficulties.

Hallman (2008) also has recognized "certain diagnostic and behavioral or personality patterns among women with SSA." This experience has led her to describe four common "profiles" that guide how she serves each woman. These profiles include the following: 1) Empty, depressed, withdrawn, and isolated. 2) Tough, angry, sarcastic, and barricaded. 3) Energetic, caretaking, drama-oriented, and never "home." 4) Pragmatic, perfectionistic, distant, and smugly self-assured (cf. pp. 158–180). Hallman emphasizes that the terms associated with each profile are intended to identify common "characteristics or traits that have most likely emerged out of a woman's unique survival modes and defenses [self-defeating habits of self-protection], compensations or false selves." While such characteristics "may highlight" some of a woman's "true strengths

and authentic inner conflict[s] . . . they are *not* descriptive of a woman's truest and fullest God-given self" (p. 159).

Hallman explains further that while such profiles enable the therapist to understand and establish "appropriate treatment guidelines and goals . . . they are primarily descriptive in nature. ...... [I]ndeed, many women *may* identify with one profile or another, but will most likely see parts of themselves in each of the other profiles as well" (p. 159). Hallman views these profiles as overlapping and "perhaps better understood as various *personas* within each individual woman based on her salient needs and the therapeutic themes experienced at different stages of her process." It is likely that the identified needs and suggested treatment approaches for each of the profiles "will benefit every woman in due time" (p. 159). Hallman reports that she is cautious about sharing such therapy-guiding profiles with clients, lest they experience confusion or a sense of being judged or unhelpfully *labeled*.

Women—and also men—with unwanted SSA who are public about practicing their religious faith and who accept the teaching that homosexual behavior is inconsistent with moral maturity and human flourishing may experience additional difficulties. As Hallman (2009) writes:

> Faith-based women struggling with same-sex attraction face some unique issues, such as *profound shame*, *sense of condemnation*, *fear of sharing* about their struggle with others, *finding more support from the gay community* than their church, and possibly a long string of *relational breakups*. (p. 139; emphases added)

Some may suffer from "condemnation" by fellow church-goers—or their own parents or other family members—based on misunderstanding of the genesis or nature of SSA (for example, the belief that people choose to develop SSA or that "feeling" SSA

in itself is sinful). Others may suffer from a "misguided mercy" within the church—or their family—that accepts, perhaps even condones or celebrates, the practice of behaviors that place the persons who practice them at significant risk for physical, psychological, relational, and spiritual harm (see Section VII below) .[7]

V. Same-sex attractions may and often have meaning beyond the simple desire for sexual gratification.

This section includes my integration and summary of what a number of therapists and a few researchers have observed and theorized about two things: first, which factors are correlated with and may have contributed to a given client's or many clients' experience of unwanted SSA, and second, which core or additional issues the client

[7] A discussion of the spiritual and religious needs of persons with SSA is beyond the scope of this paper. Such needs are recognized and efforts to meet them are strongly encouraged. The spiritual and religious needs of the clients of licensed mental health professionals in general have been the focus of much research and clinical practice (Richards & Bergin, 2000; 2004; 2005). Also, Principle E: Respect for People's Rights and Dignity of the APA (2010) Ethical Principles of Psychologists and Code of Conduct clearly advises psychologists to "respect the dignity and worth of *all* people" and to be "aware of and respect cultural, individual, and role differences, including those based on . . . *religion*" (p. 2; emphasis added). The *APA Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation* (2009) likewise repeatedly asserts that religious beliefs in regard to homosexuality must be respected (cf. pp. 5, 19–20, 51, 53, 56, 59, 64, 69, 70, 77–78, 82, 120).

There also have been efforts to understand the wise use of scientific research and clinical experience in discussions about how religious practice and pastoral care may serve the needs of believers who also experience SSA (Jones & Yarhouse, 2000), as well as research documenting that some persons are better able to manage and resolve unwanted SSA through religious and spiritual resources and activities (Jones & Yarhouse, 2007, 2011; Phelan, Whitehead & Sutton, 2009). Guideline 3 of the NARTH (2010) "Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior" encourages *all* clinicians "to respect the value of clients' religious faith and refrain from making disparaging assumptions about their motivations for pursuing change-oriented interventions" (p. 18). Hopefully, persons whose deeply held religious values motivate them to seek professional assistance to deal with unwanted same-sex attractions will find professionals both willing and able to help them.

may want help with when seeking help to deal with, manage, or resolve unwanted SSA. For example, a client who seeks professional help to stop smoking probably needs help learning how to relax in healthier ways. In this case, his or her urge to smoke may mean a need to relax and an inability to do so. Similarly, clients who experience unwanted SSA may need to deal with one or more other factors. The therapist and client both need to understand what the SSA means in order for timely assistance to be offered and received.

My review of the clinical and scientific literature, along with my own clinical experience, suggests that a client reporting unwanted SSA may need to work on further growth in his or her intrapersonal and interpersonal development. This "un"-done work may include dealing with unrealized growth and maturation, unmet needs, unhealed hurts, unresolved feelings, unreconciled relationships, unclear boundaries, unrealistic hopes, fears and expectations (for self and others), an unfulfilling and inauthentic self-image or self-identity, and unmanaged co-occurring (i.e., comorbid) difficulties. In some, these factors and issues may overlap; in others, they may not be relevant.

At times, unmet developmental needs and unfortunate experiences with members of one's family of origin and/or peers may leave someone with unprocessed feelings, the need for grieving, and the challenges of growing up. Other times, a person may have worked through them on his or her own. Also, behaviors and habits of homosexual gratification, as well as many co-occurring difficulties and disorders, may be preexisting, coexisting with, and/or consequential to the development of SSA. For some persons, these co-occurring difficulties may have developed as ways of attempting to compensate or substitute for, numb, or otherwise deal with other underlying issues, including SSA and the factors contributing to its development.

I have summarized below a list of possible meanings—in other words, undone work—under five categories. To illustrate and validate some of the undone work that SSA may indicate, I offer observations and interpretations from a number of mental health professionals who have served persons with unwanted SSA. As explained above,

while the following statements may represent the life stories or challenges of some—and perhaps even many—persons who experience unwanted SSA, the statements may not apply to a given individual. It's important to realize that each person has his or her own unique story and immediate life circumstances and challenges.

• ***Unmet needs and unrealized growth and maturation***. Therapists who serve persons with unwanted SSA commonly find that their clients may have had developmental needs that for one or more reasons were *not* fulfilled. As a consequence, such persons may have failed to grow and mature in ways that persons whose needs were met commonly grow and mature. Commenting on her experience of persons in general, psychologist Maria Valdes (1996) observes:

> Every child has certain basic needs that have to be met so that he (or she) is able to attain full psychological development; psychosexual development is included. Some of those needs are *affection, individuation, autonomy, independence, acceptance,* and *gender identification with one's own physiological makeup.* (p. 347; emphases added)

Commenting on her experience with persons with SSA, Valdes (1996) considers that a "person with a homosexual condition is one with an *incomplete or arrested psychosexual development* that manifests itself by the need of that person to stay at a homopsychosexual stage of development rather than to complete the psychosexual cycle and become heterosexually oriented" (p. 346; emphasis added). Valdes describes "psychosexual development" as including "attitudes and ways of perceiving and relating to others, in other words, a kind of mind set that is more than sexual" (pp. 346–347).

A commonly unmet need shared by many who experience SSA is the need to experience—again or perhaps for the first time—genuine *affirmation*, or unconditional love:

having another recognize one's intrinsic worth and having the other attend to and serve one's ultimate, authentic well-being. Related needs include growing in genuinely, mutually affirming same- and/or opposite-sex relationships, which enables the development of appropriate and timely same- and opposite-sex attachment/affiliation, as well as opposite-sex (dis-) identification. Meeting such needs ultimately allows persons to flourish or thrive in their innate masculinity (if a boy or man) or femininity (if a girl or woman).

The work of psychiatrists Conrad Baars and Anna Terruwe (Baars, 2008b; Baars & Terruwe, 2002) on helping people understand and satisfy their universal human need for affirmation—and resolve the effects of its absence—offers insight for understanding the meaning of SSA. All human beings have the need to be "adequately affirmed during their developmental years by unselfishly loving, affectionate, mature parents and/or other significant persons" (Baars, 2008b, p. 190).

The experience of being un- or underaffirmed commonly leads to difficulties with the mature expression of sexuality, whether one's objects of attraction are heterosexual or homosexual. Baars (2008b) explains that *all*

> unaffirmed persons have one concern and need: to become affirmed, to be loved for *who they are* and not for *what they do*. They are literally driven to find someone who truly, unequivocally loves them....... If affirmation by a significant other is not forthcoming, many unaffirmed persons will use their talents, intelligence and energy to try to convince themselves and the world in a variety of ways that they *are* worthwhile, important, and significant, even though they don't feel that they are. The most common ways of doing this are by the acquisition, display and use of material goods, wealth, power, fame, honor, status symbols, or sex. (p. 191; emphasis in original)

Concerning the development of SSA in particular, Baars (2008b) comments: "[A]ny of the factors which in very early life cause the innate predisposition to a heterosexual orientation to change to a homosexual one are at the same time detractors from or obstacles to full affirmation" (Baars, 2008b, p. 189). Nicolosi (2009b) offers a similar observation that a lack of same-sex *affirmation*—which he calls *attention*, *affection, and approval*—contributes to the development of SSA. Writing about men, Nicolosi states: "I see homosexual attraction and behavior as an attempt at 'reparation' [or compensation] . . . attempting to "repair" normal, unmet same-sex affective needs for 'attention, affection and approval,' as well as gender-identity deficits through an erotic connection with another man" (pp. 32–33).

Janelle Hallman (2009) has observed that female clients wishing to manage and resolve unwanted SSA experience similar, complementary needs. Hallman writes that women commonly need to grow in authentic, emotional, and relational *interdependence*. "At the heart of most female same-sex relationships is *an extremely deep emotional bond* [emphasis added] . . . often more restrictive than fulfilling to each individual woman . . . referred to as fusion, merger and *emotional dependence"* [emphasis added] (p. 149). Hallman observes that when two women are engaged in such an emotionally dependent relationship, "[W]hen the pressure of relational need achieves maximum intensity, while at the same moment, a new woman comes along who is compassionate and empathetic or has other qualities worthy of admiration . . . a response of *emotional overattachment* [may be] triggered" [emphasis added] (p. 149).

Other therapists have complementary perspectives on both male and female SSA, having noted their clients report many unmet needs and also exhibit relational immaturity in same- and opposite-sex relationships. For example, Dean Byrd (2009) observes that homosexuality commonly develops as a response to the lack of—and is resolved through the engendering of—mature, same-sex relationships. He explains:

> Essentially, homosexuality is interpersonal both in its genesis and in its resolution. The attainment of healthy, non-sexual, same-sex relationships is a prerequisite to . . . begin the heterosexual journey toward wholeness . . . to the development of heterosexual attractions and subsequent heterosexual relationships . . . allowing gender complementarity to emerge and be nurtured and sustained. (pp. 85–86)

Mettler and van den Aardweg (2010) view SSA as a search for the masculinity that a man perceives he lacks or the femininity a woman perceives she lacks—and the attempt to obtain or fulfill these qualities by relating to another person of the same sex who seems to have what one lacks. Mettler and van den Aardweg observe: "Homosexual desire is an obsessive quest for masculinity, for belonging to manhood (in the case of the lesbian woman, for femininity, for belonging to womanhood) and for male (or female) affection, to compensate for inferiority feelings regarding one's own gender" (p. 5).

As men and women experiencing SSA begin to understand, manage, and resolve both the experiences of having such basic needs unmet and their learned intra- and interpersonal habits for responding to these experiences, psychosexual maturing and flourishing may occur. For example, Hallman (2009) describes the process by which a woman who receives adequate personalized support may come to address "her *authentic dependency and attachment needs* [emphasis added] . . . also . . . to progress through the stages of forming and solidifying a *sense of self*" [emphasis added] (p. 150). Hallman explains that addressing such needs with a supportive therapist may enable the woman to "to challenge [her] core beliefs such as the assumption [that] she cannot exist without a special friend." Therapy may enable a woman "to learn about and evaluate her relational boundaries," which includes helping her to "work on objectively naming and separating her emotional state from that of her friend." This process commonly involves supporting a woman as she learns how to "negotiate her own emotions and distinguish between what

she feels and what her friend is feeling" in order "to experience her own set of emotions [and life] apart from what her friend is feeling or experiencing" (p. 150).

Writing about men as well as women, Baars (2008b) explains that when human beings have been "adequately affirmed during their developmental years"—or even *belatedly* during their adult years—they have "received the gift of themselves" that enables them to "feel worthwhile, significant, and loveable," as they are, unconditionally. Such persons grow and mature into knowing "who they are."

> They are certain of their identity. They love themselves unselfishly. They are open to all that is good and find joy in the same....... They find joy in being and doing for others. They find joy in their loving relationship with their Creator. They can share and give of themselves, be a true friend to others, and feel at ease with persons of both sexes. (Baars, 2008b, p. 190)

Valdes (1996) observes further that when a person who experiences SSA (the "homosexual condition") due to "incomplete or arrested psychosexual development" (p. 346), he or she may strive to complete or mature in his or her psychosexual development. Valdes comments further that if such a person "attains heterosexuality, [her or his] homosexuality has not been reversed; rather, [his or her] psychosexual development has been completed" (p. 347). (The observation that change in SSA is best considered on a continuum—meaning that *some* but *not all* clients may experience such completeness of their "psychosexual development"—is discussed below in Section VII.)

• ***Unresolved feelings, unhealed hurts, and unreconciled relationships*.** Clients who seek professional assistance for unwanted SSA commonly report a number of concerns, including distressing emotions and other feelings, such as anxiety, depression, anger, sadness, sorrow, and shame, and the pain of rejection, abandonment, or not being good enough. Such feelings may be the result of past and/or present experiences of actual

and/or perceived rejection by—or estrangement from—parents, other adults, siblings, peers, and past or present love objects. Consequences from unfortunate experiences in such relationships are discussed above in Section IV.

Psychologist Gerard van den Aardweg (2011) summarizes a review of the clinical literature, in light of his experience of serving many clients, as follows:

> [M]any studies have shown that the most significant factor which correlates with homosexuality is "gender nonconformity" or *same-sex peer isolation* [emphasis added]. Another factor closely associated with homosexuality is an *imbalance in parent-child interaction* [emphasis added], notably forms of over-influence of the opposite-sex parent in combination with a deficient relationship with the same-sex parent. (Abstract, p. 330)

Relevant to van den Aardweg's observation about persons with SSA often experiencing an *imbalance in parent-child interaction,* psychiatrist Richard Fitzgibbons (1999) offers the following observations about the painful emotions that are commonly experienced and left unresolved in such situations:

> [When there is] a lack of involvement by the father in the life of a son [who develops SSA] . . . a common pattern of reaction to *emotional pain* can be observed and identified. When a person is hurt in a relationship . . . first *sadness* develops, then *anger* accompanied by *low self-esteem*, and finally a *loss of trust*. It is essential to resolve the *anger* associated with all these types of *betrayal pain* .... The approach that seems to be successful is to help the client face the *pain*, resolve the *betrayal anger* by working at understanding and forgiving his father and be healed of the *craving for father love*. (p. 91; emphasis added)

As significant a factor a disaffirming relationship with one's father can be for boys, both Fitzgibbons and van den Aardweg consider disaffirming experiences with same-sex peers as potentially even more important for a boy. Fitzgibbons (1999) states that in his clinical experience, more important than a man having had a "poor emotional relationship with [his] father" is the "weak masculine identity" resulting from "severe peer rejection." Such rejection commonly is associated by a "sports wound"—in other words, an inability to play sports well enough to feel accepted by his male peers—that "will negatively affect the boy's image of himself, his relationships with his peers, his gender identity and his body image" (p. 88).

Van den Aardweg (1997) also emphasizes the importance of experiences and relationships with peers in the development of "the homosexual wish," or SSA. Van den Aardweg observes that SSA is rooted in "unconscious self-pity and *feelings of gender inferiority*." Under the influence of "his *masculinity/femininity inferiority complex* or *gender inferiority complex*," a man with SSA "partly remains a 'child', a 'teenager'." As significant as "specific parental attitudes and parent-child relationships may" be in predisposing a young man to develop "a homosexual gender inferiority complex, . . . the *lack of same-sex group adaptation* weighs even more heavily as a predisposing factor." Van den Aardweg asserts that more than "the great importance of child-parent interactions, the final determining factor generally lies more, however, in the adolescent's self-image in terms of gender, *as compared with same-sex peers*" (pp. 19–20; emphasis in original).

As mentioned above in Section IV, Hallman (2009) notes that women may develop SSA as a consequence of distressing experiences with parents, peers, or others. These may include various difficulties: in the attachment process with their mothers; in their developmental relationship with their fathers; with various family dynamics; in experiences with peers; and as a result of painful or overinvolved—if not abusive or otherwise traumatic—experiences with intended or actual girlfriends, with boys

or young men, and/or with other adults. Hallman further explains that a survival and coping mechanism—for men as well as women—is *defensive detachment* and *same-sex disidentification* (p. 65).

Hallman notes that defensive detachment was first described as such by Elizabeth Moberly (1983) as "not only childhood withdrawal or childhood withdrawal or disinclination to emotionally connect with the same-sex parent, but also the decisive refusal to *ever* reconnect" (Hallman, 2009, p. 65; emphasis in original). Nicolosi (2009a) likewise observes in males with SSA the development of what Moberly called "defensive detachment" as well as self-protective "dissociation," often leading to passive-aggressive nonassertion and the experience of "shame" (pp. 78–79).[8]

With wisdom suitable also for a man, Hallman (2009) advises the woman who is dealing with unwanted SSA—or any *intra*- or *inter*personal responses to unfortunate relationship experiences—to "expect and prepare for *grief* and *depression*" [emphasis added] (p. 150). In order to let go and discover "God's design for healthy intimacy," a woman—or man—with SSA must learn to cultivate "multiple relationships with healthy limits that are free and generous with ample give and take" (Hallman, 2009). Doing so

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[8] A metaphor that I use in sessions with clients, working on a variety of issues, may be helpful. Clients and I often talk about their *emotional sunburn*—leftover feelings from past situations that are commonly aggravated in the present. This may be as simple as having had a bad day and then overreacting to someone who did something we found disappointing or annoying. In such a case, one may unload or displace preexisting sadness or frustration along with any new feelings onto the person who is the occasion of one's disappointment or annoyance in real time. Perhaps that person was also the occasion of some or much of one's emotional leftovers. Sometimes people learn to respond to their emotional sunburns by avoiding people, places, and things that may (re-)aggravate or engender the unwanted feelings. Defensive detachment, discussed above, may be a way of avoiding, distancing oneself emotionally from, or relating only superficially with a particular person—parent, sibling, etc.—or group of people (such as all men or women) in order to protect from (re-)feeling their emotional sunburn. Other habits—such as sexual gratification, substance abuse, or eating disorders—likewise may enable a person to ease the discomfort of his or her emotional sunburn. Sometimes such easing may occur without a person being consciously aware that the discomfort is there.

commonly requires that a person allow himself or herself to become aware of and feel the anger—and the sadness, pain, and perhaps fear that commonly underlie this anger—that is left over from earlier unfortunate experiences.

Similarly, writing about men but with wisdom relevant for women, Fitzgibbons (1999) explains that, "It is essential to resolve the *anger* associated with all these types of *betrayal pain*....... The approach that seems to be successful is to help the client face the *pain*, resolve the *betrayal anger* by working at understanding and forgiving his father and be healed of the *craving for father love*" (p. 91; emphasis added). Nicolosi (2009a) likewise discusses the need for "grief work" that enables a man to (re-)discover his previously repressed and suppressed emotions and (re-)experience the emotional vitality necessary for assertive living.

In general, persons with SSA—and/or other difficulties—may need to do the often uncomfortable work of resolving persisting anger toward offending *significant others*—whether parental, peer, partner, and/or other—through assertive self-care, grief work, forgiveness, and perhaps reconciliation, if the latter is possible and wise (Baars, 2008a; Enright, 2001, 2012; Enright & Fitzbibbons, 2000). For as Baars (2008b) summarizes, "In the therapy of homosexual and heterosexual unaffirmed persons, the vicious circle of *feeling unloved—seeking/buying love—being frustrated—and feeling more unloved* is broken" (p. 195), not uncommonly through resolving repressed (unfelt, unconscious) self-protective anger.

• ***Unrealistic hopes, fears and expectations for self and others, and unfulfilling—and inauthentic—self-image/identity*.** Therapists commonly find that clients who experience unwanted SSA expect themselves and/or others to be perfect or ideal. Conversely, clients often live with the belief that they are worthless—or at least not good enough. Many may perceive others as having the ideal qualities that they themselves lack or being the ideal persons they believe they themselves need to be. Such unrealistic expectations for self and others may lead persons with SSA to relate to others

in a self-defeating cycle: *idolizing/idealizing* others, then *demonizing* them when they fail to meet expectations. Persons with SSA, although initially attracted to someone, nonetheless may in their emotional hearts truly expect the worst—rejection—and act in ways that contribute to the very rejection they fear. Persons with SSA also may come to identify themselves with their sexual feelings, as if *having* SSA determines their *being*—their essence or nature, *who* or *what* they *are*—instead of SSA expressing merely *how* they may happen to feel, think, or act at a given time.

Van den Aardweg (1997) makes some sobering reflections about the nature and consequences of the self-identification reported by many persons with SSA. He views self-identifying according to how one feels or acts or to the lifestyle one is living as a risky, self-defeating venture. He asserts that it is a "psychologically dangerous *decision* to identify oneself as a different species of man: 'I *am* a homosexual.'. . . It may give a sense of relief after a period of struggle and worry, but at the same time it is defeatist" (p. 23; emphasis in original).

According to van den Aardweg, "The self-identified homosexual takes on the [*tragic*] role of the definitive outsider. . . . That role brings certain rewards. ......It makes one feel at home among fellow homosexuals. It temporarily takes away the tension of having to fight homosexual impulses, and yields the emotional gratifications of feeling unique and *tragic*—and of course of having sexual adventures." Unfortunately, "[r]eal happiness, let alone inner peace, is never found that way. Restlessness will increase, as will the feeling of an inner void. Conscience will send out its disquieting and persistent signals" (p. 23; emphasis in original).

Van den Aardweg believes that for all persons with SSA, and experientially for persons for whom SSA is unwanted, discontent results from "the unhappy person" having "identified with ....a false 'self'." For such a person, identification with a false self "is a seducing dream; in time it turns out to be a terrible illusion." For "'being a homosexual' means leading an unreal life, ever farther away from one's real person [self]" (p. 23).

Writing about *gender* vs. self-identity, Valdes (1996) explains that "the homosexual experience" for the adolescent or young adult male involves the "fusion"—one might also say *confusion*—of his experiencing an inability to identify with other males (in other words, a *lack of authentic gender identity*), with his emotional needs for autonomy and independence, and with directing his sexual energies toward males. Valdes explains:

> The emotions and feelings experienced by the boy during [the] period in which he struggles for independence, autonomy, and gender identity tend to become fused with each other making them appear to the child as if they were the same....... When the boy attains puberty, he uses his sexual drive, strongly perceived at this time, not to relate to the opposite sex, but to satisfy an unmet need for gender identity. (p. 348)

Valdes also observes that sexual identity confusion may result when a boy or a man misunderstands the nature of his felt "need to have sexual activity with another male." When a male becomes conscious of desire for "the homosexual experience," he commonly is unaware of authentic, unmet needs, such as *independence*, *autonomy*, and *individuation*, which may underlie this desire. In this sense, a boy's or man's gender identity needs may remain fused with these other basic needs. Valdes speculates that this "fusing of unmet basic needs might be one possible explanation as to why so many men report that they have felt the lack of gender identity from a very early age and have experienced themselves as different from other male peers as long as they can remember" (pp. 348–349). Consequently, "since this combination of needs resembles the basic emotional needs that he felt as a boy, he concludes that he is a homosexual, rather than recognizing that he has not attained gender identity" (p. 349).

Nicolosi (2009b) describes this experience in similar ways. For Nicolosi, "the homosexual impulse is also an attempt to rediscover the free, expressive, open,

powerful, gendered self that each man was created to claim. The intent of the impulse is 'reparative' in that its goal is gender affirmation; the man strives to be 'seen' by other men as an attractive male" (p. 33). Nicolosi (2009b) has also observed that many of his clients have come to therapy not "just to change their unwanted behavior," but "to change their sense of self." And some clients seek not just to diminish SSA, but to become "more heterosexual, and not just to 'act' heterosexually." Nicolosi explains that many male clients "want to feel comfortable in relationships with straight [non-homosexual] men" (p. 28).

In addition to being seen as an attractive, salient man by other men, many clients also want to learn to be seen by women as a salient man. Nicolosi (2009b) remarks that part of his clients' goal of fulfilling "their latent heterosexual potential" often includes learning "to hold onto their masculine autonomy with women" (p. 28). Van den Aardweg (1997) speaks about the same concern using different terms. He observes that the "*[f]ear of the opposite sex*" that is frequently experienced by both men and women with SSA may be "a symptom of *gender inferiority feelings.*" Such feelings "can be activated by members of the opposite sex, who are perceived as expecting sex roles the homosexual feels unable to perform" (p. 20; emphasis in original).

Finally, as discussed earlier in this section, Baars (2008b) has noted the challenges and common negative consequences that result when anyone—particularly persons with SSA—identifies and tries to live according to a false sense of self in order to gain the love, attention, acceptance, and approval of others. Baars explains that *unaffirmed* persons who experience SSA commonly try to obtain *affirmation*—unselfish, life-giving love—in one of two ways:

> First, by *always being "nice" and pleasing others*, by *never getting angry*, and by *never hurting other people's feelings* [emphasis added]—in short by nonassertive behavior. Second, in sexual contacts using the

> mistaken notion that sex equals love. The more total the frustration of the fundamental need for affirmation, the greater the drive and the more desperate the *desire to bind another to oneself* [emphasis added] . . . . By and large, these sexual acts.......represent a measure of the depth of a person's fundamental deprivation, since they indicate either the intensity of the *need to please others* ......or the *fear of being rejected or considered "unmanly"* [emphasis added] in the "gay" world. (p. 192)

• ***Unmanaged or unresolved co-occurring compulsions and addictions—to, among other things, sex, alcohol, other drugs, and food—as well as disorders of mood (anxiety, depression) and personality.*** Gratifying SSA—as well as opposite-sex attractions—may serve a temporary, *self-medicating* purpose, allowing someone to temporarily numb or avoid experiencing one or more unwanted feeling states. If such behaviors become habitual, they are in some cases properly regarded as compulsive or addictive. In addition, persons with SSA may experience one or more psychological or behavioral difficulties, including diagnosable disorders, which themselves are problematic.

Regardless of whether SSA thoughts and behavior are unwanted, all sexual and emotional compulsions or addictions—whether motivated by SSA or not—are problematic in themselves and are difficult to manage or resolve. Whitehead and Whitehead (2013) describe how sexual addictions are essentially a drug problem caused by the repeated experience of pleasurable sensations caused by "drugs" (hormones and other chemicals) produced by the body. The repeated presence of these drugs, especially if they are associated with the relief of distressing emotions, commonly leads to a physical dependency on these drugs that the person comes to perceive as a need. Over time, the person may come to perceive their repeated use as an "uncontrollable compulsion." The Whiteheads note that while the physiology of one's cells does make it possible for a person to develop an addiction, the person enables this to happen

through repeated use. Thankfully, it always remains "possible to reverse the process and rediscover the old normalcy (or find a new one)" (p. 100).[9]

Considering SSA in particular, various therapists describe the potentially—and for too many persons, actually—addictive process of emotional and/or sexual addiction involved in gratifying SSA. For example, van den Aardweg (1997) comments: "Giving in to homosexual wishes [may] create a sexual addiction. Persons who have reached this stage [now] have essentially two problems: their gender inferiority complex and a relatively autonomous sexual addiction" (p. 20).

Fitzgibbons (1999) notes that "Increasing numbers of young people become involved in sexual experimentation and develop an addiction to same-sex activity" (p. 90). Reflecting on "the number of sexual partners, dangerous behaviors, and other negative aspects typical of the homosexual lifestyle," Fitzgibbons notes that for some persons, "*[s]exual addiction* may . . . be a major problem within the homosexual lifestyle" (p. 96).

Compulsions and addictions develop because, while the experience of physical or emotional pleasure and emotional relief—sometimes called self-calming or self-soothing—may be intense, the feelings do not last and may leave greater discomfort after the biochemical-induced high has faded. Valdes (1996) describes this process for male adolescents:

> [W]hen the adolescent feels a sense of failure, rejection, lack of acceptance, powerlessness, and so on, he is inclined to meet those needs by eroticizing

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[9] The research and theorizing based on the Trans-Theoretical Model of Intentional Behavior Change, or TTM (DiClemente, 2003; Prochaska, Norcross, & DiClemente, 1995), is recommended for understanding in more detail how persons may develop and also may be helped to change *any* behavioral habit, compulsion, or addiction.

> them—usually resulting in some form of sexual acting out, as if by this acting out, he would gain acceptance by males in general. (p. 348)

"Most of the time," sadly, "after acting out, [the adolescent] discovers that he feels worse and that the sexual gratification did not satisfy any of his needs" (pp. 348–349).

Valdes explains further that "sexual acting out to fulfill the unmet needs of gender identification has a negative effect." This occurs largely because "relating only to members of the same sex who exhibit a similar condition will not satisfy the gender identity unmet need because they have the same kind of deficit." Unfortunately, engaging in such behavior "does not heal the condition but rather perpetuates it and makes it even more addictive" (p. 364).

Nicolosi (2009b) observes that for men, "homosexual acting-out is an attempt at restoring [the person's] psychic equilibrium. Through an erotic connection with another man, they unconsciously seek to attain a self-state characterized by assertion, autonomy, and gender-relatedness." Regrettably, this attempt works only temporarily at best. In Nicolosi's experience, the men he serves find that behaving in this way "eventually brings them none of these things—only a nagging feeling of inauthenticity, and still deeper discouragement" (p. 33). Ultimately, while such acts may be momentarily exhilarating, "the brief, false vitality our clients feel when engaging in sex with other men . . . is not satisfying for very long: in fact it is compulsive, stereotypic, and repetitive" (pp. 34–35).

Hallman (2009) has observed a compulsive or addictive quality to the patterns of emotional dependency and overinvolvement commonly experienced by the women with SSA whom she has served. Hallman observes:

> This addictive way of relating [in which the female client] most likely medicated powerful emotions through her overattachments [must be addressed]. ......She has a legitimate drive for relational connection and

> intimacy [but she must learn to] relate to others in the limited doses that they are able to offer. Her pattern of developing instant [emotional] intimacy must be broken and replaced with relationships—plural, not just one—that evolve over time. (p. 150)

In addition to experiencing sexual addictions, persons with SSA commonly experience a number of psychological or behavioral difficulties, including diagnosable disorders, several times as frequently as do persons without SSA (NARTH, 2009; Phelan, et al., 2009; Whitehead, 2010).[10] The abstract of Neil Whitehead's (2010) article, "Homosexuality and Co-morbidities," is worth quoting at length:

> Clients with unwanted SSA . . . who present to therapists, often have co-occurring problems. ......[A] score of mental health conditions are present in the general SSA population at rates three or more times greater than in the OSA [opposite-sex attraction] population, involving almost every DSM *[Diagnostic and Statistical Manual of Mental Disorders]* category. These conditions include bipolar, OCD [obsessive compulsive disorder] and schizophrenia, but are predominantly mood disorders, depression, substance abuse and suicidality....... People reporting SSA have a more widespread and intense psychopathological burden than probably any other group of comparable size in society, though college-age people may have more substance abuse. ......Surveys in recent literature suggest objective discrimination is not to blame for suicidality, but

[10] The Phelan, et al. (2009) and Whitehead (2010) references list many studies that document the nature and relatively higher frequency of a number of *co-occurring* (also called *comorbid*) medical, psychological, and behavioral difficulties and disorders among those with SSA as compared with persons who do not engage in same-sex gratifying behaviors.

> *perceived* discrimination....... [P]articular emotion/avoidant based coping mechanisms used by people reporting SSA almost entirely account for the effects of this perceived discrimination. (p. 125; emphasis in original)

VI. To be helpful, professional care—including medical and mental health services, including therapy, counseling, guidance, and education—for unwanted homosexuality, like all professional care for any presenting concern, must be given personally, one client at a time, to those who freely seek it.

Over the past century and a half, the medical and mental health arts and sciences have changed in their understanding of how homosexuality may develop and how unwanted SSA may be managed and alleviated. As discussed previously, clinicians and scientists have described many possible causes and have offered various theories in order to try to either explain homosexual behavior or to suggest how the desire to engage in such behavior may be prevented or remediated if the person experiencing them seeks such assistance.

Abbott and Byrd (2009) offer a useful perspective in understanding the possible but limited relevance of the diversity of theories and research findings that exist:

> In general, theories are explanations of why we behave as we do (Green & Piel, 2002). Theories give us clues about possible causes of behavior (White & Klein, 2002). If causes can be identified then intervention and remediation can (or may) occur ...... This solution, of discovering and then controlling causes of behavior, is not as simple as it appears, because most complex social behaviors (such as those associated with . . . homosexuality) are influenced by multiple factors acting over many years. Identifying and controlling one or two causes that may contribute to the undesirable behavior may not be enough to prevent the (re-)occurrence of that unwanted behavior. (p. 19)

Effective professional care to any person for any presenting problem is an art and requires a truly interpersonal—in other words, person-to-person—relationship focused on helping a client meet his or her realistic goals as he or she defines them. Mental health professionals wisely recognize and encourage their clients' individuality and their need, duty, and right to make their own decisions. Serving clients as such begins with making possible the client's authentic *informed consent.* As Hamilton and Henry (2009) write, obtaining informed consent from clients means

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

In order to ensure that clients not feel or "be forced or coerced into changing," possible clients or patients "should be given full and accurate information" in order to "determine their own therapeutic goals" (p. xxiv).

Byrd (2009) explains that "describing one's approach to psychological care" in general is inherently difficult. "Whatever the approach, it must [be] adapt[ed] to the particular patient" and his or her unique needs, concerns, and life circumstances (p. 84). Psychological care for unwanted SSA is no different.

Mary Beth Patton (2009), who works exclusively with women, comments similarly:

> My client has the right to self-determination. As an adult I respect her ability to make decisions for herself. She [typically] has been wounded by

> the over-control of others and I want to be sure not to repeat that pattern. Collaboration is my goal. I am the expert on the big picture; she is the expert on herself....... She needs to know and be assured that I am invested in her good. My goal is to delight in her as a person and in her uniqueness (not just in what she can [or cannot] do). (pp. 91–92)

Those who work primarily with men with unwanted SSA offer similar comments. Byrd (2009), a psychologist trained in interpersonal and cognitive behavioral therapy, notes:

> In many ways, providing psychological care for men who present with unwanted homosexuality is not very different than dealing with other patient populations: the therapist begins where the patient is and demonstrates respect for patient autonomy, patient self-determination and diversity. (p. 84)

Respect for client diversity means not imposing treatment on clients, regardless of whether the treatment seems reasonable to the therapist. Respect for client well-being and the ethical duty of beneficence and nonmaleficence (doing good and avoiding harm) also require that therapists not yield to demands by clients for unreasonable treatment—for services that either are not beneficial or may be harmful.

VII. Homosexual feelings and behavior are not innate or immutable, and homosexual behavior is not without significant risk to medical, psychological, and relational health.

As mentioned previously, the APA (1998, 2008) acknowledges that homosexuality is not "innate"; that psychological and social factors, as well as genetic and other biological factors (both nature and nurture) influence the development of homosexuality.

In other words, persons with SSA are *not* "born that way"! Also, while the APA claims that there is insufficient empirical evidence to show that sexual orientation itself may be changed through therapy or other means (such as pastoral intervention), the APA (2009) does acknowledge that sexual behavior, attraction, and orientation identity are "fluid"—in other words, not fixed or immutable. While the APA warns potential consumers that "sexual orientation change efforts" (SOCE) *may* be harmful, their 2009 report also concludes: "There are no scientifically rigorous studies of recent SOCE that would enable us to make a definitive statement about whether recent SOCE is safe or harmful and for whom" (p. 83, cf. 2, 3).

In a proactive response published several months before the anticipated 2009 APA report, the National Association for Research and Therapy of Homosexuality (NARTH) reviewed more than a century of experiential evidence, clinical reports, and research literature. NARTH's report, "What Research Shows" (Phelan, et al., 2009; NARTH, 2009), documents

- that it *is* possible for both men and women to change from homosexuality to heterosexuality, both with and without professional assistance[11] (cf. Whitehead and Whitehead, 2013);

[11] "What Research Shows" (NARTH, 2009) reviews 125 years of clinical and scientific reports documenting that professionally-assisted and other attempts at volitional change from homosexuality toward heterosexuality have been successful for many and that such change continues to be possible for some who are motivated to try. "Clinicians and researchers have reported positive outcomes after using or investigating a variety of . . . paradigms and approaches . . . to treat homosexuality, including *psychoanalysis, other psychodynamic approaches, hypnosis, behavior therapies, cognitive therapies, sex therapies, group therapies, religiously-mediated interventions, pharmacology* [emphasis added], and others. In many cases, combinations of therapies have been used. There have also been reports of spontaneous change, i.e. of persons experiencing various degrees of 'sexual reorientation' without professional or pastoral guidance." (p. 2)

- that efforts to change are not unreasonably or unacceptably harmful; and

- that homosexual men and women *do* indeed have greater risk factors for medical, psychological, and relational problems than do the general population (cf. Diggs, n.d.; NARTH, 2009; Whitehead, 2010).

It is important to acknowledge that *everyone* who has attempted to change the feelings, thoughts, or behaviors associated with unwanted SSA—with or without professional assistance—has *not* accomplished his or her goals as completely as he or she intended. Yet it is also important to remember that many clients seeking to resolve unwanted SSA have accomplished their goals to greater or lesser degrees (cf. Phelan, et al., 2009, pp. 12–280). *Some* persons who have experienced SSA—including some who once fully "lived the lifestyle"—*have* learned to live serene lives without homosexual gratification. And *some* of these *have* developed their heterosexual potential enough to now be married with children. NARTH (2012) offers a helpful perspective for understanding the possibility of change of unwanted SSA:

> NARTH believes that much of the expressed pessimism regarding sexual orientation change is a consequence of individuals intentionally or inadvertently adopting a categorical conceptualization of change. When change is viewed in absolute terms, then any future experience of same-sex attraction (or any other challenge), however fleeting or diminished, is considered a refutation of change........Rather than pigeonholing homosexual sexual orientation change into categorical terms, NARTH believes that it is far more helpful and accurate to conceptualize such change as occurring on a continuum. . . .

> NARTH affirms that some individuals who seek care for unwanted same-sex attractions do report categorical change of sexual orientation. Moreover, NARTH acknowledges that others have reported no change. However, the experience of NARTH clinicians suggests that the majority of individuals who report unwanted same-sex attractions and pursue psychological care will be best served by conceptualizing change as occurring on a continuum, with many being able to achieve sustained shifts in the direction and intensity of their sexual attractions, fantasy, and arousal that they consider to be satisfying and meaningful.[12]

As mentioned above, research shows that attempting to change unwanted SSA does not subject a client to unacceptably high risks of "harm." There have been recent and are current efforts by legislatures and professional bodies at the state, national, and international levels to attempt to stop medical and mental health professionals from offering assistance to "change unwanted SSA." Legislation and pronouncements by professional bodies commonly cite one or more studies in support of their efforts to prevent potential clients from receiving and professionals from offering such assistance. Typically, such research has been reported in a manner that ignores the studies' authors' own awareness of the studies' methodological limitations and irresponsibly claims that the research says more than it does. Too often, ideological bias and irresponsible science or concerns about ethical, professional practice appears to be driving such legislative and professional activism.

[12] Firsthand testimonies of former clients who have sought and gratefully recount their experience of receiving such professional care may be read, heard, or viewed at PATH (n.d.), www.voices-of-change.org

For example, the study by Shidlo and & Schroeder (2002) is commonly cited as "proving" that professional efforts to change unwanted SSA are unacceptably harmful. While this study *may* offer legitimate examples of real, unwanted negative consequences experienced as a consequence of persons who participated in "conversion therapy"—one of several generic names commonly given by critics to the practice of professional and nonprofessional assistance for unwanted SSA—it offers no proof of anything. As Shidlo and Schroeder themselves comment: "*The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical violations in conversion therapy*" (p. 250; emphasis in the original). In spite of such a responsible qualification about the meaning of the results of their study, activists within state, national, and international bodies have irresponsibly used this study to attempt to ban professional "conversion therapy" (Rosik, 2013a, 2013b; Sutton, 2014).[13]

A foundational principle for ethical and beneficial practice by all medical and mental health-care professionals is *respect for clients' and patients' right to "self-determination.*" As Principle E: Respect for People's Rights and Dignity of the APA (2010) Ethical Principles states: "Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination." Surely, this must include the rights of persons to choose to manage and diminish same-sex attractions and behaviors, and perhaps even try to foster opposite-sex attractions and behaviors!

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[13] A decade later, several studies conducted with methodological weaknesses similar to the Shidlo and Schroeder study also attempt to "*document the harm*" (Shidlo and Schroeder, 2002). Undoubtedly, it is only a matter of time before one or more state, national, or international legislatures or professional bodies uses one or all of these new studies in attempting to discredit and prevent the professional practice of change-oriented professional care (Rosik, 2014).

Ironically, on paper, the APA (2009) would seem to agree with NARTH (2010) and allied medical and mental health professionals about the importance of a therapist respecting the "dignity and self-determination of all their clients, including those who seek to change unwanted same-sex attractions and behavior" (Practice Guideline 4). Unfortunately, in practice, the APA and other medical and mental health professional associations seem bent on limiting such self-determination.[14]

When considering the ethics of whether, when, and how to offer professional help to persons whose experiences of SSA feelings, thoughts, behavior, lifestyle, and/or identity are unwanted, the uniqueness of the person who is a potential or actual client must always be remembered. In addition to the ultimate uniqueness of the influences and experiences associated with each person's development of SSA—and indeed, opposite-sex attraction—each person who experiences SSA as unwanted likewise does so out of personal, if sometimes also common, motives. For example, Julie Harren Hamilton and Philip Henry (2009), coeditors of the *Handbook of Therapy for Unwanted Homosexual Attractions*, explain that clients who seek help to cope with and resolve unwanted homosexual attractions may do so for a variety of reasons, such as "a lack of fulfillment in their homosexual identity, incongruence with personal values, deeply held religious beliefs, personal goals of heterosexual marriage and children, and many other such internal motivators" (p. xxi).

[14] As the APA 2009 report states, licensed mental health providers (LMHP) "should strive to maximize autonomous decision making and self-determination and avoid coercive and involuntary treatments" (p. 76). "We also believe that LMHP are more likely to maximize their clients' self-determination by providing effective psychotherapy that increases a client's abilities to cope, understand, acknowledge, explore, and integrate sexual orientation concerns into a self-chosen life in which the client determines the ultimate manner in which he or she does or does not express sexual orientation" (p. 69), and that "clients perceive a benefit when offered interventions that emphasize acceptance, support, and recognition of important values and concerns" (p. 63). Ironically, professionals who do wish to assist clients or patients in changing unwanted same-sex attractions and behavior are able to agree, in theory, with each of these APA assertions (cf., NARTH, 2010).

Other internal motivators may include realistic concerns about preserving or reacquiring one's medical, psychological, and/or relational health. The evidence of increased medical, mental, and relational health risks for those engaging in SSA behaviors compared with those who don't is significant and alarming. Those risks include a myriad of medical problems and diseases directly related to homosexual practices; AIDS and other STDs; substance abuse; suicidal ideation and attempts; psychological and psychiatric concerns including depression, anxiety, paranoia, personality disorders, and eating disorders; and same-sex relationship violence (Phelan, et al., 2009, p. 87; NARTH, 2009, p. 4). Such risks—and a client's self-determination to reduce or avoid them—must be borne in mind by professionals, pastors, and lay persons who are in a position to offer help, whether such helpers in general support or oppose offering therapy or other professional care to help persons manage or resolve unwanted SSA. As the NARTH (2010) Practice Guidelines recommend, potential helpers are advised to seek adequate education, training, and supervision, both before and while offering such care.

VII. Concluding remarks

While I am a psychotherapist trained in clinical psychology and marriage and family therapy, this paper was not intended to and does not offer practical suggestions for *how* to help people who freely choose to act or live differently to understand, manage, and to a greater or lesser extent diminish unwanted SSA. The *pragmatics* of assisting people to change how they think, feel, and act relating to SSA has not been my main concern here; others have written elsewhere about the ethics, nature, and efficacy of psychological and pastoral care for unwanted SSA (e.g., Baars, 2008b; Byrd, n.d.; Consiglio, 2000; Fitzgibbons, 1996; Hallman, 2008; Hamilton & Henry, 2009; Jones & Yarhouse, 2011; Nicolosi, 2009a; Valdes, 1996; van den Aardweg, 1997). My intent has been to discuss the issues—including the potential risk factors and bio-psycho-social

realities—that men, women, and children with unwanted SSA may have had and/or may still have. I hope that this discussion offers understanding and helpful guidance to the medical and mental health professionals to whom persons with unwanted SSA may come seeking assistance. I also hope that persons who experience SSA, and anyone whom their lives touch, may come to better understand SSA.

In closing, I am mindful of some of the basic questions that are answered and lived out in some way by each person inevitably, but perhaps unreflectively. What does it mean to be a (male or female) human being? Is it good to be a (male or female) human being? What is the proper role and meaning of mothering—and fathering—in *biological*, as well as *spiritual* (including *psychologica*l) parenting, in the lives of children and the adults responsible for their procreation—and education? How necessary are permanence, fidelity, and fecundity to the relationship in which one experiences sexual gratification—and, at least potentially, engenders and nurtures to adulthood a new human being? I think that one's answers to such questions, whether consciously known or not, both affect and are affected by the development of SSA.

It may be helpful for anyone who aspires to love anyone who experiences same-sex attractions (including oneself) to realize that *how* one defines or describes the *essential nature* of every human being—and especially one's own or one's loved one's *fundamental identity*—significantly influences how one deals with life in general, and one's sexual attractions in particular. I think it is foolish—as well as untrue—to define oneself by one's "sexual orientation." Believing that the most important characteristic of one's self is whether one is attracted emotionally and/or sexually to and experiences sexual gratification, only or primarily, with members of one's own sex—or even of the opposite sex—is reductionistic, demeaning, and ultimately self-defeating. More fundamental than one's sexual orientation is the fact that one is a human being with intrinsic dignity and worth that precedes and co-occurs with any particular experience or expression of one's sexuality.

This reminder of the intrinsic personhood, dignity, and worth of every human being, including anyone who experiences SSA, serves as a fitting ending to this paper. While there appear to be common experiences and bio-psycho-social issues shared to a greater or lesser extent by some—sometimes many—persons who experience SSA, each person has his or her own story. Every human being warrants respectful and compassionate attention, understanding, and—if desired—care to "be(come) who he or she is," and to live accordingly. Whether one is a medical or mental health professional, pastor or civil servant, someone with unwanted SSA, and/or someone who is simply personally concerned, all persons are challenged to attempt to understand and honor the person, story, and life of each man or woman we encounter.

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