Journal of Human Sexuality, Volume 8

The *Journal of Human Sexuality* is an academic, peer-reviewed journal, an official publication of the Alliance for Therapeutic Choice and Scientific Integrity.

Editorial Offices:

301 West 5400 South, Suite 203, Murray, UT 84107
Telephone: 1-888-364-4744; E-mail: contactus@TherapeuticChoice.com;
Web: http://www.journalofhumansexuality.com

Editorial Board

Editor: Christopher H. Rosik, PhD
Managing Editor: David Clarke Pruden, MS

Alliance Board of Directors

Carolyn Pela, PhD, President
Christopher Rosik, PhD, Past President
Keith Vennum, MD, President-elect
Michael Davidson, PhD
Daniel Harrop, MD
Geoff Heath, JD
Joseph Nicolosi, PhD
David Pickup, MFT
Paul Popper, PhD
Philip M. Sutton, PhD

© Copyright 2017, by the Alliance for Therapeutic Choice and Scientific Integrity. All rights reserved. Written permission to reprint articles or reproduce materials from this journal for publication, use in the classroom, research, and other scholarly purposes must be requested from contactus@TherapeutivcChoice.com. The Alliance for Therapeutic Choice and Scientific Integrity reserves the right to deny permission at its sole discretion.

Requests for copies of this journal should be addressed to the Alliance for Therapeutic Choice, 301 West 5400 South, Suite 203, Murray, UT 84107, or can be ordered by phone at 1-888-364-4744.

Contents

Editor's Comments 3

Alliance Statement on SAFE-T

Christopher H. Rosik, Sexual Attraction Fluidity Exploration in Therapy (SAFE-T): Creating a Clearer Impression of Professional Therapies That Allow for Change 4

Papers

Christopher H. Rosik, A Tale of Two Task Forces: Evidence of a Growing Diversity Problem within Psychology? 11

Nathan A. Solomon, Joanne: Psychoanalytic Psychotherapy with a Homosexual Woman ………….... 27

Józef Szopinski, Family Determinants of Homosexuality: A Case Study ……………………………... 38

Christopher H. Rosik, In Their Own Words: Therapists Who Support a Client's Right to Explore Sexual Attraction Fluidity Respond to Questions Posed by Lesbian, Gay, and Bisexual Therapists 61

Book Review

Keith Vennum, How Did He Do It? A Review of *Overcoming Homosexuality* by Robert Kronemeyer …………………………………………………………………………….. 93

Film Review

Silke Edelmann, A Review and Summary of the Documentary: *Voices of the Silenced: Experts, Evidences and Ideology* (Directed by Michael R. Davidson) ………………………………….. 99

Editor's Comments

The Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) is a multi-disciplinary professional and scientific organization dedicated to preserving the right of individuals to obtain the services of a therapist who honors their values, advocating for integrity and objectivity in social science research, and ensuring that competent licensed, professional assistance is available for persons who experience homosexual (same-sex) attractions (SSA). The Alliance's mission is to promote and ensure a fair reading and the responsible conduct and reporting of scientific and clinical research about the factors that contribute to and/or co-occur with homosexuality (same-sex attraction and behavior, or SSA) and that allow psychological care to be effective for those experiencing homosexual attractions. The Alliance upholds the rights of all individuals, including questioning individuals or those with unwanted SSA, to receive competent professional medical and mental health care and the rights of professionals to offer that care.

In 2009, the Alliance launched the *Journal of Human Sexuality* (*JHS*) in service of this mission and as a way of presenting, encouraging, and producing quality clinical and scientific scholarship on these topics. After its inaugural issue, *JHS* also has included articles on other sexual minority issues and on human sexuality in general.

In this, Volume 8 of the *Journal of Human Sexuality*, the reader will find five professional papers, one book review, and one film review. The authors of these articles and reviews are held to a high standard, requiring that what is written needs to be based on a fair reading and the responsible reporting of scientific data and demonstrable professional experience. We trust that the reader will find the edition both useful and thought-provoking.

David Clarke Pruden, MS

Managing Editor

Sexual Attraction Fluidity Exploration in Therapy (SAFE-T): Creating a Clearer Impression of Professional Therapies That Allow for Change

Christopher H. Rosik, Ph.D.

Abstract

The Alliance/NARTH Institute has recommended new terminology be utilized in describing licensed mental health care for unwanted same-sex attractions with change-oriented goals: Sexual Attraction Fluidity Exploration in Therapy (SAFE-T). This formal announcement of the organization provides a scientific rationale for the employment of SAFE-T language as well as suggestions on how this new language can be used.

During its May 27th, 2016, meeting, the board of the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) voted unanimously to endorse new terminology that more accurately and effectively represents the work of Alliance therapists who see clients with unwanted same-sex attractions. The board has come to believe that terms such as reorientation therapy, conversion therapy, and even sexual orientation change efforts (SOCE) are no longer scientifically or politically tenable. Among the many reasons the board felt it time to retire these older terms as much as possible were the following:

1. These terms imply that categorical change (from exclusive SSA to exclusive OSA) is the goal. This is a degree of change that is statistically rare and not demanded of any other psychological experience as a condition of legitimate psychological care.
2. The current terms imply there is a specific and exotic form of therapy that is being conducted (not standard therapeutic modalities).
3. These terms imply that sexual orientation is an actual entity (i.e., the terms all reify sexual *orientation* as immutable).
4. The terms imply that change is the therapist's goal and not that of the clients (i.e., it's coercive rather than self-determined).
5. These terms (especially SOCE) do not differentiate between professional conducted psychotherapy and religious or other forms of counseling practice.
6. These terms have been demonized and/or developed by professionals completely unsympathetic to therapies that allow for change in same-sex attractions and behaviors. This means that Alliance clinicians are immediately on the defensive as soon as they reference their therapeutic work in these terms.

For all these reasons and more, first the Alliance Executive Committee and then the Alliance Board discussed potential new terminology and finally settled upon the name "Sexual Attraction Fluidity Exploration in Therapy" (the acronym of which is SAFE-T). The Board believes this term has many advantages that commend its usage. First, it addresses all of the concerns noted above. It does not imply that categorical change is the goal and in so doing create unrealistic expectations for many clients. Nor

does it imply that change which is less than categorical in nature cannot be meaningful and satisfying to clients. It also makes clear that SAFE can occur in any number of mainstream therapeutic modalities. Furthermore, by focusing on sexual attractions, it avoids the implicit assertion that orientation changes or that orientation as an immutable reality even exists. By stressing therapeutic exploration, the new term accurately conveys that the therapist is not being coercive but merely assisting individuals in a client-centered examination of their sexual attractions. The Board also appreciated the fact that the acronym SAFE-T immediately challenges portrayals of the professional therapy utilized by Alliance clinicians as harmful.

Scientifically, the fluidity of sexual orientation (and, for our purposes, especially same-sex attractions) for many women and men is now beyond question (Diamond & Rosky, 2016; Katz-Wise, 2015; Katz-Wise & Hyde, 2015). The language of SAFE-T highlights this reality and points to human experience that cannot be denied, again without the complicating focus on orientation. The only counterarguments to SAFE-T on fluidity grounds might be that therapy-assisted fluidity has not been proven to occur and such efforts could be harmful. These arguments are much easier to defend against with SAFE-T than when one is trying to defend implications of complete orientation change. First, we know that sexual attraction fluidity occurs in response to relational and environmental contexts, the very factors that therapists routinely address in their work (Manley, Diamond, & van Anders, 2015). Second, there is research in progress to support the occurrence of therapy-assisted sexual attraction fluidity (Santero, Whitehead, & Ballesteros, in press; Pela & Nicolosi, 2016), not to mention a rich history of past research, as good as any research of its era (Phelan, Whitehead, & Sutton, 2009). Finally, recent research on "ex-ex-gays" (e.g., Bradshaw, Dehlin, Crowell, & Bradshaw, 2015; Flentje, Heck, & Cochran, 2013) tells us no more about SAFE-T than research focused on divorced consumers of marital therapy would tell us about its safety and efficacy. While it is reasonable to conclude that more research is needed to better comprehend the extent of therapy-assisted sexual attraction fluidity, denying the potential for such a therapeutic process would seem to be much more a matter of ideological compulsion than it is one of theoretical or scientific implausibility.

Due to all of these important considerations, the ATSCI Board encourages Alliance members and supporters to join them in employing the terminology of SAFE-T in their professional work. One might say, for example, “I practice a cognitive form of SAFE-T” or “I practice SAFE-T from an interpersonal perspective” or “There is no scientific basis for banning any form of SAFE-T” or even “I don’t do SOCE, I only practice SAFE-T.” Because this term represents what Alliance clinicians actually do in a scientifically accurate and defensible manner, the Board anticipates that the professional interests of these therapists and the public policy interests of supporters will be much better served by SAFE-T.

References

Bradshaw, K., Dehlin, J. P., Crowell, K. A., & Bradshaw, W. S. (2014). Sexual orientation change efforts through psychotherapy for LGBQ individuals affiliated with The Church of Jesus Christ of Latter-day Saints. *Journal of Sex & Marital Therapy*. Advance online publication. doi: 10.1080/0092623X.2014.915907

Diamond, L. M., & Rosky, C. (2016). Scrutinizing immutability: Research on sexual orientation and its role in U.S. legal advocacy for the rights of sexual minorities. *The Journal of Sex Research*. Advance online publication. doi: 10:1080/00224499.2016.1139665

Flentje, A., Heck, N. C., Cochran, B. N. (2013). Sexual reorientation therapy interventions: Perspectives of ex-ex-gay individuals. *Journal of Gay & Lesbian Mental Health, 17*, 256–277. doi: 10.1080/19359705.2013.773268

Katz-Wise, S. L. (2015). Sexual fluidity in young adult women and men: Associations with sexual orientation and sexual identity development. *Psychology & Sexuality*, *6*, 189–208. doi: 10.1080/19419899.2013.876445

Katz-Wise, S. L., & Hyde, J. S. (2015). Sexual fluidity and related attitudes and beliefs among young adults with a same-gender orientation. *Archives of Sexual Behavior*, *44*, 1459–1470. doi: 10.1007/s10508-014-0420-1

Manley, M. H., Diamond, L. M., & van Anders, S. M. (2015). Polyamory, monoamory, and sexual fluidity: A longitudinal study of identity and sexual trajectories. *Psychology of Sexual Orientation and Gender Diversity, 2*, 168–180. doi: 10.1037/sgd0000107

Pela, C., & Nicolosi, J. (2016, March). *Clinical outcomes for same-sex attraction distress: Well-being and change.* Paper presented at the Christian Association for Psychological Studies conference, Pasadena, CA.

Phelan, J. E., Whitehead, N., & Sutton, P. M. (2009). What the research shows: NARTH's response to the APA claims on homosexuality. *Journal of Human Sexuality, 1*, 5–118. Retrieved from http://www.scribd.com/doc/115507777/Journal-of-Human-Sexuality-Vol-1

Santero, P. L., Whitehead, N. E., & Ballesteros, D. (in press). Effects of therapy on U.S. men who have unwanted same-sex attraction. *Linacre Quarterly*.

A Tale of Two Task Forces: Evidence of a Growing Diversity Problem within Psychology?

Christopher H. Rosik, Ph.D.
Link Care Center & Fresno Pacific University

Christopher H. Rosik, Ph.D., is a clinical psychologist and director of research at the Link Care Center in Fresno, California, and a clinical faculty member in the Department of Psychology at Fresno Pacific University. He is also the Past-President of the Alliance for Therapeutic Choice and Scientific Integrity. Correspondence concerning this article should be addressed to the author at Link Care Center, 1734 W. Shaw Ave., Fresno, CA, 93711. E-mail: christopherrosik@linkcare.org

Abstract

In this brief historical analysis, I compare and contrast two different American Psychological Association task forces, both of which were charged with reviewing the scientific literature regarding different but equally controversial clinical practices. Convened just over a decade apart, the first of these investigations involved recovered (repressed) memory therapy (RMT), and the subsequent review examined sexual orientation change efforts (SOCE). I observe that the SOCE task force, unlike the RMT working group, was devoid of ideological diversity and strongly dissuaded clinicians from engaging in the practice under review, in spite of indications that far greater and more certain harms were occurring through RMT than through SOCE. These differences may be another symptom of organized psychology's increasing lack of sociopolitical diversity, with accompanying risks for conservative clinicians and the public perception of psychology's credibility when addressing contested social issues. I close with a brief discussion of this concern and note some recommendations that can begin to address it.

Keywords: SOCE, repressed memory therapy, sociopolitical diversity, professional psychology.

Understanding history is often valuable in comprehending the present. In the following analysis, I hope to show how this statement applies to the American Psychological Association's (APA's) approach to sexual orientation and therapies that allow for the potential of change (labeled by the APA as sexual orientation change efforts, or SOCE). The issue of harm, and especially harm to minors, has been paramount in the arguments surrounding SOCE bans by legislative bodies across the continent. I will argue here that changes within the APA have led to the dominance of advocacy interests over scientific humility where contentious social issues are concerned. I illustrate this contention by comparing the APA's management of the controversy over SOCE with how the association addressed concerns about harm attributed to an earlier and equally contentious therapeutic practice.

Recovered Memory Therapy

In the later 20th century, increasing scrutiny by the public and politicians began to be placed on what was termed recovered (or repressed) memory therapy (RMT). RMT was the clinical portion of a larger debate that was occurring in psychology regarding the historical accuracy of memories of childhood sexual abuse (CSA) recalled during psychotherapy. In RMT, there was often a focus on the use of various techniques in order to uncover past traumatic experiences that presumably would help resolve client distress. Surveys of psychologists at that time suggested that upward of 25% engaged in some form of RMT, and a much higher percentage employed various techniques believed to aid in memory retrieval (Polusny & Follette, 1996; Poole, Lindsay, Memon, & Bull, 1995). Yet in spite of its popularity among clinicians, the practices associated with RMT were far from benign.

In response to some dramatic and highly publicized claims of CSA (including satanic ritual abuse) remembered by clients in psychotherapy, by 1993 legislatures in nearly half the states had passed laws allowing alleged victims to sue the accused perpetrators within three to six years following the emergence of their repressed memories (Jaroff, 1993). These laws helped to foment an increase in clients suing their alleged perpetrators, who were often parents, for events typically said to have happened 20,

30, and even 40 years earlier (Loftus, 1993). Not infrequently, this occurred with the blessing of clients' therapists. Families were shattered and hundreds of lawsuits were generated through the clinical practices and legal environment created in part by RMT (APA, 1996; Loftus & Ketcham, 1994). According to Porter and Lane (1996), "Recovered memory therapy based on the theory of repression has devastated thousands of lives in the last ten years" (p. 26). In response, thousands of individuals and families sought assistance from a new organization whose views on the matter were reflected in its name: the False Memory Syndrome Foundation. Eventually countersuits and ethical complaints against therapists and hospitals by alleged perpetrators were instigated, and these efforts met with more than occasional success (Jaroff, 1993; Porter & Lane, 1996). Foreshadowing the terminology applied two decades later to therapists who engage in SOCE, Stanford social psychologist Richard Ofshe predicted that, "Recovered-memory therapy will come to be recognized as the quackery of the 20th century" (Jaroff, 1993, p. 55).

Debates within psychology at the time over RMT and the reliability of memories of CSA recalled in psychotherapy were often intense and marked by a barely controlled acrimony (e.g., Williams, 1994a, 1994b; Loftus, Garry, & Feldman, 1994). Defenders of the possibility that recovered memories could be based in historical abuse, much like SOCE apologists today, often presented case studies and research derived from their clinical experience (Chu, Frey, Ganzel, & Matthews, 1999; Lewis, Yeager, Swica, Pincus, & Lewis, 1997; Williams, 1994a; Young, Sacs, Braun, & Watkins, 1991). Critics of recovered memories techniques, similar to contemporary SOCE opponents, tended to be psychologists and researchers who had not clinically practiced the controversial therapy (Loftus, 1993; Loftus et al., 1994; Spanos, 1996). In February of 1993, the APA waded into this controversy by forming a task force, designated as the Working Group on Investigation of Memories of Childhood Abuse.

The APA's working group was tasked with reviewing the current scientific literature and identifying future research and training needs pertaining to the evaluation of memories of childhood abuse (APA Working Group, 1998a). The six-member working group was composed of an equal number of clinical psychologists and research scientists, half identified with feminist psychology and/or trauma treatment and half known for their work in memory research.[1] On February 14, 1996, the working group

released its findings. Sharp ideological differences within the working group resulted in the two groups issuing separate reviews. Although there were some areas of agreement, particularly as relates to the need to consider the perspectives of both groups and the importance of conducting further research, stark differences in perspectives could not be overcome and prevented the working group from recommending any substantive corrective action (Cummings & O'Donahue, 2008). As the working group confessed:

> As suggested above, one of the most consistent observations emerging from our deliberations has to do with the very divergent epistemologies and definitions used by psychologists who study memory and those who study and treat the effects of trauma. Although there are exceptions, we frequently do not speak the same professional language or define phenomena in the same manner; we read different journals and books, and we attend different specialty meetings; and each group finds useful and compelling studies that the other group sees as problematic and questionable. Many of the difficulties that we have encountered in attempting to achieve consensus reflect these profound epistemological differences. (APA Working Group, 1998b, p. 934)

Arguably, many of these observations might also help explain the divergent viewpoints of supporters and critics of SOCE, whose very different moral frameworks and personal experiences constitute significant obstacles to achieving any kind of consensus on the issue.

Sexual Orientation Change Efforts

Ten years later, on March 13, 2007, addressing another controversial clinical practice, the APA authorized the creation of a task force to update their 1997 resolution on appropriate therapeutic responses to sexual orientation. This task force was charged with reviewing the literature and making recommendations pertaining to SOCE (APA, 2007). It should be recalled that forces within the APA attempted but failed to have the APA formally declare SOCE unethical in the 1990s. Apparently, these efforts were unsuccessful due to concerns regarding both a lack of supporting scientific evidence and legal vulnerability, including potential claims against the APA by both professionals and clients should

the APA have promulgated a formal resolution. Hence, this request for updating the 1997 resolution took place in the context of increasing pressures coming from within the association and within the broader cultural and political environment. However, while the controversial nature of both RMT and SOCE resulted in the formation of respective APA task forces, the similarities break down from there. The emotional and relational harms connected to RMT practices and litigation were widespread, well-documented, and impacted thousands of clients and their families. By contrast, the harms to clients associated with licensed therapists who engaged in contemporary forms of SOCE were equivocal, with minimal research of sufficient quality to be directly pertinent. As the APA (2009a) Report acknowledged, "Thus, we cannot conclude how likely it is that harm will occur from SOCE" (p. 42). Moreover, few, if any, therapists were on record as losing their licenses or having to defend themselves against ethics complaints due to engaging in allegedly widespread and egregious SOCE-related conduct that would most certainly have run afoul of existing state regulatory policies for psychological practice and invited legal action (e.g., applying electric shocks to genitals or inducing vomiting paired with homoerotic images).

While the APA sought to comprise the RMT working group with a diverse group of scholars and practitioners, the SOCE task force was comprised of six expert psychologists with little viewpoint diversity, five of whom were sexual minorities and none who engaged in the practice of SOCE.[2] Several qualified psychologists, including both conservative academics and seasoned SOCE practitioners, were nominated to serve, yet all of them were rejected. The director of the APA's Lesbian, Gay and Bisexual Concerns Office, Clinton Anderson, offered the following defense at the time: "We cannot take into account what are fundamentally negative religious perceptions of homosexuality—they don't fit into our world view" (Yarhouse, 2009). This is an understandable moral litmus test for the APA given that they, like the great majority of mental health associations, have increasingly adopted left-of-center sociopolitical sympathies (Duarte et al., 2015), wherein the most sacred value is that of preventing harm to disadvantaged groups such as sexual minorities (Haidt, 2012). However, such exclusion also had the unfortunate consequence of weakening the credibility of the task force's conclusions among a large

number of conservative professionals and politicians (Ferguson, 2015; Jones, Rosik, Williams, & Byrd, 2010; Robiner, Fossum, & Hong, 2015).

Unlike the viewpoint diverse RMT task force's inability to provide strong prescriptive guidance for clinical practice, the SOCE task force's findings were touted by the APA as all but definitive.

> Contrary to claims of sexual orientation change advocates and practitioners, there is insufficient evidence to support the use of psychological interventions to change sexual orientation. . . . Scientifically rigorous older studies in this area found that sexual orientation was unlikely to change due to efforts designed for this purpose. Contrary to the claims of SOCE practitioners and advocates, recent research studies do not provide evidence of sexual orientation change as the research methods are inadequate to determine the effectiveness of these interventions. (APA, 2009b)

Regarding the issue of harm from SOCE, the task force appeared to evidence more modesty: "There are no methodologically sound studies of recent SOCE that would enable the task force to make a definitive statement about whether or not recent SOCE is safe or harmful and for whom" (APA, 2009a, p. 83). While there were some common sense recommendations that clinicians not promise sexual orientation change nor consider sexual orientation as a personal choice, the overarching sentiment offered in a uniform manner by the task force is that clinicians should avoid SOCE altogether.

It is highly probable that had the SOCE task force included a genuine diversity of perspectives on the issue, the final product would have been far less likely to effectively undergird the ongoing legal efforts to ban licensed therapists from engaging in a client-centered process that explores the potential for sexual orientation fluidity. Critics of the Report noted that the task force drew conclusions about SOCE efficacy from only six studies deemed of sufficient methodological rigor which were conducted between 1969 and 1978, all of which employed aversive or other behavioral methods on many men who were court-referred for psychiatric and sexual concerns and fearful of criminal or legal penalties (APA, 2009a, p. 82; Jones et al., 2010). These authors then posed an important question and observation:

> If the six studies deemed of sufficient scientific quality to merit the focus of the Report a) targeted samples that would bear little resemblance to those seeking SOCE today, and b) used methods no longer in currency among those offering SOCE today, then on what basis does the Report move beyond scientific agnosticism to argue affirmatively that sexual orientation change is uncommon or unlikely? The Report seems to want to affirm together two assertions that are incompatible: a) we do not have credible evidence on which to judge the likelihood of sexual orientation change, and b) we know with scientific confidence that sexual orientation change is unlikely. (Jones et al., 2010, p. 9)

Even more pertinent to the current political efforts to ban SOCE is the apparent double standard of the task force in assessing the potential for harm. The task force appeared to adopt very rigorous evidentiary standards for drawing conclusions about SOCE efficacy but abandoned such precision in assessing harm[3]. Jones and colleagues (2010) noted that, "The standard with regards to efficacy is to rule out substandard studies as irrelevant. No such standards appear to be used with regard to studies of harm" (p. 9). It is telling that scientifically definitive claims purporting serious and widespread harm from SOCE now being circulated in legislative bodies across America were fueled in large part by a task force validation of just six outdated studies and a collection of essentially anecdotal accounts. This has the appearance of an extremely low scientific threshold for legally infringing upon professional practice.

Finally, both the SOCE and RMT task forces called for further high quality research on their respective subjects. Unfortunately, the SOCE task force analysis begs the question of how SOCE could meet high research standards if the task force's advice is to discourage its practice. Moreover, while the Report observes the precipitous decline in SOCE-related research in the last four decades, it does not acknowledge a primary reason for this (i.e., such research is now fraught with a multitude of potentially career threatening landmines for those scholars most in a position to conduct it, particularly if findings do not align with left-of-center advocacy interests) (e.g., Woods, 2013). The ability to conduct quality research is now being made impossible by SOCE bans, which have gotten the support of APA experts (e.g., Declaration of A. Lee Beckstead, 2012; Declaration of Gregory M. Herek, 2012) and raise questions

as to the earnestness of the APA task force's call for research in the first place. Of course conscientious therapists should aspire to a particularly high degree of professionalism when clinically addressing client concerns regarding same-sex attractions and behaviors. Unfortunately, the activism and legislative course of events set in motion by the APA's ideologically homogeneous task force on SOCE brings into question the judgment of all licensed clinicians who would entertain a client's request to explore the extent to which a therapeutic process might assist in promoting change.

Whither Sociopolitical Diversity in Psychology?

The controversy over RMT within professional psychology has largely subsided today, with subsequent scientific study and clinical reflection leading to more cautious therapeutic practice and less rancorous discourse. Tellingly, all of this was achieved without recourse to legal prohibition and is in stark contrast to the extensive activism now being committed to SOCE bans. The professional and political maelstrom that contemporary SOCE finds itself in today indicates that the moral landscape within the culture and within professional psychology has changed rather dramatically (Twenge, Sherman, & Wells, 2016), beginning years prior to the APA's SOCE Report and seeming to accelerate up into the present. Organized psychology appears to be rapidly becoming less sociopolitically diverse and hence less tolerant of viewpoints that run afoul of preferred political and advocacy interests (Duarte et al., 2015; Ferguson, 2015; Gouchat, 2012).[4] In the long run, this has the potential to undermine the credibility of psychology's pronouncements on scientific matters before the public, politicians and the courts.

Sociopolitical homogeneity may impact the production and dissemination of social science at many levels, and especially so with regard to controversial subjects. The focus of this analysis concerned the apparent decreased interest of the APA in forming task forces inclusive of divergent perspectives regarding controversial practices, which plausibly has serious implications for the integrity of its formal resolutions and pronouncements on these topics. However, the movement toward less sociopolitical diversity within organized psychology can also be evidenced, for example, as bias in research citation

(Ferguson, 2015; Schumm, 2015), peer review (Honeycutt & Freberg, 2017; Inbar & Lammers, 2012), and hiring practices (Honeycutt & Freberg, 2017; Inbar & Lammers, 2012).

More generally, Duarte and colleagues argue that the lack of diversity embeds left-of-center values in psychological theory and method, concentrates the profession on topics that validate progressive narratives and avoid topics that contest these narratives, and risks producing a psychological science that mischaracterizes the traits, attributes, and motivations of religious and other conservative providers who accept the possibility of therapy-assisted fluidity in the components of sexual orientation (i.e., identity, attraction, and behavior). While there is no quick fix to this diversity problem within organized psychology, acknowledging the problem, enhancing opportunities for non-liberals to participate in task force deliberations and other apparatuses of psychological science, and adding sociopolitical diversity to the profession's diversity aspirations would constitute a productive starting point (Duarte et al., 2015; Robiner et al., 2015).

References

American Psychological Association (1996, February 14). *APA panel addresses controversy over adult memories of childhood sexual abuse*. APA News Release.

American Psychological Association (1998a). American Psychological Association working group on investigation of memories of childhood abuse: Preface to the final report. *Psychology, Public Policy, and Law, 4*, 931–932. doi: 10.1037/h0092731

American Psychological Association (1998b). Final conclusions of the American Psychological Association working group on investigation of memories of childhood abuse. *Psychology, Public Policy, and Law, 4*, 933–940. doi: 10.1037/1076-8971.4.4.933

American Psychological Association (2007, March 13). *APA task force on appropriate therapeutic responses to sexual orientation*. APA Public Relations Affairs Office.

American Psychological Association (2009a). *Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Retrieved from http://www.apa.org/pi/lgbt/resources/therapeuticresponse.pdf

American Psychological Association (2009b, August 5). *Insufficient evidence that sexual orientation change efforts work, says APA*. APA Press Release.

Barnett, J. E., & Shale, A. J. (2013, April). Alternate techniques. *Monitor on Psychology, 44*, 48–56. Retrieved from http://www.apamonitor-digital.org/apamonitor/201304?pg=50#pg50

Chu, J. A., Frey, L. M., Ganzel, B. L., & Matthews, J. A. (1999). Memories of childhood abuse: Dissociation, amnesia, and corroboration. *American Journal of Psychiatry, 156*, 749–755.

Cummings, N. A., & O'Donahue, W. T. (2008). *Eleven blunders that cripple psychotherapy in America: A remedial unblundering*. New York: Routledge.

Declaration of A. Lee Beckstead in support of defendant's opposition to plaintiffs' motion for preliminary injunction, *Pickup v. Brown*, E.D. Cal. Case no. 12-02497-KJM-EFB (2012, November 9). Retrieved from http://cdn.ca9.uscourts.gov/datastore/general/2012/12/17/12-17681_appellee_opposition.pdf

Declaration of Gregory M. Herek in support of defendant's opposition to plaintiffs' motion for preliminary injunction, *Pickup v. Brown*, E.D. Cal. Case no. 12-02497-KJM-EFB (2012, November 9). Retrieved from http://cdn.ca9.uscourts.gov/datastore/general/2012/12/17/12-17681_appellee_opposition.pdf

Duarte, J. L., Crawford, J. T., Stern, C., Haidt, J., Jussim, L., & Tetlock, P. E. (2015). Political diversity will improve social psychological science. *Behavioral and Brain Sciences, 38*, e130. doi: 10.1017/S0140525X1400043

Ferguson, C. J. (2015). "Everybody knows psychology is not a real science." *American Psychologist, 70*, 527–542. doi: 10.1037/a0039405

Gauchat, G. (2012). Politicization of science in the public sphere: A study of public trust in the United States, 1974–2010. *American Sociological Review, 77*, 167–187. doi: 10.1177/0003122412438225

Haidt, J. (2012). *The righteous mind. Why good people are divided by religion and politics.* New York: Pantheon Books.

Inbar, Y., & Lammers, J. (2012). Political diversity in social and personality psychology. *Perspectives on Psychological Science, 7*, 496–503. doi: 10.1177/1745691612448792

Honeycutt, N., & Freberg, L. (2017). The liberal and conservative experience across academic disciplines: An extension of Inbar and Lammers. *Social Psychological and Personality Science, 8*, 1115–1123. doi: 10.1177/1948550616667617

Jaroff, L. (1993, November 29). Lies of the mind. *Time*, *142*, 52–59.

Jayson, S. (2011, August 5). Citing new research, psychology group supports gay marriage. *USA Today*. Retrieved from http://usatoday30.usatoday.com/news/health/wellness/marriage/story/2011/08/Citing-new-research-psychology-group-supports-gay-marriage/49798054/1

Jones, S. L., Rosik, C. H., Williams, R. N., & Byrd, A. D. (2010). A scientific, conceptual, and ethical critique of the report of the APA Task Force on sexual orientation. *The General Psychologist,*

45(2), 7–18. Retrieved from http://www.apadivisions.org/division-1/publications/newsletters/general/2010/10-issue.pdf

Lewis, D. O., Yeager, C. A., Swica, Y., Pincus, J. H., & Lewis, M. (1997). Objective documentation of child abuse and dissociation in 12 murders with dissociative identity disorder. *American Journal of Psychiatry, 154*, 1703–1710. doi: 10.1176/ajp.154.12.1703

Loftus, E. F. (1993). The reality of repressed memories. *American Psychologist, 48*, 518–537. doi: 10.1037/0003-066X.48.5.518

Loftus, E. F., Garry, M., & Feldman, J. (1994). Forgetting sexual trauma: What does it mean when 38% forget? *Journal of Consulting and Clinical Psychology, 62*, 1177–1181. doi: 10.1037/0022-006X.62.6.1177

Loftus, E. F., & Ketcham (1994). *The myth of repressed memories*. New York: St. Martin Press.

Pace, P. R. (2014, October). NASW PACE prepares for candidate endorsements. *NASWnews, 59*(9), 1. Retrieved from https://www.socialworkers.org/pubs/news/2014/10/pace-candidate-endorsements.asp

Pignotti, M., & Thyer, B. A. (2009). Use of novel unsupported and empirically supported therapies by licensed clinical social workers: An exploratory study. *Social Work Research, 33*, 5–17. doi: 10.1093/swr/33.1.5

Polusny, M. A., & Follette, V. M. (1996). Remembering childhood sexual abuse: A national survey of psychologist's clinical practices, beliefs, and personal experiences. *Professional Psychology: Research and Practice, 27*, 41–52. doi: 10.1037/0735-7028.27.1.41

Poole, D. A., Lindsay, D. S., Memon, A., & Bull, R. (1995). Psychotherapy and the recovery of memories of childhood sexual abuse: U.S. and British practitioners' opinions, practices, and experiences. *Journal of Consulting and Clinical Psychology, 63*, 426–437. doi: 10.1037/0022-006X.63.3.426

Porter, L. S., & Lane, R. C. (1996). Iatrogenic creation of false childhood sexual abuse memories: Controversy, dynamics, fantasy, and reality. *Journal of Contemporary Psychotherapy, 26*, 23–42. doi: 10.1007/BF02307703

Robiner, W. N., Fossum, T. A., & Hong, B. A. (2015). Bowling alone: The decline of social engagement and other challenges for the American Psychological Association and its divisions. *Clinical Psychology: Science and Practice, 22*, 366–383. doi: 10.1111/cpsp.12124

Schumm, W. R. (2015). Navigating treacherous waters: One researcher's 40 years of experience with controversial scientific research. *Comprehensive Psychology, 4*, 24. doi: 10.2466/17.CP.4.24 Retrieved from http://www.bmartin.cc/dissent/documents/Schumm15.pdf

Spanos, N. P. (1996). *Multiple identities and false memories: A sociocognitive perspective*. Washington, DC: American Psychological Association.

Stapleton, P., Chatwin, H., Boucher, E., Crebbin, S., Scott, S., Smith, D., & Purkis, G. (2015). Use of complementary therapies by registered psychologists: An international study. *Professional Psychology: Research and Practice, 46*, 190–196. doi: 10.1037/pro0000015

Tierney, J. (2011, February 11). Social scientist sees bias within. *The New York Times.* Retrieved from http://www.nytimes.com/2011/02/08/science/08tier.html?_r=3

Twenge, J., Sherman, R., & Wells, B. (2016). Changes in American adults' reported same-sex sexual experiences and attitudes, 1973-2014. *Archives of Sexual Behavior, 45*, 1713–1730. doi: 10.1007/s10508-016-0769-4

Williams, L. M. (1994a). Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. *Journal of Consulting and Clinical Psychology, 62*, 1167–1176. doi: 10.1037/0022-006X.62.6.1167

Williams, L. M. (1994b). What does it mean to forget child sexual abuse? A reply to Loftus, Garry, and Feldman (1994). *Journal of Consulting and Clinical Psychology, 62*, 1182–1186. doi: 10.1037/0022-006X.62.6.1182

Woods, P. (2013). The campaign to discredit Regnerus and the assault on peer review. *Academic Questions, 26*, 171–181. doi: 10.1007/s1219-013-9363-5

Yarhouse, M. A. (2009). The battle regarding sexuality. In N. Cummings, W. O'Donahue, & J. Cummings (Eds.), *Psychology's War on Religion* (pp. 63–94). Phoenix, AZ: Zeig, Tucker, & Theisen, Inc.

Young, W. C., Sachs, R. G., Braun, B. G., & Watkins, R. T. (1991). Patients reporting ritual abuse in childhood: A clinical syndrome report of 37 cases. *Child Abuse & Neglect, 15*, 181–189. doi: 10.1016/0145-2134(91)90063-1

Footnotes

[1]Members of the working group were Judith L. Alpert, Laura S. Brown, Stephen J. Ceci, Christine A. Courtious, Elizabeth F. Loftus, and Peter A. Ornstein.

[2]Members of the task force were Judith M. Glassgold, A. Lee Beckstead, Jack Drescher, Beverly Greene, Robin Lin Miller, and Roger L. Worthington.

[3]Another apparent double standard regarding how professional psychology in general and the APA specifically treat SOCE involves the APA's promotion of novel and unsupported alternative therapeutic techniques such as aromatherapy, Reiki (spiritually guided life force energy), massage therapy, and chiropractic and their frequent endorsement by mental health clinicians (Barnett & Shale, 2013; Pignotti & Thyer, 2009; Stapleton et al., 2015). The noticeably differing treatment within professional psychology of contemporary SOCE in comparison to these alternative techniques despite similar methodological limitations in their respective research bases (APA, 2009a; Barnett & Shale, 2013) hints at the influence of extra-scientific factors such as moral, cultural, and advocacy demands.

[4]Some clear examples of the lack of sociopolitical diversity on contested social issues include the 157–0 vote by the APA's Counsel of Representative in August of 2011 in favor of a resolution supporting marriage equality (Jayson, 2011) as well as the National Association of Social Workers (NASW) uniform endorsement of only Democrat candidates (339 out of 339) to federal offices in recent elections (Pace, 2014). Haidt has observed that these numbers represent a statistically impossible lack of diversity and give credence to his concerns (Haidt, 2012; Tierney, 2011) that:

> In the same way, each individual reasoner is really good at one thing: finding evidence to support the position he or she already holds, usually for intuitive reasons. . . . This is why it's so important to have intellectual and ideological diversity within any group or institution whose goal is to find truth (such as an intelligence agency or a community of scientists) or to produce good public policy (such as a legislature or advisor board). (p. 90)

Joanne: Psychoanalytic Psychotherapy with a Homosexual Woman

Nathan A. Solomon

Private Practice, Brooklyn, NY

Address correspondence regarding this article to Nathan Solomon, Ph.D., at nas1@optonline.net. This paper is dedicated to the memory of Dr. Joseph Nicolosi, who encouraged its submission to this journal.

Abstract

A thirty-year-old, married, Orthodox Jewish woman complaining of same-sex attraction was treated with psychoanalytically oriented psychotherapy after trying several other therapies, including sex therapy. Among the primary determinants of her presenting problem were alienation from her unpredictable, narcissistic mother, gender identity confusion, and impounded anger. After about two years of treatment, the patient achieved connection with feelings of affection and desire, improved and loving relationships with her children, regular orgasmic sex with her husband, and remission of pre-existing colitis.

Initial Presentation

Dressed in jeans, a sweatshirt, and work boots, Joanne does not look like the usual Orthodox Jewish woman. When I ask her what brought her to my office, she states flatly, “I’m gay.” At thirty years of age, married and the mother of two children, Joanne is very distressed and sad over the cloud that hangs over her otherwise very good marriage. She states she has no desire for intimacy with her husband, is attracted more to women than to men, and, in order to achieve arousal with her husband, has homosexual fantasies.

She was referred for treatment by her mother’s therapist. At presentation, she is oriented to person, place, and time and well-related. Rapport with her was easily established. Joanne’s intelligence is above average, her reality testing is intact, her thinking is logical, and her speech is clear and coherent. She reports her mood is depressed. She is taking Wellbutrin prescribed by a psychiatrist. Her affect is somewhat constricted.

History

Joanne has seen several therapists for this problem without success. A sex therapist thought her problem was hormonal. Joanne’s mother is a chronically depressed and angry woman, who is difficult to tolerate, though Joanne insists she has been a positive influence in her life. Her father is a pleasant but passive and quiet man, who is not terribly accessible.

Joanne has a history of ulcerative colitis, possibly secondary to obsessive rumination. She has never had a crush on a male, though she says she is somewhat attracted to her husband. She has always been a tomboy, preferring sports and vigorous work to more feminine pursuits. She rates her marriage a 10 out of 10, except for physical intimacy, which is difficult and sporadic at best. She reports that her husband is her best friend.

Joanne rated herself an average student throughout her Orthodox Jewish religious schooling; she was not particularly academically oriented. She did have friends. Beginning at about age 13, she began masturbating once every 2 weeks or so. At around age 15, she began to

be attracted to and have sexual fantasies about females. Soon, she had 4 or 5 offers of sex from other girls, but she declined. Currently, she reports homosexual dreams, sometimes about trying to find a private place to have sex.

We agree to meet twice weekly.

Initial Phase of Therapy

Joanne prefers to use humor to avoid painful affect from the very beginning to almost the end of therapy. She spends a great deal of time extolling her mother and her husband. She wants to know how a perfectly normal childhood could yield a problem such as hers.

During our 11th session, Joanne goes blank. She has nothing to say. I say this sometimes means that something is trying to come out. She immediately responds, "Okay, I guess I have to say it," and reports a memory from age 6. She is at a children's concert, sees a 15-year-old girl on the stage, and is mesmerized by her, probably aroused. She imagines the girl without her clothes and focuses on her sex characteristics.

Memories like these embarrass Joanne terribly. Before the next session, she calls and reports that she has developed a tremor and agitation. She believes it has to do with her memory from the last session. At my suggestion, she calls the psychiatrist, who believes it is an abreaction to the Wellbutrin. She cuts back to start more slowly. In session, she reports three more memories of childhood sex play with other girls at ages 8 and 10. She insists she got nothing out of these interactions, which were initiated by the other girls. She also reflects upon her mother, who in her later life has become critical and bitter. No one wants to be in her company. In fact, Joanne is becoming angry with her.

The real (non-neurotic) relationship (Greenson, 1967) between Joanne and myself has developed smoothly. We are frank and easy with each other; our banter is frequent and often jovial. But she appears to fight a *transferential* (i.e., unconscious and neurotic) relationship by missing occasional sessions and often coming late. I see in this an *avoidant attachment*. This

expresses itself in her relationships with her mother and her husband. My own countertransference (i.e., my unconscious, neurotic emotional response) involves being seduced into avoidance of important material by her clever humor. I enjoy the banter at the beginning of our sessions. I feel somewhat paternalistic and am extremely frustrated by her lateness and missing sessions.

Middle Phase

Three months into the treatment, Joanne's true feelings about her mother begin to surface. Although she is closer to mother than father, she hates her mother's proclivity to manipulate. As she begins to speak of anger, she also states plainly that she fears losing control of it. This fear of her own anger—and therefore of therapy—will characterize the entire course of our work together. She fears she will abandon her mother, who never hugged or kissed her, was too preoccupied with her own desperate need for validation, and sought it in embarrassing ways. Joanne feared her mother's explosive rages and arrived home from school with apprehension, never knowing which kind of mother would be there.

Her parents' marriage is not a good one. Her mother dominates the household; her father is quiet and often depressed. She describes him as also lacking any affectional ties to her. He is a sweet but socially isolated man.

The transference is soon expressed in terms of dismissal—the primary defense in avoidant attachment (Wallin, 2007). Our work is sometimes pushed aside in favor of quips about myself (calling me "Doc," for example) and cracking jokes. I see this as a defense against fears of emotional abandonment. It is only through patient reliability, being present and dependable, that I am able to help her work through her transferential fears that I will abandon her (and thus provide a corrective emotional experience for her) (Alexander, 1963).

During this third month of work, Joanne shares that she always felt that boys had more fun. She was bored by dolls and playing house. She once wore a boy's suit and liked it. She tried urinating from a standing position and still has sexually charged dreams of doing this.

Discussing her sexuality lifts a tremendous burden from her. She confides that her homosexual dreams are more satisfying than intimacy with her husband. For the first time in her life, she declares to me that her life as an Orthodox Jew is a sham. She is really a hedonist and cannot trust herself. She is desperate to feel free. It is during this early middle phase of treatment that Joanne reports improved intimacy with her husband, frequent orgasm, and heterosexual dreams. This coincides with her realization that *she wants to be nothing like her mother.*

With this realization, the therapy descends into a desperate darkness. Joanne's anger rises, is turned against the self, and a deep depression overtakes her. Her libido disappears. She feels "used" by her mother and repulsed by her mother's new, awkward attempts at affection. This is accompanied by substantial feelings of guilt.

In our sixth month of work, during our 41st session, Joanne realizes for the first time that, for many years, she has patterned much of her life after a reverse image of her mother. *I wonder if that could include her sexual object choice*. Though she says she has been thinking this, she is still stunned by my suggestion.

She says she is attracted to women she admires. She recalls that an earlier therapist that she hated for his bluntness and arrogance told her she was seeking someone more feminine than her mother. He was right, she says; but *she* needed to say it and thus could not accept it from him. I have been more patient, she says; now, she feels liberated. A tremendous load has been lifted from her. She no longer feels "deviant." She begins to see her mother as "disturbed," which somewhat mitigates the anger.

Working-Through Phase

Joanne's family has begun to complain to her about her obvious apathy; yet she believes a breakthrough is coming. She is able to admit now that her mother also nurtured her. She is calling her mother more frequently and has fewer homosexual thoughts. She connects her colitis to her guilt over speaking about her mother to me but also ties it to her intense anger against her mother.

Her core relationship problem (Horner, 2005) is clearer now: Out of fear of abandonment, she tightly controls her rage against a narcissistic, neglecting mother. She also begins to allow herself to feel and express her long-repressed resentment of her husband's obsessive, demanding behavior. He faxes her to-do lists during the day, and presses her for intimacy at night. She is beginning to believe that this could be a contributing factor to her low libido. She begins to become more assertive with her husband.

Not coincidentally, she pays more attention to make-up and dress and feels more feminine, when she is dressed up and when she is intimate with her husband. In fact, she reports a tremendous orgasm while feeling very connected to him. He tells her she is passionate, and she likes this.

She speaks of her identification with her father, whom she views as kind but ineffectual (a dis-identification with mother, and identification with father). Repeated interpretation of her defenses of denial, avoidance, and repression begin to pay off. As she loosens her tight, unconscious grip on her painful emotions, Joanne is able to look at her impounded anger. I point out to her several times that it is this anger that drives her depression. She says she wishes the mother who never loved her were dead. Nevertheless, with a vote of confidence from me, she is able to have a civil conversation with her.

During the 16th month of therapy, Joanne begins to sleep excessively. She calls the psychiatrist, who ties this to her emotional issues. She is waiting for her mother to call to show

that her love for Joanne supersedes her own honor. She cannot believe she is doing this. As we discuss sleep as an escape from pain, she confesses that she is doing what her mother did; and she hates it. She is a coward. In the past, others came to her when they needed someone strong. I suggest to her that she feels sorry for others but not herself. Her mother was always weeping and feeling sorry for herself. She asks, "Would a *man* feel sorry for himself?" It becomes clear now that Joanne resolved her pain by assuming a masculine caricature of cold reason. She begins to contemplate the beginnings of her gender identity.

A week later, Joanne speaks of how she always likes to be the center of attention—except when it is *her* party, in which case, she would not feel she deserves it. In this, I say, she agrees with her mother. She seems stunned. She does not want to get into this. She will "fall apart" with self-pity. This would be like her mother. She startles herself with this revelation, even though the words are nothing new (timing is everything).

I ask about her father. He is the opposite. He smiles, is jovial, and engages in a great deal of denial. *I now posit to her that, upon distancing herself from her pitiable mother and adopting her father's style, she left her femininity behind*. She agrees and says she is leaving the session lighter than when she entered.

Eighteen months into the therapy, Joanne concludes that her depression (she did nothing but sleep for 3 days) is a result of anger at her mother turned inward. She is more terrified than ever of losing control. I offer that she has never been in control, and that is why she came to see me. She agrees completely. She says she avoids anger at all costs. Nevertheless, she is aware of growing anger against her husband for his neediness and control.

In between sessions before Passover, she leaves a voicemail thanking me for helping her and saying that she is looking forward to the holy day for the first time.

But she does not return for another seven months. She says she has run out of funds; and she declines an offer of a lower fee, saying she would not feel comfortable with such an arrangement.

When she does return, her libido has hit rock bottom. There is the beginning of a relationship with her mother now, but her husband makes her feel "worthless." She declares there is pain that she will not touch; sessions are exhausting. She acknowledges for the first time that her adolescence was not happy, building as it did upon an unhappy childhood of emotional neglect. She feels our sessions have become "important," helping her to see hidden parts of herself.

She describes herself as "tough" when sober, and tender and affectionate when she drinks. Thus, *her uninhibited self is feminine, while her false persona is masculine*. She has always isolated her true feelings. The only feeling she recognized as a child was anger.

Soon she reports that she is beginning to feel emotionally present with her family. Her own greater emotional accessibility has fostered burgeoning warmth among the children and between the children and the parents. When her son leaves for his first day of school, she experiences a new feeling—sadness—and she likes this.

Yet, she remains generally quite distant from her feelings. When she discovers that her cleaning lady has been stealing from her, she says she understands. She says she now feels "neutral" about her mother. When she describes how her own love does not lead to physical expression, I note that all her feelings have been submerged. *I tell her I believe her impounded anger is an indirect cause of her homosexual feelings.*

Nevertheless, her progress in reintegration of her frightening emotions continues. The marriage is better than ever, and Joanne feels greater affection for her children. There is more access to feelings, particularly caring and tenderness. The family is coming together.

Termination

Finally, after a little more than two years of therapy, Joanne declares herself "a different person." Her colitis is in remission, her libido is better than ever; she is quite active sexually with her husband. She is getting along (within limits) with her mother.

A month after we terminated, Joanne called to say she is enjoying life and has never had such mastery of it. Several months later, I happened to meet her at a resort and could not believe how attractive and feminine she looked.

Discussion

In this case, one sees the value of uncovering therapy in resolving issues underlying homosexuality. Impounded rage, fear of abandonment, ambivalent attachment set the stage for the dis-identification with the same-sex parent and identification with the opposite-sex parent. These and other undiscovered parts of the patient’s psychological experience are unearthed so that even associated features, such as her depression and colitis, remit.

Psychoanalytic interpretation of sexual fantasy and object choice as they relate to unrealized parts of the ideal self relieve the burden a patient feels, especially when no one else will hear it. Harrowing urges are accepted and discussed. Early origins of sexual identity are analyzed. In this way, even a woman who was a tomboy in childhood can allow her femininity to blossom. The careful loosening of repression leaves the patient freer to experience and express feelings of tenderness and desire.

References

Alexander, F. (1963). *Fundamentals of Psychoanalysis*. New York: Norton.

Greenson, R. (1967). *The Technique and Practice of Psychoanalysis*. New York: International Universities Press.

Horner, A. J. (2005). *Dealing with Resistance in Psychotherapy*. New York: Jason Aronson.

Wallin, D. J. (2007). *Attachment in Psychotherapy*. New York: Guilford Press.

Family Determinants of Homosexuality: A Case Study

Józef Szopiński

Humanitas University in Sosnowiec (Poland)

Abstract

Deficiencies in the parental relationship—emotional dismissal or actual disappearance of a parent—may cause a traumatic situation to arise within a family unit. Often such events will cause a child to make efforts to replace the missing parent by becoming a surrogate partner to the remaining parent. Three elements—the absence of a bond between parents, the undervaluation of the father, and erotic entanglement—appear to be constitutive to homosexuality. From their existence appears a wealth of varying symptoms which cannot be eliminated without rebuilding the constitutive elements. In an environment suffused with emotional and erotic entanglement, homosexuality may provide protection against incest.

Keywords: family relations, fusion, entanglement, homosexuality.

Introduction

The goal of this article is to present a typical case study of a young homosexual man in his natural family context, and the stages of the restoration of his original orientation and identity as a heterosexual. Howard Gruber, a famous American researcher of creativity issues, favored case study over other methods of research (1980). He simply avoided the laboratory, where things can be analyzed (i.e., n = 30, n = 60, etc.), and concentrated on case study where $n = 1$, because the individual case is worth knowing. Gruber's research concentrated on analyzing notes, diaries, and manuscripts of such great personalities as Vincent van Gogh, Sigmund Freud, and Albert Einstein.

In accordance with case study methodology, exhaustive efforts have been made to provide answers to the question regarding *how* the given environment and situation came to be (Yin, 2009). A further question can be investigated, namely, what is the probability of observing this same outcome for other men or *repeated occurrences* of homosexuality where similar family dynamics exist. This would give a basis for *generalization* (Lee, 1989; Darke, Broadbent & Shanks, 1998) as well as opposition to the opinion of Freud in terms of homosexuality. Freud regarded homosexuality as irreversible. Take, for example, a letter written to the mother of a homosexual (Freud, 1951): *"Question: can I presume that you are thinking that I can replace homosexuality with heterosexual behavior? The answer is that, taking things in general, we cannot promise that this is possible."* Knowing the conjectures of biographers suspicious of Freud being a homosexual (Gay, 1995), it is understandable that Freud's response appears to dismiss and trivialize the problem. Socarides (1995) endeavors to deter contemporary psychiatrists from taking such a stance. Freud's followers include the relationship with the object in their considerations. Modern scholars of homosexuality focus on the study subject's bad relationship with his father (Bieber & Bieber, 1979) or overprotective mother (Fitzgibbons, 1999).

Nicolosi and Nicolosi, a married couple, (2002) differ from most other authors with a more comprehensive look at the problem. They go the furthest with regards to the prevention of homosexuality, without losing sight of the whole family and by making the connection between homosexuality and a deficit in the parents' bond. My observation over forty years of family and marriage counseling is that an understanding of the family contributes to a richer and fuller process. The connection between the parent's bond and homosexuality is an important issue I write about comprehensively in my recently published book (Szopiński, 2016).

Case study allows for a straightforward construction of a model of homosexuality. The development of homosexuality stems from skepticism towards forming satisfying relationships between a man and a woman (Fitzgibbons, 1999). This may result from experiencing a lack of good relationships and bonds between parents, perhaps precipitated by an absent or unappreciated father, or an unsatisfying mother/father relationship which causes the mother to seek an emotional, erotic intimacy with her son. A woman who loves her husband is happy when her little boy runs to his father. It would never occur to her to tell (even non-verbally) the joyful child running to his father, "Stop, don't go to your father!"

Three important elements are generally present in homosexual men: the absence of a bond between parents, the undervaluation of the father, and erotic entanglement. Their existence nurtures a wealth of varying symptoms which cannot be eliminated without rebuilding these constitutive elements. While Freud brings much to psychology, the intra-psychological concept of the Oedipus complex constrained his thinking by disallowing him to take the next mental step to something worse, i.e., that homosexuality has the function of defending the son against incest. However, systematic observation of the family as a whole is capable of supplementing this theoretical limitation.

Deficiencies in a parental relationship, specifically emotional dismissal or the actual disappearance of a parent, may cause a traumatic situation to arise within a family unit. For example, when disturbed by some troubling interaction between parents, a child may attempt to

fill the emotional void in order to help them. In effect, the missing parent is replaced by the child who becomes de facto the surrogate partner of the remaining parent. Entering such an entangled emotional and erotic relationship with one of the parents leads to the development of defense mechanisms which facilitate the child's survival in this strange and unnatural framework.

Scars are inevitable and they persist. Sometimes the mechanism may present as an inability to grow and mature. At other times the more serious form (e.g., homosexuality) becomes apparent. This level of entanglement has been well known for centuries. The peculiar relation between mother and son was discussed long ago in ancient literature. Consider for example, Sophocles' *Oedipus Rex*. In recent times, it has not only been a subject of interest for psychiatrists and psychologists, but also in art (e.g., Rafal Olbiński, *Oedipus Rex*) and in film (*Savage Grace* from 2007[1]; *The Decalogue after the Decalogue* from 2008; and *I Killed My Mother* from 2009[2]).

The basic components of this kind of entanglement will be outlined in this article. The impact upon a child caught in this situation will also be considered. Both aspects will be illustrated by the case of a 28-year-old man who, during a two-year-long process of psychotherapy, identified an erotic entanglement with his mother and how, for him, homosexuality served as a defense against this entanglement. In this case, having the opportunity to establish clear boundaries in family relationships during therapy allowed him to return to his heterosexual identity.

---

[1]This film shows the psychological truth and faithfully reproduces details of the process of entangling the son by the mother, who provokes and seduces him sexually and has sexual relations with him. Afterwards the son kills his mother, stabbing her in the abdomen, and sits down on the floor next to her body while eating sandwiches. After psychological in-patient treatment, he comes back to his grandmother who takes care of him. In a short time, he also kills her with a knife. The film is based on a true story.

[2]The director does not try to conceal his homosexual orientation. What is most striking in the film is the excessive and realistic exposition of homosexual sex, with the concealing and masking of the erotic relation with his mother. The film may be a visual illustration of the homosexual theme for psychology students; only the possibility of therapy is missing.

Elements of the Mother/Son Entanglement

Insufficiency of the Parents' Bond

Aspects of the Oedipus complex may emerge when difficult situations erupt between a married couple. Mothers deprived of emotional support from their husbands are known to look for that support from their children, especially their sons (Szymczyk, 2013). At a very early age, even in the first or second year of life, a child will begin to identify the quality of the relationship between the mother and father (Mahler, Pine & Bergman, 1975). For example, a child will notice when parents, although living in a shared home, have separate lives and spend decreasing time together. They may argue or almost completely ignore one another and drift apart. A wife may be dominated by her husband or a husband may assume a childlike role rather than that of a true partner.

Less rancorous scenarios better accommodate a child's self-identification process (Urbaniak, 1996). The process will be more positive if a clear and accurate understanding of the dynamics within the family setting is established, namely, the assumption of parental roles appropriately referenced to each other and to the child.

The basic components of this kind of entanglement will be outlined in this article. At the beginning of therapy, the 28-year-old man noted:

> As I started to mature and become physically similar to my father, I began to shave. Then my mother began to reject me, so I started to want to more resemble a girl, so as to not lose her love but rather gain her acceptance. Thoughts came to me about how my father was bad, a drunk, violent, he didn't wash, he smelled, and I didn't want to be that kind of man. Today I know that those judgments were not my own, but my mother's, who pushed her husband away.

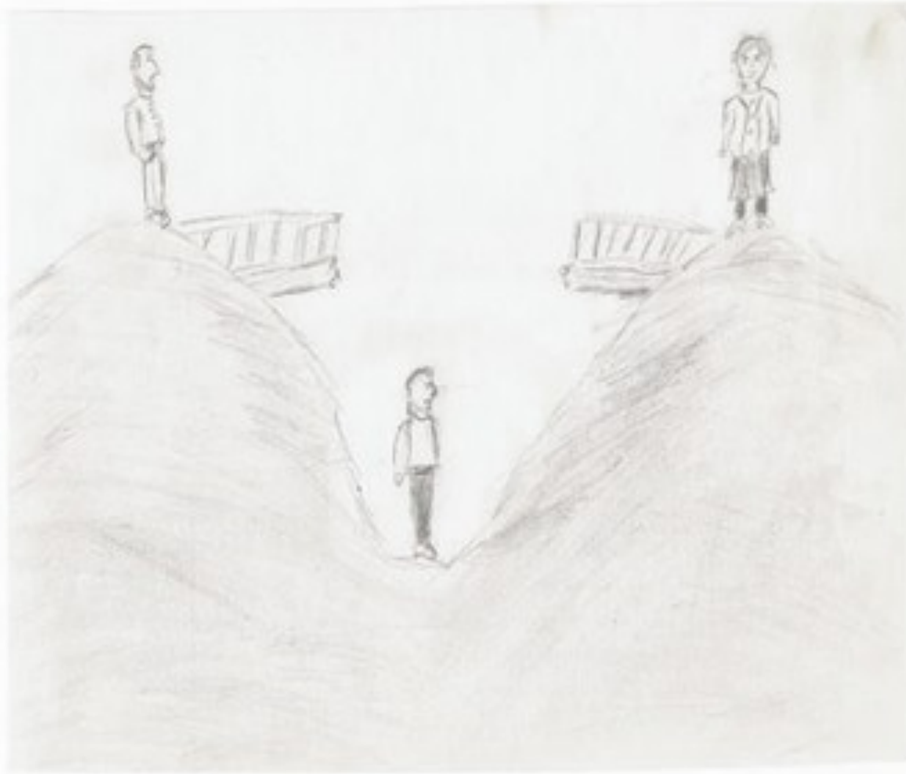
It is hard to decide if the mother, having lost the bond with her husband, always builds a bad image of the father, or if she only makes it sharper. However, being guided by her own interest, she by no means straightens it out. A dynamic develops here where an adolescent son may want to compensate for his mother's loss by replacing his impaired father, but this situation stirs up two opposite emotions in him. On the one hand, he wants to give his mother more than

his father can give, but on the other hand, guilt may arise for having mentally annihilated his father. Participation in shaping the involvement of both the mother and son should be emphasized. Indeed, the deficient bond with the spouse does not have to be an objective fact. The adolescent son can subjectively judge the father as too cold to show feelings for the mother, which is why he takes this role.

Bion (1959) introduced the concept of an attack on the bond. He described how a psychotic personality attacks the importance of thoughts and survives by destroying the connections between them. This process is described in metaphorical form as an attack on sex between the parents. Britton (1989) believes that the mental denial of sex between parents has serious consequences: the inability to form relationships and an explanation of the causes of sterile sex manifested (for example, in masturbation, pornography, and homosexuality). This mechanism is made graphically clear by a client's drawing (pictures 1 and 2) during therapy sessions entitled, "My parental relationships."[3]

---

[3]NOTE: The illustrations included in this article are not all associated with one individual. They are used to further explain aspects of the entanglement mechanism.



Picture 1

Picture 2

A Bad Image of One's Father

Socarides (1975) writes: *"The homosexual consistently describes his father as weak, passive and distant; or as angry, cold, and brutal" (p. 145).* With this premise in mind, it is argued that the father's absence or *emotional*—not necessarily *physical*—elimination from the parental relationship takes place. This contributes significantly to entanglement. His being simply cast aside beyond the borders of the relationship creates a 'vacant space' beside the mother, which the growing boy feels obliged to fill in order to compensate for her existing situation.

Compared with the intrinsic and extrinsic conflict generated by the serious boundary issues associated with an Oedipal complex (Kutter, 1998), the erotic-type bonding that may occur in any mother/son relationship results in something much less. A stronger feeling of dependence rooted in the early-childhood mother/child relationship appears to ameliorate the issue. By way of highlighting this dichotomy consider the following comment made by my client: "I felt in that moment a vague fear, and at the same time anger, that my mother was not allowing me to grow, that she was creating a conflict between my father and me."

He also noted:

> My mother did not respect my deep, real feelings. I remember as a 10-year-old in the bathroom taking a bath, in my father's presence my mother tried to check the mobility of my foreskin in order to rule out pseudo-phimosis. It was difficult to avoid having an erection.

This event from his childhood must have weighed upon the client since he revealed it early on during the first therapeutic session. Possibly the presence of both his mother and father at that moment could have been for him a form of showing his mother that, like the father, he could also have an erection and fulfill her.

In this situation, the boy is compromised by his mother's action. It makes it difficult for him to enjoy a less conflicted mother/child relationship, which may, in turn, have allowed more typical sexual development. In light of his experience, the following comment from him is

interesting: "I noticed that computer games protected me from entering into a sexual relationship with my mother, because thanks to them I could feel like a little boy."

Experience has shown that a person seeking therapy is, initially, more easily able to express unequivocal negative emotions with respect to the bad parent. Expressing perceptions regarding a toxic relationship with the good parent is more difficult and occurs at a later stage of the therapy. In any event, for the most part, the mechanism will be the same: regardless of the child's age or maturity, it is formulated by the hand of the other parent—an **idealized mother-woman**. In fact, a symmetric relationship develops in which the child is idealized by the mother. In this case the client admits: "I love my mother. . . . I fell in love with her, she is beautiful. She is my goddess. I want to always be there for her, I never want to leave her, I always want to be at her side."

The question arises here of whether the man in the street may be dreaming about sex with a goddess. Indeed, he could sully her. This subtle and delicate barrier on the one hand allows remedying the faulty relation of the mother and the father, and on the other, efficiently defends against completely assuming the role of the mother's sexual partner. This form of idealization prevents realization (Freud, 1912; Klein, 1989).

It has to be stressed that in European literature similar trends can be seen: those of idealizing the woman-wife, writing poems venerating her while having "dirty sex" in brothels. The mother on the other hand is saying, in front of others, *My little son. He is very clever.*

Successful therapy in such cases is not possible without healing both the child/father and child/mother relationships. The work must proceed collaterally as resolution is especially complicated in the case of an Oedipus complex, given the need to relinquish exclusive sole possession of the desired parent (Britton, 1989).

Erotic Entanglement by the Mother

The third element is a specific, hidden erotic entanglement by the mother. Intimate or private actions in the company of her son cause a certain type of situation. For example, disrobing

or bathing with the door open; sleeping in the same room while the father sleeps in another room; bringing breakfast in bed; and wearing new clothes bought with the son's approval, may promote patterns of behavior characterized by *pursuit* and *escape* (Miller, 1981). The 28-year-old male wrote:

> No! I didn't do that, even though I know that I loved her (mother)! Isn't it terrible? I feel as if I loved and love my mother with my whole male sexuality and for this reason chose homosexuality. This awareness led me to extreme arousal and orgasm. I know that thinking this way about one's mother I had to masturbate and look at pornography because there was no other choice . . . that is, incestuous sex with my mother! How is it possible to love such a woman, dream of her, of her breasts, hips, her soft, warm, sweet-smelling and rounded body, and not desire to be united with her, to be in her? This is indeed how I love my mother. It's true!

Picture 3

This *pursuit* and *escape* situation is not only restricted to the mother/son relationship (Picture 3.). It becomes an overarching pattern of behavior in the young person, appearing in many spheres or sometimes in all spheres of his life. It may even be observed in non-verbal body language. It is amazing that by blocking an erotic relationship between mother and son *all* relationships may also be blocked (Lowen,1990). Examples of this phenomena may include

studies at university may be dropped before graduation, or dreams of, and efforts towards starting, a business are squashed before any success is achieved. Sometimes psychological immobility (i.e., a weakness and inability to make decisions) is accompanied by significant agitation and great physical activity, perhaps manifested, for example, in aimless walks for hours around town.

> The first time I missed one of my university classes, because I had not prepared (I had been playing on the computer for a long time), I didn't know what was happening to me—instead of being better, it seemed to me to be worse!

Although this article is largely focused on the mother/son relationship, it is important to note a co-existing factor for daughters in an erotic entanglement with their fathers. There may be negation and contempt of their own physicality along with serious psycho-physiological concerns such as erratic menstruation, anorexia, and bulimia, as well as self-harming behaviors such as cutting. The form of young women's escape from their corporeality and sexuality that I have encountered as a counselor is their depicting of themselves in their relation with the father as an angel. Maybe also transsexualism is such a form of escape from their gender that is perceived as dangerous.

In entanglement situations where the father is rejected by the mother, in the child's world, the relationship with the mother is *the* preeminent relationship. It is experienced as the source of life. Consequently, when it becomes threatened, the child feels he may lose his life (Britton,1989). Erotic relationships do not develop in a vacuum. The impact of this intensely powerful single erotic relationship is particularly influential at the time of sexual maturation. In these situations, *woman* and *mother* fuse into one in the emotional life of the growing boy.

> In an earlier meeting when I was talking about my mother, I was talking about my mother, but in my feelings, there was only a little of my mother; it was 90% about a woman. I did not understand how to achieve a division in myself of woman-mother.

It is important to note in the narrative above that in the man's impressions, even in his wording, *woman* and *mother* are fused. It is also revealing of a certain opposition or bipolarity in

the psyche (i.e., an adult man mature enough for sexual relations, and a little boy who will not allow himself to grow up since growing up might end in catastrophe). Here the great price paid by the adolescent son attempting to remedy the mother/father relationship should be pointed out. By merging the relationships of the mother and the woman, a grown man must give up having sex with women. However, since the sex drive has not been wiped out, some other form of fulfillment needs to be found.

> When I was a little boy, I loved my mother as a mother, but after a certain experience I began to treat my mother as a woman, so that when I felt sexual desires, I directed them towards my mother as a woman, and since I could not allow this, this is where the homosexuality came in as a solution.

It should be said that not all men experience this entanglement in the same way. As they mature they may pursue and commit to marriage. However, problems of a sexual nature may arise, for example, an inability to consummate the marriage or maintain normal sexual relations (Malachowska, Jakima, 2007). Giving up erotic relationships links with the loss of his mother. The client wrote: *"I understood and experienced that there is a feeling of guilt in leaving the woman-mother."* In order to create a pure relationship with the mother and an openness to sexual relationships with other women, a conscious division of these two roles is intrinsic to psychotherapeutic interaction in such a case.

A situation of erotic entanglement can lead to the raising of numerous barriers which impede imagined sexual contact between mother and son. Although not exclusively so, homosexuality is one such barrier. The following statements from men trapped in this entanglement indicate other physical and/or psychological barricades:

- Physical abuse of small boys
- Fear of bad sex or of having no sex
- Creating their own virtual world via the internet and/or computer games
- Becoming introverted, solitary, withdrawn from other people.

Erotic entanglement does not preclude sexual relationships with other women. However, in the subconscious of the young man, to partake in a sexual relationship with a woman there exists a fear of a loving union with the woman-mother. It may prevent the fully satisfying co-mingling one with another, or promote undefined feelings of guilt.

> I feel strange, because even though I like women, I keep having feelings of guilt, not to betray my mother. I think that if I brought a girl home and introduced her to my mother she would be glad and would not criticize her—contrary to my father. However, I would have a strange feeling that I have another woman on the side.

Emotional and Physical Manifestations of Entanglement

The world of external manifestations and the world of the unconscious do not keep in contact. That which a client experiences and that which he does to veil his fear and frustration are two separate things. Alongside the absence of internal space, obsessive thoughts appear, which are meant to absorb the mind. They can take on the form of mental compulsions (e.g., continual repetition of some action, incessant deliberation or uncertainty and hesitation), which, in effect, leads to an impediment to thought and action (Nicolosi, 2009). Compulsive behavior shifts the emphasis to another pain, for example self-injury, phobias, masturbation (Coleman, 2009) perfectionism, continual house-cleaning or washing. Obsessive thinking allows the person to remain in a state of ignorance and protects him from experiencing an Oedipal situation (Kubiak, 2013).

> Guilt feelings continually accompany me like a nightmare. I think that I am escaping through the guilt feelings to masturbation. I feel that these two things are connected. That is to say, when my guilt feelings become unbearable, I cannot stop thinking about masturbation, because then it seems to be the only way to relieve the stress.

Obsessive certainty is characterized by rigidity, not admitting other points of view. Doubts are not allowed (Sodre, 1994). Obsessive defenses include a firm adherence to some idea together with a need for rituals meant to prevent any type of encroachment on the resolve, because every new idea, every other point of view, is felt as a *third wheel,* an intruder which must

be immediately eliminated for the preservation of the present exclusive relationship with the one parent. To go fluidly from one thought to another, from one opinion to another, permits the sustaining of a permanent triangular situation, in which no one side is excluded. It facilitates both evasion and an unpleasant feeling of being on the outside, and the feeling of guilt in excluding someone else (Kubiak, 2013). Making a decision and persevering with it, continuing uninterruptedly in one idea, is possible only when there is the acceptance of both parents remaining in an intimate relationship (Aronson, 2010). As this client expressed it: "Don't I want to be homosexual? Am I supposed to leave my parents' bed? Am I not supposed to feel guilty? I don't know; now I am all muddled about everything."

A person capable of perceiving that he both hates and loves one and the same person, feels the authenticity of human relationships. If, however, the **feeling of ambivalence** is removed in order to establish a division between relations with the completely good parent and with the completely bad parent, then the feeling for truth is distorted in the process. In the Oedipal relationship, it can happen that a clear separation between the good parent and the bad parent extends to the entire good and bad multi-generational family, as well as to all spheres of activity. Whilst this division is very clear to the external observer, the person endeavors, at all costs, to maintain only one dimension of these relationships. Freud called this the conflict between love and hate. Love does not extinguish hatred but only displaces it to the subconscious. On the other hand, hatred in the subconscious can not only survive, but also grow. For these varied feelings toward a parent to be an integration, they must be tolerated by the child. A mother who is seen as nurturing and loving must also be seen as a sexual mother, the sexual partner of the father and, in this role, unavailable and thus also frustrating (Klein, 1989). Combining these various truths about the mother is not easy, and consequently it is not uncommon to encounter a distorted image of woman. A subtle form of distorting her image may also be idealizing her as a woman. The developing child, who defends himself against the awareness of any kind of negative feeling towards his mother, is torn by an unsolvable quandary.

> Therapist: In your last email you wrote that you feel anger towards your mother.
> Client: Yes, because she permitted a situation which has broken me for life. I feel anger that she transferred her feelings about her husband onto me.
> T: Are you glad about this?
> K: [laughing] I am angry that in my presence she humiliated and offended my father, because I took it as if she were trying to turn me against my father and bind me even more strongly only to herself.
> T: You are talking about being angry with your mother, but at the same time you don't express it to her. And now, recounting it, you laugh. Could it be that you don't feel a difference between anger and love?

Irrespective of whether it is psychological or erotic entanglement, sexual abuse and, or molestation, all are associated with the manipulation of a more powerful, wiser, more mature parent who is looking for support and understanding from the weaker child (Garber, 2005).

> When I started to mature, my dad noticed that there was "something wrong" with me, that I was a little "womanly." He tried to take me to the gym—typical manly things like that. It didn't have any effect though, because I told my father that actually I had a hernia. I remember as if it were yesterday how he answered me more or less like this: "Oh, yes. I forgot. Too bad." But in his face I saw defeat, disappointment, and helplessness. When I write about it, I feel like crying because I see now how my father fought for me, for my masculinity, and I didn't see it. I remember too, that my mother defended me from my father—when he perceived that I was too "soft" and was strict, my mother would protect me. Why?! She wanted to have her little boy!!! And she rejected my father! How blind I was! How greatly I wounded my father. Unknowingly but I wounded him! And on top of that I was grateful to my mother for protecting me from my father!

In conclusion, Britton's (1989) words deserve to be repeated, that the Oedipus complex is concurrent with depression, and also that **resolving an Oedipus complex is not done once and for all, but rather sometimes certain life situations will activate vestigial aspects of it. It must be worked on throughout the whole of our life.** This thought may awaken internal resistance in us. My first publication treating this problem, *The Oedipus Complex and Professional Rivalry* (Szopinski, 1998, pp. 39–54), is connected to the conviction that there may be definitive closure after long-term therapy if the client has married, had children, functions in his profession. However, I presently observe that this particular client has been unemployed for a long time. After resuming contact in the context of therapy, at the first meeting dedicated to ways of looking for work, his erotic relationship with his mother was very clearly manifested. When I asked him if a picture represented his looking for a job, he answered, *"For me it reminds me of the breasts of*

an old woman." At the same time, I also noticed a kind of inability, an absolute stupor, in discussing the current relationship with his wife.

We understand now that unresolved Oedipal emotions of early childhood neither ebb away nor disappear, but remain, steadily becoming stronger as the youth matures and grows. A sort of reversal of the configuration then takes place. For the child, the parent couple is creative; for the elderly, they are the younger generation. One generation is replaced by the next, and in later life, a feeling of having lost position accompanies this. Identifying with the achievements of the younger generation, however, can ease the feeling of being left out. Identification with the happiness of his parents can help a child alleviate the painful Oedipal fears stirred up by his awakening to the realization of his parents' sexual relationship which excludes the child (Balfour, 2009).

Oedipal illusions are fantasy defenses meant to obscure psychological reality. In a situation where illusion reigns, curiosity leads to catastrophe. In the tragic situation existing in the Oedipus context, the uncovering of the Oedipal triangle is experienced as the death of the two parents. Britton (1989) expresses the conviction that we all sometimes believe in such notions. In feeling the sorrow of the loss of an exceptional relationship, we can understand how the Oedipal triangle doesn't kill the relationship itself, only the image of it. A characteristic of entanglement is, in the end, a rigidity in outlook on the topic of the existing relationship. Its elements include a conviction about the immobility of such a form of relationship and the impossibility of changing it. Each change in the relationship is considered destructive. The rigidity manifests itself not only with respect to the familial relationship but also by the way it influences thought processes in situations of confrontation with differing ideas on social and political issues. An unresolved Oedipal relationship is passed on to the next generation. This statement is not surprising when we look at the family as system.

> I saw that my father was also very strongly attached to his mother. He didn't know how to express either anger or opposition either to his mother or to his

> wife. I have had the experience that this is not only my own history playing out, but also my father's.

Work with this man lasted two years. We were working directly, through psychotherapy meetings and, because my client was living abroad making regular meetings impossible, virtually by Skype. His last letter expressed his happiness that now. After discovering the erotic entanglement with his mother and leaving it, he finally has the power to do what he really wants.

Conclusion

The emotional union with one's mother is an entanglement easy enough to diagnose as it has certain very distinctive characteristics. Most frequent and clear in the client's narratives is the division between good and bad parents. During the course of therapy, other hallmarks spring to the eye: indecisiveness, guilt feelings, ambivalence in activity characterized by simultaneous effort and avoidance, reluctance to grow up, inability in developing relationships with the opposite sex in addition to phobias or compulsive behavior. Compulsive behaviors assume a variety of forms. For example, religious people carry many devotional items, starting from a T-shirt with Michael the Archangel struggling with the devil, to crucifixes, rosaries, and other sacred images. When I counted ten of them, the client opened his wallet and showed me several other examples. The impression may be that the function of these items is not to protect him from compulsive masturbation, but rather expiation.

Coming out of entanglement can sometimes take several years. In retrospect, I have observed various degrees of entanglement which appear to dictate the length of the coming out process. Entanglement will range from a purely emotional dependence to a deeper and more erotic entanglement, about which, at a certain stage of therapy, a young man will loudly and unequivocally tell about his hitherto suppressed sexual desires regarding his mother. More often, for obvious reasons, men come to me for help. This does not mean it is a problem unknown between fathers and daughters.

Finally, the question arises as regards to why one child in one family pays a very high price for undertaking a "mission impossible" to repair the relations between his parents, while another child, perhaps in similar familial circumstances, grows up without any disturbances. It must be stressed that perceptions of the poor bond between parents triggering the child's compensative behavior is not always an objective fact. While parents may be functioning correctly and subjectively satisfied with their relationship, their child may interpret it differently (e.g., a son interprets his mother as a warm person and his father as exacting and tough). A child idealizes and takes more from the parent considered to be "better." The child may consider him or her "his own," and thus give more to that individual than the "worse" parent.

An accumulation of internal and external factors may be noticed in the creation of this peculiar situation. It may be said that all these behaviors are characterized by an underlying antagonism exacerbated by the son's anxiety about being close to his mother, his will to integrate the family, the will to give the mother more than the father gives her, while at the same time desiring more from the mother than from the father. This antagonism is destructive for the patient but is efficient in keeping the permanent balance of trying to be close to the mother while yet avoiding the closeness—it efficiently protects against incest.

Final Words

We owe a lot to Freud in psychology, but if we remained faithful to him today, we would have to experience helplessness against homosexuality. Infidelity to the father of psychoanalysis has turned out to be a blessing. Fortunately, we have gone further today. But Socarides (1995), the famous continuator of Freud, encouraged looking for the deepest causes of homosexuality in further research. I hope that this article is faithful to his ideal.

References

Aronson, E. (2010). *Not by chance alone: My life as a social psychologist.* New York, NY: Basic Books.

Balfour, A. (2009). Intimacy and sexuality in later life. In C. H. Clulow (Ed.), *Sex, Attachment and Couple Psychotherapy*, 217–236. London, UK: Karnac Books.

Bieber, J., & Bieber, T. (1979). Male homosexuality. *Canadian Journal of Psychiatry, 24*(5), 409–421.

Bion, W. R. (1959). Attacks on linking. *International Journal of Psycho-Analysis, 40,* 308–315.

Britton, R. (1989). The missing link: Parental sexuality in the Oedipus complex. In J. Steiner (Ed.), *The Oedipus Complex Today: Clinical Implications*, 77–93. London: Karnac Books.

Coleman, W. (2009). What do we mean by “sex”? In C. H. Clulow (Ed.), *Sex, Attachment, and Couple Psychotherapy,* 74–99. London, UK: Karnac Books.

Darke, P., Broadbent, M., & Shanks, G. (1998). Successfully completing case study research: Combining, rigour, relevance and pragmatism. *Information Systems Journal, 8*, 273–289.

Freud, S. (1912). On the universal tendency to debasement in the sphere of love (Contribution to the Psychology of Love II). *Freud’s Complete Works, 11*, 179–190.

Freud, Z. (1951, April). Historical notes: A letter from Freud in *The American Journal of Psychiatry, 107*(10), 786–787.

Fitzgibbons, R. (1999). The origins and therapy of same-sex attraction disorder. In C. Wolfe (Ed.), *Homosexuality and American Life*, 85–97. Dallas, TX: Spence Publishing Company.

Gay, P. (1995). *Freud: A Life for Our Time.* London: Papermac.

Garber, B. (2005). Parental alienation and the dynamics of enmeshed parent-child dyad: adultification, parentification and infantilization. *Family Court Review, 49*(2), 322–335.

Gruber, H. E. (1980). Cognitive psychology, scientific creativity, and the case study method. In M. D. Greek, R. S. Cohen, G. Cimino (Eds.), *On Scientific Creativity,* 295–322. Amsterdam: D. Reidel.

Klein, M. (1989). Oedipus complex in the light of early-childhood fears. In J. Steiner (Ed.), *The Oedipus Complex Today, Clinical Implications*. London, UK: Karnac Books.

Kubiak, A. (2013). *Zaburzenia obsesyjno-kompulsywne w świetle Kompleksu Edypa [Obsessive-compulsive disorders in light of the Oedipus complex].* Warszawa: Instytut Psychoanalizy i Psychoterapii.

Kutter, P. (1998). *Moderne Psychoanalyse: Eine Einführung in die Psychologie unbewusster Prozess*. Stuttgard: Klett-Cotta.

Lee, A. S. (1989). Case studies as natural experiments. *Human Relations, 42,* 117–137.

Lowen, A. (1990). *The Spirituality of the Body*: *Bioenergetics for Grace and Harmony.* Hinesburg, VT: The Alexander Lowen Foundation.

Mahler, M. S., Pine, F., & Bergman, A. (1975). *The Psychological Birth of Human Infant: Symbiosis and Individuation*. New York: Basic Books.

Małachowska, E., & Jakima, S. (2007). Cechy osobowościowe w związkach nieskonsumowanych [Personality traits in unconsumated marriages]. *Seksuologia Polska, 5*, 41–50.

Miller, A. (1981). *Du solls mich merken. Variationen uber das Paradis-Thema.* Frankfurt am Main: Suhrkamp Verlag.

Nicolosi, J., & Nicolosi, L. A. (2002). *A Parent's Guide to Preventing Homosexuality*. Downers Grove, IL: InterVarsity Press.

Nicolosi, J. (1997). *Reparative Therapy of Male Homosexuality. A New Clinical Approach* (2 Ed.). New York, NY: Jason Aronson, Inc.

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

Socarides, C. H. W. (1975). *Beyond Sexual Freedom.* New York: Quadrangle/New York Times Book Co.

Socarides, C. H. W. (1995). *Homosexuality: A Freedom Too Far*. Phoenix: Adam Margrave Books.

Sodre, I. (1994). Obsessional certainty versus obsessional doubt: From two to three. *Psychoanalytic Inquiry, 14*, 379–392.

Szopiński, J. (1998). Kompleks Edypa a rywalizacja zawodowa [The Oedipus complex and professional rivalry]. *Psychoterapia, 4*, 39–54.

Szopiński, J. (2016). *Więź rodziców a kreatywność dzieci [Parents Bond and Creativity of Children]*. Warszawa: CeDeWu.

Szymczyk, L. (2013). Relacje w rodzinie a rozwój tożsamości i identyfikacji płciowej dzieci w wieku przedszkolnym [Relationships in the family and the development of sexual identity and identification]. *Fides et Ratio. Kwartalnik Naukowy, 3*(15), 86–97.

Urbaniak, A. (2000). Ojcostwo: dar i zadanie [Fatherhood: A gift and a task]. In A. Garbarz (Ed.), *Horyzonty ojcostwa [Horizons of Fatherhood],* 11–17. Rzeszów: Wydawnictwo UR.

Yin, R. K. (2002). *Case Study Research, Design and Methods* (2nd Ed.). Newbury Park, Sage Publications.

Author's Note

Józef Szopiński has a doctorate in Social Psychology from the Catholic University of Lublin, Poland. He has also received training as group trainer at the Workshop Institute for Living-Learning International in Switzerland.

For many years he has been dealing with two spheres of activity: psychotherapy and adult education. He gives lectures and leads psychological workshops for various professional and other groups of people (for example, business owners and managers, clerks, tradesmen, clergymen and monks).

In addition to his group work, he also spends much of his time teaching at various universities within and outside the borders of his native Poland—specifically in Slovakia and Ukraine. In Poland he has given lectures at Marie Curie-Skłodowska University, the Catholic University of Lublin, the University of Warsaw and the University of Rzeszów, and WSB-National Louis University in Nowy Sącz. At present he is professor at Humanitas University in Sosnowiec and can be contacted at jszopinski@poczta.onet.pl.

In Their Own Words:
Therapists Who Support a Client's Right to Explore Sexual Attraction Fluidity Respond to Questions Posed by Lesbian, Gay, and Bisexual Therapists

Christopher H. Rosik, Ph.D.

Abstract

In the current politicized climate concerning professional therapies that allow sexual attraction fluidity exploration (SAFE-T), meaningful dialogue between psychotherapists who support and oppose change-oriented goals is quite rare. Recently, a group of lesbian, gay, and bisexual therapists proposed a list of six questions they wished therapists who engaged in SAFE-T would answer. In order to promote understanding and the exchange of ideas over this subject, I submitted these questions to several therapists who have extensive experience working with clients who report unwanted same-sex attractions (SSA) and may desire to pursue change. Questions addressed interventions and theory associated with SSA change, accounting for potential harms of SAFE-T, and the effects of minority stress. In a concluding section, some common themes among respondents were highlighted along with the significance of these themes for clarifying controversies that currently exist regarding SAFE-T.

Keywords: SAFE-T, sexual attraction change, therapy.

In the current professionally and politically volatile climate that surrounds the practice of sexual attraction fluidity exploration in therapy (SAFE-T)[1], there are few opportunities for clinicians who work in this area to respond in their own words to questions that reflect the concerns of lesbian, gay, and bisexual (LGB) mental health professionals. When such a group of LGB therapists[2] provided a short list of questions they wished to pose to clinicians who provide SAFE-T, I sensed this could be such an opportunity for needed professional exchange. I then set out to contact several therapists who are experienced clinicians in this area and invited them to briefly share their own beliefs and practices in response to the questions. A few of these clinicians declined to participate out of concern for their professional standing. All were offered the option of responding in an anonymous fashion to protect their identity, and some participated only on this basis. A total of nine therapists who utilize SAFE-T provided responses to the questions. Below is some general information about each of these invited respondents, who have a combined 160 years of clinical experience in this area of practice:

Joseph Nicolosi, Ph.D.; Psychologist and Director of the Thomas Aquinas Psychological Clinic in Encino, California. He is the founder of Reparative Therapy, a form of SAFE-T. For 30 years he has worked almost exclusively with men with unwanted homosexuality.

Paul Popper, Ph.D.; Psychologist in independent practice in San Francisco, California. He has provided SAFE-T to men for 24 years.

Jane Doe #1, Psy.D.; Psychologist residing in the USA who has served both men and women for 15 years.

John Doe #1, Ph.D.; An American-trained psychologist who has practiced SAFE-T with men for 9 years.

Michael Davidson, Ph.D.; Psychologist residing in the United Kingdom who has 7 years of SAFE-T experience working with men.

Janelle Hallman, Ph.D.; Counselor, Educator, and Assistant Professor at Denver Seminary who has 25 years of serving women in this area.

David Pickup, M.A.; Marriage & Family Therapist practicing in Dallas, Texas, and Los Angeles, California. He has provided SAFE-T in the form of reparative therapy to men for 8 years.

Carolyn Pela, Ph.D.; Marriage & Family Therapist in the Department of Behavioral and Social Sciences at Arizona Christian University in Phoenix, Arizona. She has provided SAFE-T to women for 25 years.

John Doe #2; Ph.D.; Psychologist, Marriage & Family Therapist, and Clinical Social Worker. He has worked primarily with men in the USA for 18 years providing SAFE-T.

Questions

1. **Which interventions do you use if a person wants to change and/or reduce her or his sexual attractions to the same sex? Would those same methods work on any same-sex attracted individual?**

Nicolosi: I use psychoanalytic, affect focus, object relations, EMDR, trauma theory, neuro-biology, and mindfulness meditation-based interventions. The exact selection of approaches would be dependent upon the person and where the person is in treatment.

Popper: I would explore their motivations for coming to therapy, for whom they are doing it and why. I clarify that doing it for others, even for God, does not lead to attraction change in my experience. This is often followed by several years of exploration of their dependent/compulsive/depressive/anxious personality traits, which in this clinician's experience most often correlate with SSA in clients who do not identify with their SSA and look for change towards a more complementary intimate partnership with a female. Initially therapy focuses on mirroring clients' pain connected to the formative experiences associated with their dependent, compulsive/anxious/depressive traits, often connected with their inability to connect with their father and other male peers. Later the focus will include pointing out to them the choices they make in the present, when they run away from that pain in their unique individual pattern,

often through compulsive sexual acting out. As they feel more autonomous and set more appropriate boundaries, their relationships with male peers become more balanced, more mutual and more fulfilling, and often simultaneously the same-sex strivings start to decrease in intensity and frequency.

Regarding the second question, I do not work with folks who choose to live out their same-sex attractions (SSA), so from my clinical experience, I do not know. I would guess that some folks living out their SSA, if engaged in therapy resolving similar personality issues of dependence, etc., would surprisingly find some opposite-sex attractions (OSA) appear in their experience that was not present before.

Jane Doe #1: To answer the second question first: As in all therapy, no one method/intervention works for all clients. The interventions I use depend on the client, their goals (which aren't always clearly to change or reduce sexual attractions), and concerns related to the same-sex attractions (SSA). For example, if the client believes childhood sexual abuse had a part to play in the development of their SSA, the interventions I recommend will be different than if the person has never experienced childhood sexual abuse, or if the person doesn't believe their past sexual abuse played a part in the development of their SSA.

Regarding the first question: It is rare that a client comes in *only* and *resolutely* to change or reduce sexual attractions to the same sex. More often, my clients say they are coming to therapy because of mental health difficulties or other difficulties in their lives. Their same-sex attractions might be related to their primary reasons for seeking treatment or they might be a focus later in therapy. As for interventions, these are common: (1) following my client's lead in what they want to talk about, when they want to talk about it, and how they want to talk about it; (2) allowing my client space to talk about their SSA (many of my clients haven't yet come out) without pressing them toward a particular direction/behavior/decision; (3) addressing complicating factors such as family of origin relationships, faith and values, sexual stigma, desire to have a spouse and family, etc. that impact the person's experience and decisions; (4) reducing shame interventions (identifying a shame cycle, developing skills to exit shame); (5) reducing risk interventions (if the client is involved in risky behavior); (6) teaching

emotional regulation skills, such as DBT skills; (7) teaching and practicing relationship skills and building a supportive community; (8) addressing ambivalence; and (9) Sexual Identity Therapy interventions.

John Doe #1: I look for the emotional meaning behind the attraction. Often times this is elicited by asking the patient what he thinks about himself in relationship to the person he feels an attraction towards. Once that thought is obtained (i.e., "I am inferior," "I am a weak man"), I use two interventions: body work (a form of affect-focused therapy), and EMDR. In both cases there is a focus on past experiences (i.e., traumas) that contributed to the formation of this thought. Usually before I do these interventions, I will introduce some cognitive behavioral techniques including the triple column technique so that a person can more quickly identify and name the cognitive distortions that he falls prey to. In this technique I have the client identify a negative automatic thought, and then by identifying the cognitive distortion behind it arrive at a rational self-assessment. These distortions may or may not directly relate to his same-sex attraction, but often contribute to his self-perception, and I believe that any work that helps the client improve his self-perception will also help the individual with his same-sex attraction.

Davidson: Talking therapies, and some action techniques. Usually this involves behaviour modification – reducing behaviours that appear to the client to be harmful: PMO (Pornography, masturbation, orgasm) link is explored and work is done to understand dopamine addiction. Action techniques revolve around role training—especially in relation to trauma work—in order to discover alternative responses. Our work is about enhancing client self-esteem and teaching assertiveness through assertiveness training. I try to get a feel for a client's "Social Atom." When there are high levels of internet pornography, we work on building real relationships and other socialization goals, such as increasing communication skills in terms of making friends. Work is usually done to de-erotise same-sex connections and demystify "sameness." We explore "difference" versus "sameness" models of romance. We also do work on labeling—deconstructing binary model concepts—notions such as "orientation" (versus "patterning").

Hallman: Most women who experience incongruence between their same-sex sexuality and faith convictions do not necessarily come to therapy to “change” their sexual attractions. They come to therapy because of the confusion, conflicting thoughts and emotions, and general stress that this existential reality presents. They seek to stabilize their internal world, understand their sexual attractions and same-sex relationships (meaning making), work on their lives in terms of broader issues or past trauma, establish a primary identity based on their belovedness and unique self versus their sexuality, understand themselves as a unique and special woman, challenge their religious beliefs, establish safe and healthy community, etc. I therefore offer standard psychotherapy following the theories and techniques that are evidence-based or widely accepted as effective for these types of issues. After engaging in this type of work, many clients experience shifts in their cognitions, emotionality, relationality, spirituality, and sexuality (such as a reduction in the intensity of their attraction to certain women).

For clients who initially come to therapy with the explicit request (or rather hope) to “change” their sexual orientation, I remain in a mode of assessment to determine the source of this request. Many times women feel pressure from their families or churches to “change,” fear the loss of these relationships should they act on their same-sex attractions, or experience deep shame over the belief they are flawed or an abomination to God. This request therefore often arises out of fear or shame. When this is the case, I direct therapy towards their very real and legitimate fears or probable internalized shame. It is often during this phase of therapy that a woman realizes there are broader issues to discuss. Her original goal of “changing” typically falls by the wayside.

There are no techniques that I use (or am even aware of) that can directly “change” a person’s sexual orientation. Sexual orientation (at least for women) is an integrated aspect of a person’s development and sense of self and therefore does not present as an isolated characteristic that can be simply “changed.” Nevertheless, not all people will necessarily formulate a primary or typological identity around their sexuality. This is true for many of my clients. While they continue to be primarily sexually attracted to women, they choose to identify as heterosexual based on their belief that this was God’s original purpose for their sexuality.

Pickup: I primarily use a psychodynamic approach, with added Cog-B methods. These methods, which are professionally accepted methods that have been used for decades, would benefit any same-sex attracted individual. However, depending on the client's personality traits and preferences, narrative, client-centered and holistic approaches can also be beneficial.

Pela: First, there are no special interventions—this is not a special type of therapy. I am a Narrative Therapist who happened to have the opportunity to collaborate with clients who present with goals related to their sexuality, including distress and discomfort with SSA experiences.

I'm guessing that the long answer—that is, a detailed explanation of Narrative Therapy interventions—is not appropriate for this investigation. But, to provide a clue—for this presenting concern (distress and discomfort related to SSA)—I would begin with a protocol of inquiry that helps me understand what it is about SSA that is concerning the client. Given the current cultural narrative, this concern might be that the client has introjected the current narrative that SSA is somehow intrinsic to her identity. This has been a common concern in my work with college-aged women who have become involved in a same-sex sexual relationship and have become convinced by the popular mantra that they are now a lesbian-for-life. They often present with depression and despondency, believing that they have no choices about their future relationships and sexuality. Most of the women who I have collaborated with have expressed a desire to be free from the boundaries and limitations of the narrative that sexual attraction is intrinsic to one's identity.

The client and I also need to uncover more information about the experiences, beliefs, and values that they associate with the label, SSA. I want to know what attributions they associate with SSA. This is a highly collaborative process and requires the client (not the therapist) to identify the meaning of the problem. The client's story about SSA is more important than mine, or Freud's for that matter (although it's okay for the therapist to have a metanarrative).

The question identifies the client's goal as desiring to "change and/or reduce" her SSA. This gives me an explicit label for the problem. Labeling the problem with a label salient to the client is essential. The client's goals are more important to me than my goals for her. Narrative therapy takes a

radical stand for the self-determination of the client. Narrative therapy proceeds from here by discovering the influence of the problem in her life. Since the question identifies SSA as the problem, I want both of us to explore how SSA has disrupted her life and caused her distress with the utmost detail. This is a clarifying process—it allows us to discover if SSA is actually the problem, or perhaps she will discover a different problem in the process.

Narrative therapy is best known for the externalization and the personification of the problem. This is accomplished through the use of language that extricates the problem from within the client. This begins with my first conversation with a client. In this case SSA is not who she is—nor would OSA be who she will become (again—the goal implied in the question). Rather, SSA is externalized through the use of personifying language so we can see the complexity of the relationship that she has with SSA.

Later, we identify exceptions to the problem, all the while externalizing the problem from the core identity of the client. By seeking the exceptions to the problem, we uncover an alternative story that is congruent with the client's chosen values-identity to the cultural narrative about SSA. Through this process the client's sexuality is restored as her own and no longer dictated by a culturally mandated narrative. This allows the client to explore relationships and romantic experiences that were previously off limits.

This is leaving us halfway through the process of therapy—this is not a comprehensive "treatment plan" but is meant to give the reader a sense of the interventions used by a Narrative therapist when working with someone with the identified presenting problem.

John Doe #2: My interventions include EMDR, CBT for Impulse Control Habits (e.g., Schwartz Four Step), assertiveness training, referral for Twelve-Step group support, meditative breathing, journaling, and help for co-occurring difficulties as appropriate. *No* method works for everyone who has the same presenting concern, whether unwanted SSA or any other issue. Sometimes, it is not so much the "attraction" itself but compulsive or otherwise habitual behaviors which clients want to change (e.g., same-sex pornography use).

2. Which interventions do you use if a person wants to be sexually attracted to the opposite sex when previously the person never felt any sexual attractions to the opposite sex? Which interventions do you use if the person experiences sexual disgust or aversion (not emotional aversion) toward having sex with the opposite sex?

Nicolosi: I would likely be working on past trauma in the form of psychological education, EMDR, body work, and mindfulness regarding the client's mother and other significant, dominant woman. Those same methods listed above to increase opposite-sex attractions.

Popper: Once clients are experiencing more autonomy, genuine mutuality, and satisfaction in their male relationships, it is time to explore if there is a part of them which resonates, however vaguely, with a potential partnership with a woman, whether in a sensual, affectional, or friendship context. As this area is explored, most often mother-related issues surface in all kinds of forms, along with other historical material related to relationships with females, along with sexual abuse history, etc. As the client risks experimenting with approaching females as a male looking for a complementary partner, the childhood pain related to formative relations with females begins to emerge, along with the survival narratives to avoid this pain. Here, the work is to learn to not identify with the childhood narratives connected to the pain, but choose to acknowledge other concurrent inner responses in the present as they are experienced with female companions, and allow their reality to sink in. These responses may, for example, be expressed as nurturing touch, fun playtime together, and sensual impulses.

Jane Doe #1: This specific example has not presented itself in my clients. The clients who have wanted to be more sexually attracted to the opposite sex typically have some element of attraction toward the opposite sex to begin with. In addition, the clients who feel disgust or aversion toward having sex with the opposite sex have not had a goal of increasing their opposite-sex attractions. Typically those clients' goals are related to their own self-development (e.g., feeling comfortable in their own body, identity development, reducing shame, managing anxiety, etc.). But to be clear, I have never used aversion therapy with any of my clients (same-sex attracted or otherwise).

John Doe #1: In these cases I will do EMDR around a woman the man would like to feel an attraction towards. The themes that usually emerge from these sessions revolve around feeling insufficient in the eyes of a woman. This sometimes leads to EMDR around past memories where these beliefs took root.

Davidson: I would work to understand the depth and nature of the aversion and understand the nature of the aversion and the extent to which it is emotional. I would be more comfortable in working with the emotional aversion. Regarding the physical aversion, I would check the age-appropriateness of any events that had contributed to or were associated with the aversion's beginning. Exposure of post-pubescent "sex education" materials to pre-pubescent children might be an issue. I would check the safety measures that might need to be in place to address this—is there a supportive opposite-sex partner who might work with this in terms of incremental exposure to areas that the client is averse to. Psychodrama is useful in symbolizing areas that are distasteful and can be instructive through the stepping in and out of any action to mark what the client brings out.

Hallman: I do not utilize interventions to "make a woman" feel attracted to men. Frankly, most women I work with have no interest in being with a man. They simply long to live a fulfilling life as a single, strong, and centered woman or to be in a healthy same-sex relationship that is not fraught with emotional dependency. Obviously for the latter group, some shift in their religious beliefs surrounding homosexuality has usually occurred.

Some of my clients, however, present as more bisexual. They have experienced attraction to men in the past or even currently. Yet many of these women have nevertheless been solely sexually active with women. They therefore lack the opportunities and experiences in relating to men romantically and sexually. These women often do request to work through the obstacles that might prevent the openness to and cultivation of long-term relationships with men. This might include (1) challenging negative core beliefs, such as "Men only want one thing," or "No man will ever want to be with me"; (2) challenging any fears associated with intimacy with men that may have been learned or formed out of past disappointments; (3) healing from past trauma that involved men; or (4) dealing with her sense of

immaturity in terms of relating with men romantically (such as recognizing social cues or knowing how to do the flirtation dance).

In summary, therapy is not so much directed towards attempting to instill something new into the client, but is directed towards resolving or reframing potential obstacles or restrictions that prevent the client from reaching her goals for personal growth, development, and expansion of her personhood, as well as the full expression and manifestation of all aspects of her true and unique self.

Pickup: I use the same interventions as I noted for the first question. To date, every client who wants this therapy has discovered that their non-attractions to the opposite sex are "hiding" earlier trauma to their gender identity. So, we work on the fulfillment or healing of their gender identity, which results in their reports of how good it feels to be authentic and whole in their own gender. When my clients feel their own wholeness, and when they feel complementarianism with the opposite sex, these clients report a development of sexual attractions to the opposite sex. This does not always happen. Some men are very happy living an authentic life without moving on to women. For those that feel disgust, I have always discovered an underlying, frequently unconscious, issue with the opposite sex from childhood. Psychodynamically, we work on resolving this issue so that the disgust can resolve itself automatically.

Pela: As to the first part of the question, I am very skeptical of this story—"I have never had sexual attraction to the opposite sex." In fact, I'm skeptical of any "never" or "always" narrative. Again, using a Narrative Therapy protocol, I look for unique outcomes (this would take place later in the therapy process). Generally, this process of looking for incidents of OSA is preceded by empowering the client over the limited introjected cultural narrative that they have come to therapy with—the story that SSA is who they are, etc., and by that time there is less of an investment in maintaining the "I have never. . ." story. They don't need it to maintain their core identity if SSA has been successfully externalized. As an aside, I have at times discovered that a Hollywood-style story of what attraction to the opposite sex looks like has limited their "seeing." If we look outside of that limiting, shallow paradigm, the story of attraction to the opposite sex will have room to emerge in their lives.

Regarding the second part of the question, this protocol assumes the client's desire to overcome the disgust and aversion. The client will first need to clarify the values/beliefs and desires at the heart of the choice to attempt to overcome these experiences. Congruent with Narrative Therapy, discovering the story around the disgust and aversion is an essential first step. A common theme that I have found for women who experience disgust and aversion related to opposite-sex sex is previous experiences of sexual abuse from a man, or witnessing their mothers' abuse. They have often witnessed or experienced suppression, degradation, and exploitation of women within opposite-sex sexual relationships. Further, parallel stories about women in healthy egalitarian-complementary sexual relationships have been occluded by this dominant oppressive story. In my experience of working with women, emotional and physical attraction are strongly synthesized; so, I believe helping them find exceptions to their stories about male-female emotional/romantic relationships is helpful in addressing the disgust/aversion. They may also be able to identify times when they were not disgusted by the thought of sex with a man. As mentioned earlier, the process of accepting these exceptions to their story usually comes later in therapy after their identity is no longer overwhelmed by the oppressive story that they are their erotic attractions.

John Doe #2: My answer is the same as the one I gave for the first question.

3. What are the theoretical assumptions underlying the above interventions?

Nicolosi: Homosexuality is a symptom of past shame trauma regarding one's gender. The result is a fear of actualizing the client's natural assertion that includes gender expression.

Popper: Accepting without shame that to a greater or lesser degree, we all carry residues of our childhood pain and the connected narratives inside of us. We often react to situations in the present identifying with those childhood narratives, which back then assured our survival, but in the present do not allow us to experience life as it is happening to us. And learning to not go along with the default identifications with the childhood survival narratives, but to identify with the adult experience and perspective, in which we exist as separate, autonomous human beings with our own thoughts, feelings,

and desires that need to be heard and respected too. As I stated above, folks who are ambivalent about their SSA and look for help towards reaching a capacity towards a more complementary relationship with a female, usually show the residues of childhood issues, which they coped with through developing dependent personality characteristics. I have not mentioned that many of these folks also exhibit an inborn temperamental baseline of great sensitivity, which reduces their chances of thriving in typical culturally defined maleness, which often is judged by their fathers and peers, contributing to their childhood issues.

Jane Doe #1: I'm guided by the ethical ideals of respecting my client's autonomy and avoiding imposing my values on them. I assume that I don't know what is best for the client, but that they have to figure that out for themselves. I also assume that my pressuring them in one direction or another (e.g., to reduce or affirm their same-sex sexuality) is not helpful. Some interventions are based on the research that's been done on sexual identity development and the various stages that sexual minorities commonly progress through, and how some individuals disidentify with a gay identity. I use a cognitive model of shame (though my interventions for shame address emotions, relationships, and behaviors as well). One assumption I have (that seems backed by research) is that shame is not only caused by sexual stigma, but may be present prior to experiencing sexual minority stress.

My theoretical assumptions include the understanding that humans are relational at their core and that in order to endure suffering, a network of support is necessary. I also understand the need for similar others, which can be difficult when the similarity is hidden. I also understand that my client's sexuality is housed within their relationality, and often addressing relational deficits (if present) can be helpful.

John Doe #1: Mainly, that homosexuality is a reaction to feeling disconnected from men. It is not a sexual problem but a developmental one. It represents the symptom of some other underlying condition. However, each story is a little bit different.

Davidson: My basis is psychodrama psychotherapy, by which I understand that the Director (therapist) plays a facilitative role to assist the client (in contract) to work on specific areas of concern. The action of working through alternative responses, reworking scenes (perhaps of traumatic experience where appropriate) making use of role play, role reversal, spiraling, mirroring (travelling backwards or

forwards in time) can be helpful in concretizing the work. Making use of the group strength where possible and identifying the "tele" (i.e., the rapport) operating between participants can be helpful.

Hallman: I operate from a psychodynamic approach attempting to honor all aspects of a client's personhood, experiences, and autonomy and self-determination. I am supremely client-centered. For clients who continue to remain in the tension of same-sex sexuality and conservative religious beliefs, this is not an easy task. Both the client's sexuality and religion must be honored and validated. I aim to reduce the shame and guilt that may be promulgated by either or both of these important aspects of a woman's life. There is no shame in having same-sex attraction, and there is no shame in holding to a conservative religious ethic. Shame tends to fragment a woman's sense of self. Most of my clients are looking for an integrated sense of self, even in light of the tension between their sexuality and religion. To honor my clients' goals in this regard, therapy, at its core, must be seeped in empathy. Empathy is what can shift a shame-based identity and provide the basis for an identity founded on worth and a sense of belonging. I therefore operate from a deeply attuned, empathic, and compassionate stance in an effort to provide a safe environment in which my clients can freely explore, question, challenge, grow, experiment, and apprehend the life that they can equally enjoy and celebrate before God.

Pickup: There are no a priori assumptions by my therapy. However, every client who wants change therapy reports two basic assumptions. First, they do not believe they were born gay. Second, they believe there were traumatic causes of their homosexual feelings originating in childhood that are centered on severe gender identity inferiority and severely unmet needs for love, affection, affirmation, and approval by major same-sex role models. With these assumptions, psychodynamic techniques reveal the truth of these wounds since they automatically come up as clients are relieved of their repression of trauma. Affect interventions, which can be a psychodynamic tool, give rise to the grief, anger, and inferiority that they discover are below their homoerotic attractions. These assumptions lead to one of the primary principles of Reparative Therapy, which is to resolve and get rid of any shame for having homosexual feelings.

Pela: I think I have articulated these assumptions throughout the questionnaire because I believe that good therapeutic interventions are inextricably connected to the theoretical assumptions of the originating theory, and these assumptions should be identifiable throughout the therapeutic process. However, a couple of additional points may be helpful to provide a broader foundation. Narrative Therapy holds to a collaborative approach where the clients determine their goals. The therapist's knowledge does not trump the client's—rather, they come together and share their views of the problem, checking out the saliency of their views for the other, each step of the way. In direct contrast to Narrative practice is the common formulaic response, as revealed in LGBT clinical literature, of assuming and subsequently projecting "internalized homophobia" onto the client as the probable explanation for her distress.

Another assumption is the belief that individuals often accept stories about themselves that others have told them along the way—stories are created in community—in relationship. Especially when individuals are hurt, vulnerable, or confused, they gravitate to cultural stories to find anchors—but these stories are sometimes limiting and are sometimes in conflict with the client's values and beliefs. Narrative Therapy seeks to help the client to become identity-congruent with their beliefs and values and allows them to question the often limiting assumptions posed by the stories that they have adopted.

Narrative Therapy is built on a social constructionist theory and fits well with Michel Foucault's understanding of the dangers of allowing our sexual experiences (attractions, desires, behaviors, thoughts) to become our identity. The reduction of our identity to support any cultural narrative limits the richness of the individual's narrative and limits their options to live a life according their preferred values.

John Doe #2: SSA, like OSA, are bio-psycho-social phenomena, which are learned. People choose whether, when, and how to gratify both same-sex and opposite-sex attractions. The gratification of such desires leads to their being strengthened and to their recurring more often. Abstinence, self-assertion, and working on "core issues" help a person manage or otherwise resolve unwanted SSA, as well as problematic OSA.

4. How do you account for the reports of specific harms found in the research literature, including reports of misrepresenting themselves, by some consumers who have attempted to change their sexual orientation?

Nicolosi: To date there has not been a systematic assessment of harm other than individual reports, which are mostly unsubstantiated.

Popper: There is subjective experience of harm in any form of therapy, especially when the hoped-for goals of the therapy are not accomplished to the client's expectations. That is why according to ethical practice, change is not promised to SSA clients who come to explore the possibility of change for themselves. Since some people do change after exploring childhood issues, like the ones mentioned above, my contract with the client is that as you, the beginning client, walk this journey out with me you will see for yourself how much change, if any, is possible for you.

Jane Doe #1: I am familiar with several studies regarding the specific harms found in scientific literature. Some articles have found evidence of possible harm, other articles concluded that there wasn't an inherent harm based on attempting sexual orientation change. I am also familiar with an article attempting to show harm that was done in this type of work, but the authors then had to change the intended title/focus of the article, because they did not find the harm they thought they would find, and in fact, some participants gained benefits from the therapy. Finally, I am familiar with the risks of psychotherapy as a general practice and from my understanding of the "specific harms" found in the research literature, I understand them to be not wholly different.

In order to minimize the risk of harm, I follow suggestions offered in research literature, such as advanced informed consent, addressing motivations for attempting to change one's experience of their sexual orientation (particularly shame-based motivations), and assisting clients in areas that are more amenable to change, such as sexual identity. I work hard on not imposing my own beliefs on my clients and stay attuned with his or her experience so I can be sensitive to what it is they desire.

As far as misrepresentation, I am sorry for the fact that people have felt pressure to present themselves in a way that is not authentic to their true experience. In general, authors frequently suggest that prevalence figures for all conditions are underestimated because people do not report their true experience. Misrepresentations are common phenomena for humans, and not limited to studies on sexual minorities. I also wonder if the questions posed by scientists have not been broad enough to encompass the full experience of a person's sexuality, which has been shown to be incredibly complex (e.g., not limited to physical attractions) and fluid over time for many individuals. This may account for some of what is termed here as "misrepresentations."

John Doe #1: There is an agenda in the psychological community to prove that this therapy is harmful. My experience has been that this therapy is not more harmful than any other sound psychological treatment. The psychological community has published numerous studies endorsing gay affirmative therapy with few participants, less than reliable sampling procedures, and data based on retrospective self-reports. However, those studying the possibility of change have to comply with the most rigorous standards, and even then, most likely face rejection of their submission in any event.

When someone comes to us in tremendous pain, as is the case with SSA, our natural inclination as well-intentioned therapists is to want to take that pain away. It is crucial that despite their urgency for help, we do not commit to things that we cannot reasonably give them. We cannot say we can definitely take it away. (I don't!) Also, many who are desperately seeking relief may only be willing to accept 100% total change and may want it so badly that they almost hear their therapist promise it. We must get the client's advanced informed consent to therapy where we tell them the potential risks and benefits involved as we should ethically do with any other therapy we perform.

Davidson: If this was raised in therapy, I would spend time looking at the research. So if it's the recurring Shidlo and Schroeder (2002) reference, I'd look at the internal stated limitations of the piece that are often ignored, and also the nature of the population group sampled—the way it was selected; I'd point out the statistical anomalies of the piece that indicate people were actually helped on average by the therapy that is in question in terms of a sense of connection and well-being.

Hallman: I have never ever supported the sensationalized claim that “Anyone can or should try to change their sexual orientation.” This indeed is false advertising. I have been aware of some misinformed therapists making this claim to unsuspecting and vulnerable clients. This clearly can be very damaging and, I would suspect, has done great harm to folks. I am very frank in communicating to clients who initially come to me to “change” their sexual orientation. I say very plainly that I do not know *how* to do such a thing but that I can offer a safe place in which they can explore *why* they want to change or engage in standard psychotherapy for the many factors that are present in their life that might be adding to the stress or felt urgency to “change” their sexual orientation.

Over the years, I am also aware that some clients maintained a secret hope that their sexual orientation would “change,” even after requesting and setting their goals to stabilize their internal world, understand their sexual attractions and same-sex relationships (meaning making), work on their lives in terms of broader issues or past trauma, establish a primary identity based on their belovedness and unique self versus their sexuality, understand themselves as a unique and special women, challenge their religious beliefs, or establish safe and healthy community, etc. Some have shared their disappointment with me, and while not claiming they were directly harmed by me, they nevertheless still experienced sentiments of harm due to their powerful disillusionment and questioning of the time and money spent in therapy. In other words, these clients were not necessarily harmed by false advertising or any direct therapeutic attempt to “change” their sexual orientation, but by an often held unconscious hope that “change” would happen. Nevertheless, this harm is still real and concerning.

Pickup: Who does this mean, “misrepresenting themselves”? Does this refer to the client or the therapist? In my experience, in reviewing the cases of harm put forth, whether in articles or in testifying before state legislatures, I’ve found almost all reports of harm come from unlicensed “therapists.” To date, all the reports of harm, or extreme harm, such as “labor camps,” or shaming episodes have no documentation to back them up. Licensed therapists do not force their views on clients. If the therapist is licensed and well trained, they show all clients unconditional positive regard. I am not aware of any research literature in which a valid study has shown harm. There were studies that obviously

demonstrated harm 35–50 years ago, such as electroshock or aversion therapies, but these are long gone. There has not been one ethical complaint to any licensed board concerning SOCE in any state for approximately the last 40 years. The American Psychological Association (2009) reported in their Task Force Report on SOCE that there is no proof of harm in the research literature (pp. 82–83). Also, many of these testimonials of harm are coming from religious "camps," but I have not found documentation of these as well. Other groups, such as men's experiential weekends, do not promise change. They emphasize security in one's own gender and meeting same-sex emotional needs. These men sign release forms as well. Also, if some men decide they are gay and want to pursue that, they are shown compassion and understanding.

Pela: Having reviewed the literature extensively as a background for conducting a quantitative, longitudinal, clinical, outcome study, and in agreement with APA (2009) task force report on the topic, I find little to no evidence supporting the contention that people seeking assistance to influence their sexual attractions are harmed by professional psychotherapy more than the general psychotherapy population. On the contrary, the research that I am conducting demonstrates that the reduction in suicidality, depression, and anxiety is statistically significant when men seek psychotherapeutic support for distress related to their SSA. Their relationships with close family and friends, and functioning in social situations are greatly enhanced while in therapy for their distress.

There is anecdotal evidence that people seeking help to change their SSA from non-professionals can experience deterioration. This is particularly evident when the claims for the possibility of change are exaggerated by the service provider.

John Doe #2: First, all approaches to "psychotherapy" for any presenting concerns have been shown to result in "deterioration" or unwanted and uncomfortable—sometimes explicitly "harmful"—consequences for *some* clients. Second, reports of harm in the literature typically do not differentiate between professional and non-professional caregivers attempting to help persons with unwanted SSA. I think it is likely that mental health professionals who give appropriate informed consent and use state-of-the-art psychotherapeutic interventions will not provide care that results in "reports of specific harms." As

with all psychotherapies, some clients may not manage or resolve their difficulties to the extent that they would like to, regardless of their own motivation to change and the skill and experience of their therapist. Also, if clients leave therapy before they reach a clear termination place, they may experience an unfortunate, perhaps avoidable, degree of discomfort as a result.

5. How do you assess and treat the effects of minority stress on your clients who are attracted to the same sex?

Nicolosi: Among the responsibilities of the therapist is to listen to symptoms of stress and assist the client in reducing those stresses. The process of reduction of stress is to determine if they are intrinsic to the condition or if they are an internalized self-criticism from a hostile environment.

Popper: I spend a lot of time exploring the motivation of the client for change and whether it is mostly motivated by minority stress or other outside pressure, because those motivational factors (i.e., wanting to move away from pain) do not lead to SSA change through the journey I guide my clients through, at least in my experience. As I stated, above, some part of the client has to resonate a bit with moving toward females for affection, nurturance, and eventually sensual touch. This resonance often appears only after the client has achieved some level of autonomy and the ability to set boundaries for himself.

Jane Doe #1: In my advanced informed consent form, I ask the client about their motivations for seeking therapy focused on same-sex sexuality. The responses include elements related to minority stress (such as “lack of social support as an LGBTQ person” and “discrimination”). As the client is willing, we address the nature of these motivations and work to identify what is sexual prejudice. In addition, as the client and I work together, I highlight when minority stress might be a factor in what they are facing.

In terms of treatment, we work to find a supportive community and use psychoeducation to talk about what constitutes safe community. We use cognitive therapy to address cognitive distortions and shame-based beliefs (which often relates to internalized homophobia). Since most of my clients identify

as spiritual, the client might wish to work on a nuanced spiritual understanding that is more accurate than perhaps he or she had learned earlier in his or her spiritual journey. Grief work and boundaries are common when important, on-going relationships contain elements of sexual prejudice.

Davidson: By "minority issues" I am assuming this revolves around prejudice and "homophobia," "xenophobia," or "islamophobia." I try to assist in the process of broadening connections, and encourage the development of skills that might enhance "cross- and inter-cultural competence" by encouraging the client to look at their achievements (in coming to the UK and entering an English language university, for example). I might share some of the findings of the Dutch international business machines (IBM; Hofstede, Pedersen, & Hofstede, 2002) research looking at such things like the differences between "paternal" and "matriarchal" societies, monochrons and polychrons; societies that value "text" and those that don't—how the interface between different hierarchies relate to different cultures coming into focus. Several short papers I wrote around this for university teachers are still helpful to me—on culture shock, etc. (http://www.nottingham.ac.uk/pesl/internationalisation/documents/).

Hallman: This is a significant focus of my therapy. However, many of my clients find it hard to face the difficult realities that are often presented within their Christian families, churches, communities, and sacred scriptures. It requires patience and acceptance to provide the time and space for a woman to admit to her disappointment and hurt surrounding experiences involving discrimination, moralizing, legalism, rejection, isolation, stigmatization, or victimization from the hands of Christians. Therefore, while I may intentionally direct a client into these discussions, I honor her ability to articulate, process, and integrate these difficult aspects of her world and experience. These experiences obviously trigger shame (and fear), so simultaneous shame-related work must be undertaken while these realities are discussed. Many of these disappointments and experiences must be processed before a woman is able to make a fully informed choice on how to move forward with the integration of her sexuality and religious identity. (NOTE: Sadly, it is this type of work that is now carelessly referred to as "reparative or conversion therapy." Just because a client is engaged in long-term therapy and remains in tension between

her sexuality and religious convictions, they are not necessarily seeking or receiving “reparative therapy.”) The specific terms, such as heterosexism, internalized homophobia, sexual stigma, and minority status, are typically too clinical or political for my clients to benefit from; nevertheless, we unpack their meaning and their appearance within their lives.

Pickup: If this question means the stress of being treated as a minority, I discover this in the first session when the client has filled out a client history form. I work with these clients to get rid of any feelings or cognition of shame-based messages that have been put onto them by others. I also work with them to build up their self-esteem regardless of what others think about them. I help them to accept themselves for who they truly are (which they define) or for whatever they are feeling.

Pela: From my perspective, minority stress is a result of a group of cultural narratives that limit, oppress, and at times promote discrimination and abuse of cultural groups identified as minorities. Cultural narratives of oppression are routinely investigated in Narrative Therapy since these stories are often influential in the development of the clients’ personal unhelpful story. Of particular concern regarding the clients that I have collaborated with is the story about “ex-gays.” (I do not encourage my clients to identify according to their former or current erotic attractions, but this is an identity that some present with.) This minority group is maligned by everyone from the groups identifying as LGBT activists to Evangelical Christian groups promoting the current narrative that our erotic attractions are a core of our identity and that at best we should seek a celibate lifestyle if we experience SSA. This narrative often goes so far as implying that LGBT-identified people require a different theological system (Gay Theology) to be reached by the Gospel. As far as I am aware, this is the first time a special system of theology has been written for a minority group. The fact that LGBT-identified religious leaders are contributors to the development of the perspective that LGBT-identified people are so different that they need a special theology just for them is astounding.

John Doe #2: I ask clients about their presenting concerns. This includes both the internal and external sources, and effects of “minority stress.” Sometimes, such incidences prove to be occasions of

traumatic familial and/or peer experiences which are treated as described in my answers to questions 1 and 2 above.

6. How do you help someone who wants to be celibate and/or married to someone of the opposite sex, who has a moderate to high sex drive, but who cannot act on her or his sexual/romantic feelings for the same sex?

Jane Doe #1: If the person's therapeutic goal is to remain celibate or married to someone of the opposite sex, but they continue to have a moderate to high sex drive towards the same sex, we would follow the interventions recommended in Sexual Identity Therapy. These help a person manage their sexual/romantic feelings in a way that is congruent with their values/goals. As an example, the person would chart the course of their same-sex sexual/romantic feelings in order to understand what influences them (e.g., loneliness, hormonal cycles, physical closeness). Learning what influenced the sexual/romantic feelings can lead the client to ideas of how to address what is going on (if possible). Another angle is to help the client normalize this experience, and help them find others who experience similar struggles (gay or straight).

Of note, one of my clients that fits this description found that being on a particular birth control pill tempered her moderate to high sex drive (she believed it was due to the shift in hormones). This is not something I recommend to other clients, but it caught my attention.

John Doe #1: Living with competing feelings is actually a good thing. It's called life. Diabetics have to make difficult choices when they look at a nice sugary danish. They have competing conflicting feelings, and they need to make a hard choice. It tastes good, but it's not good for them. And they have to choose whether they will make a decision from a place of strength or weakness. And life is full of these moment-to-moment decisions. I have a couple of hours: Do I spend time at work or with my kids? Should I choose the more fulfilling job with less money or go for the better paying but less meaningful position? As psychologists, sure, we try to minimize the intensity of these conflicts, but not to eradicate them. This

is because we realize that conflicts can't always be eradicated. We recognize that conflicts are a healthy—albeit painful—part of life, essential for personal growth. What does any therapy purport to do anyway? In this therapy, we help men who have chosen to work on their SSA, reduce it when they can, and live happily—happily and in integrity with their values, and yes, even if that means navigating competing—at times powerful—feelings in their life. After all, that would mean we help people deal with conflicts. We help people deal with life.

I will encourage people to meet their needs for same-sex connection in healthy ways, such as non-sexual intimacy with other men. This looks different to different men but often team sports can be beneficial, or taking the risk of disclosing something personal to a male friend. It is also important to get the client to become more like his projection, and develop traits that he is attracted to. In other words, become the kind of man he is attracted to. When lust plays a big role, I will also refer to SA programs. SA programs reinforce that sex, unlike food and water, is not a necessity for survival, and that acting out on one's sexual fantasies in the pleasure-saturated world we find ourselves in, is not the recipe for a happy life.

Davidson: I would focus on the issue of performance anxiety and look at the cultural shifts that have taken place over the years enhancing the hyper-sexuality of particularly western culture. If the client is an "international" client, we spend time comparing and contrasting "traditional" values with the philosophical position of the current climate in Western Europe. I would make sure that the values towards celibacy or marriage are properly owned by the client and not those of other significant others (siblings, a church, etc.). I would also challenge any spiritual misconceptions of celibacy and distinguish between "chastity" and "celibacy," the latter of which I take in Christian thinking to be an exclusive term relating abstaining (by special giftedness) from complementary opposite-sex monogamous relationships. If the client was not from a faith background, I would work from whatever values framework they presented and look at the design/evolution of male and female. I would also explore the symbolism of erotic love in the spiritual or symbolic world view of the client in front of me.

Hallman: This is the thousand-dollar question and possibly presupposes that chastity or fidelity is a ridiculous or less than beneficial lifestyle. Outside of religious settings, I can see why chastity makes little sense. The sex act is beautiful, powerful, fun, and pleasurable. It brings a sense of oneness and belonging, especially when there is an emotional connection between the two lovers. Sex is part of God's design, and it makes sense that we would want it. Within religious settings, sexuality is understood as a sacrament. Sexual union is meant to reflect the intimate and pleasurable union between God and us, and therefore serves a transcendent purpose. It is not *all* about our pleasure. Chastity then, within Christian settings, is indeed seen as an act of sacrifice to be taken by singles *and* marrieds who are within sexless or loveless marriages (which, I might add, is far more common than most people realize), for the purpose of honoring God's transcendent purpose for sex. But it is also seen as an act of service and dedication to God and others. For people who are committed to chastity (again whether married or single, gay or straight), it is within their service and abandonment to God that beauty, fun, pleasure, oneness with God, others and self, and belonging are cultivated and hopefully enjoyed.

For women, having sex is not the drive behind longing to be in a same-sex relationship; it is the desire and longing for companionship. Very few women "act out" on their same-sex attraction to merely satisfy their sex drive. They reach out for the sake of being in a relationship. This is why I do not impose an agenda on my Christian clients with respect to how they live and identify or disidentify with their sexuality. It is up to them to make decisions for their life and well-being. Many of my clients have come to peace with their Christian beliefs and sexuality by understanding the scriptures differently than they did when they started working with me. They believe that God knows about and is even sovereign over their sexual orientation and thereby makes provision for a full and healthy life by blessing a monogamous, committed gay relationship. Some come to this conclusion after they have entered a loving gay relationship. By remaining open to my clients' choices and decisions, my clients can avoid the polarization that is often created when individuals are explicitly told (or ordered) what they can or can't do. An individual cannot fully own their decision (which I believe is a healthy thing to do) if they are not allowed the full and frightening freedom to choose from all possible options, good or bad, right or wrong.

God gives each of us this type of freedom. Life is difficult. God was wise in giving us not only freedom, but also grace.

Pickup: In the case of celibacy, I work on their self-esteem and fulfilling their potential in the most important areas of their lives in which their energies can be spent. I also look for reasons why they are celibate and whether those reasons demonstrate consistency with their belief systems, and if not, to help them see their irrational cognitions in order to grow more authentically that fits their belief system.

For those married to the opposite sex, I explore their belief system to help them discover whether they believe they are genetically gay, or whether they believe there were emotional or abuse issues that caused their homosexual feelings. In my experience, almost everyone discovers they were not born gay, so we look for emotional and cognitive issues that created these feelings. This can sometimes include sexual abuse. For men in this situation, they have found that unresolved gender and/or mother wounds from their upbringing have negatively affected their feelings toward their wives. In effect, they unconsciously repeat their mother issues with their wives, so we work on resolving these deeply affective issues to help the client feel self-confident and less trapped by these issues with female role models, which can lead to greater feelings and actions of intimacy with their wives.

Pela: I'm not sure what the client's goal would be in this case. The question implies that the goals of these clients are self-evident. Never assume the client's goals for them. Also problematic: the question assumes that I would approach helping an OS married client in a similar way to helping a celibate client. That is possible, but hard to imagine.

John Doe #2: Along with the answers to Questions 1 and 2, appropriate referrals for peer group support and, if a religious or spiritual person, to persons and groups who can provide religious or spiritual resources which may help them honor their personally chosen celibate or marital state.

Concluding Observations on Participants' Responses

In reviewing these responses, a few concluding observations seem justified. I note them here in no particular order of importance.

1. **SAFE-T takes no singular theoretical or practical manifestation.** This sample of experienced therapists report a wide variety of approaches to assisting clients who may pursue change in their SSA. Psychodynamic perspectives are common, but these may be augmented by insights from such modalities as information processing (EMDR), experiential (psychodrama), and cognitive modalities. Other approaches take a mostly different direction, such as narrative therapy or sexual identity therapy. Of interest is that these latter approaches were found more among therapists who work with women, suggesting that somewhat divergent clinical models have emerged out of the clinical experiences of therapists assisting different genders. This significant diversity of standard therapeutic modalities practiced by these therapists make it difficult to understand how legal bans on SAFE-T can be enforced as a prohibition of therapy per se. In practice, such bans are more likely to function simply as legal intimidation for therapists of clients who might wish to pursue the goal of SSA change.
2. **Emphasis on understanding client motivations.** Nearly all of these clinicians indicated the importance for ethical practice of carefully evaluating client motivations for SAFE-T. These professionals expressed awareness and concern that a client's goal of SSA change could be the result of coercive pressure from family or religious communities rather than the product of an autonomous and self-determined choice. Establishing a client-centered and self-determined goal of SSA change appears to be foundational for any subsequent therapeutic process involving SAFE-T. Such a practice orientation does not seem to comport well with portrayals of SAFE-T as an inherently coercive and therapist- determined process.
3. **Same-sex attractions are usually not the focus.** Often these therapists would note that they did not primarily focus on the client's SSA, but rather on other aspects of the client's experience that are presumed to influence the development and fluidity of SSA. Rather than change being something the therapist does to the client, change appears to be conceptualized as occurring naturally for some (but not all) clients, accompanying their own personal growth in general

identity (i.e., sense of a cohesive and relationally capable self) and sex-consistent gender identity along with the resolution of relevant traumatic experience.

4. **The centrality of shame**. The client experience of shame appears to be a core component for therapeutic intervention within a SAFE-T paradigm. To an extent SAFE-T and gay affirmative therapists share the belief that a clients' shame regarding their SSA must be diminished therapeutically to promote mental health. There is evidence from participants' responses that clinicians who engage in SAFE-T acknowledge that shame can derive from social stigma related specifically to SSA. However, unlike some gay affirmative therapists, many SAFE-T clinicians also appear to allow for the possibility that experiences not specific to client SSA or gender identity (such as attachment trauma) can create shame, which they believe may be the most clinically compelling source of shame for understanding the SSA client's psychological experience. This difference may also influence divergent conceptions of client acceptance of their SSA. SAFE-T approaches appear to encourage clients' acceptance of the reality of their SSA in a self-compassionate rather than punitively judgmental way. Such a shift away from shame appears to be viewed as a step toward opening possibilities for SSA change associated with identity development or at least for the adoption of identities not based primarily on experiences of SSA. This is in contrast to the general gay affirmative perspective where clients' shame is conceived as primarily SSA related and therefore shame reduction is predicated not only on eliminating punitive self-judgment but also on clients' acceptance and enactment of their identity as gay.

Constructive professional exchange among mental health practitioners with opposing viewpoints concerning therapy assisted-change in SSA is almost non-existent in contemporary professional circles. I sincerely hope that the present compilation of responses from therapists who are sympathetic to SAFE-T to questions posited by GLB therapists constitutes a small but significant departure from this norm. When SAFE-T therapists are given the opportunity to speak for themselves rather than be caricaturized by others, these therapists appear to share with all professional clinicians a desire to assist clients toward their self-determined goals in an ethically sound manner utilizing established methodologies that

minimize the potential for harm. There are clearly some significant differences in understanding the effects on SSA of factors such as identity development, trauma resolution and shame reduction between SAFE-T and gay affirmative approaches. These are issues which certainly beg for the production of bipartisan, collaborative research specific to the population of clients who report unwanted SSA. Unfortunately, the current professional and political climate strongly precludes such research. Until this changes, the best we may be able to do is create space for alternate voices to be aired. As participant responses made evident, such space should include the voices of therapists who practice SAFE-T.

Notes

[1]SAFE-T can be defined as the client-centered exploration of sexual attraction fluidity among clients reporting unwanted same-sex attractions utilizing established psychotherapeutic modalities.

[2]The questions were posed by Lee Beckstead, PhD.; Jerry Buie, LCSW; and Jim Struve, LCSW, GLBT members of the Reconciliation and Growth Project, a group of eight mental-health practitioners from across the sociopolitical spectrum who since March of 2013 have met for ongoing dialogue to increase understand of their different viewpoints and establish an inclusive and comprehensive therapeutic approach.

References

American Psychological Association. (2009). *Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation*. Retrieved from http://www.apa.org/pi/lgbt/resources/therapeuticresponse.pdf

Hofstede, G. J., Pedersen, P. B., & Hofstede, G. (2002). *Exploring Cultures*. London, UK: Nicholas Brealey Publishing.

Shildo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumer's report. *Professional Psychology: Research and Practice, 33,* 249–259. doi: 10.1037//0735-7028.33.3.249

Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior, 32*(5), 403–417.

How Did He Do It? A Review of *Overcoming Homosexuality* by Dr. Robert Kronemeyer

Keith Vennum, MD, LMHC

Keith Vennum, MD, LMHC, is President-Elect of the Alliance for Therapeutic Choice and practices Psychiatry and Mental Health Counseling on a part-time basis in Orlando, FL, where he is licensed as a physician and a mental health counselor.

How Did He Do It? A Review of Overcoming Homosexuality

Overcoming Homosexuality by Dr. Robert Kronemeyer (1920–1995) was published in 1980, well after the 1973 decision by the American Psychiatric Association (APA) that removed homosexuality as a mental disorder from the APA Diagnostic and Statistical Manual (DSM). This book indicates that not every psychologist practicing at the time agreed that homosexuality was not worthy of treatment. While no longer in publication, a review of this book (220 pages) is worthwhile because it highlights the historical development of therapy for homosexuality. Some of the approaches used by Kronemeyer were incorporated into therapy advocated by subsequent practitioners. He was licensed as a psychologist in 1958 in New York and practiced at the New Horizon Revitalization Center in Southampton, NY. He tried to popularize his overall approach to psychotherapy, calling it Syntonic Therapy, and elucidated this better in his 1994 book, *Syntonics: A Dynamic New Program for Total Health & Happiness*, but failed to draw a significant following. In this book, he claims an 80% success rate for helping homosexual clients achieve their goals in therapy, loosely defined as normal heterosexual functioning. A number of factors likely bias his findings, as is common with most practitioners treating homosexual populations. His clients were not mostly white Catholics males, as in the case of Nicolosi, or a prison population, as in the case of Van DenAardweg. His homosexual population was largely white New Yorker males and females who had serious enough mental problems to see him as a psychotherapist. Kronemeyer characterized his clients' motivation as usually due to the breakup of a romantic relationship (p. 131). His success figures were further inflated by the fact that he excluded psychotics, psychopaths, and those forced into therapy; but included those able to direct their aggression therapeutically, and those who were strongly motivated. With such a biased sample, the 80% figure sounds more likely. He was ahead of his time in that he viewed homosexuality as a symptom of a deeper psychological problem which interfered with normal psychosexual development and not an entity to be treated per se (Chapter 9). This is the mistake that current "conversion" therapy bans make regarding homosexuality, i.e., assuming practitioners are treating the entity of a same-sex attraction and attempting to change it to an entity of opposite sex attraction.

His contribution to psychotherapy, which he called Syntonic Therapy, is not to be confused with Syntonic Light Therapy, which is also used for emotional disorders. He was of the opinion that "man is born with the self intact. He is alive and his energy is flowing" (Chapter 8). Basically, he is saying that we are born perfect with a clean slate and through contact with our poor environment we develop pathologies. From this perspective, homosexuality could never be innate, inborn, or genetic, but would be the result of environmental influences starting possibly as early as the womb. For this reason, this is not a book for parents of a gay child. He lays the majority of the blame on the mother (e.g., "when the wicked witch of the nursery is exposed and exorcised") (p. 117). Yes, it gets that bad. He does offer Chapter 13 for parents, but I would not recommend it. He is good when he recommends parents not overreact with hysterics when a son or daughter comes out (p. 202). He feels prayers are useless, thus agreeing that the "pray the gay away" approach does not work. He does give several developmental markers for identifying the pre-homosexual child (p. 198). He recommends parents take a long hard look at themselves and "get themselves straightened out to some degree" (p. 200) before attempting to help their children. Then he turns around and states, "A large spirited parent might even say—and he would only be telling the truth—'if it weren't for your parents, you wouldn't need to be seeing a therapist'" (p. 203), which is clearly not the view of most therapists engaged in this type of work today. He posits most of the damage in the first two years of life in line with others who view homosexual feelings as primarily a problem of identity which failed to develop during the first two years of individuation. Later practitioners recognize this as one type of individual who ends up gay but acknowledges other pathways into homosexuality that develop later in life. In his view, "the chief block to therapy is the *'incapacity of patients to feel'*" (p. 113; emphasis added). He adopts features of Janov's Primal Scream Therapy in attempting to get patients in touch with their bodies and feelings. A feature of this practice is carried over into Nicolosi's therapy in "body work" as described in *Shame and Attachment Loss: The Practical Work of Reparative Therapy* and in that of experiential therapy weekends offered by others. He says, "to bring about deep personality change it is necessary to have intense emotional experiences" (p. 114). "In Syntonic Therapy, rage is brought to the surface and allowed full expression so that it can thaw out and transform tension and terror.

. . . Once inner hidden enemies are challenged and overcome, strength, self-esteem, and well-being bloom. . . . The person who has reunited mind and body in a harmonious synthesis will have the natural balance and syntony to meet the vicissitudes of life . . ." (p. 119). This sounds a lot like emotive therapy elucidated in Fosha's book, *The Transforming Power of Affect: A Model for Accelerated Change* (2000), which Kronemeyer predates by about twenty years.

The author also states, "I believe in touching my patients" (p. 125). Having himself undergone psychoanalysis by Wilhelm Reich (pp. 107–109—a fascinating read), it is little wonder that he was open to touching his clients. "Reichians conducted treatment with the patient more or less naked, so that the therapist could literally observe the constricting muscular armor. . . .To the best of my knowledge, no homosexual ever found a 'cure' through orgone therapy" (p. 93). Nothing in the book suggests his touching clients went beyond what most would consider appropriate. There is no advocacy for holding therapy as has been done by some in an attempt to treat "touch deprivation." Holding therapy and inappropriate touch violate item 6 of the Alliance Guidelines for Therapy, which says, "Clinicians are encouraged to utilize accepted psychological approaches to psychotherapeutic interventions that minimize the risk of harm when applied to clients with unwanted same-sex attraction."

Kronemeyer calls circumcision "the rape of the phallus" (p. 211), another trauma of early childhood. Interestingly, this is a physical characteristic that can be relatively easily reversed without surgery. A key part of his therapy involved vocalization in varied form, borrowing heavily from Janov's Primal Scream Therapy introduced in the 1970s. "Sounds trigger emotions because—the language of infancy—they are able to kindle buried memories and experiences" (p. 124). Another technique employed by him was to have clients draw pictures of themselves at various stages of therapy. This indicated in his view progress in therapy as the pictures became fuller, more detailed "with no parts missing" (p. 129).

In Chapter 11 he gives several success stories. Eight vignettes are discussed: five male and three female cases. All achieved goals which included heterosexual expression, but only one male specifically mentioned a new sexual attraction to women. Two went on to heterosexual marriage, four to heterosexual

relationships, and two males who were already married at the start of therapy reported an improvement in their marriage.

In Chapter 12, “Self Help for the Homosexual,” he discusses body health including nutrition, deep breathing and relaxation exercises, emotional health, mental health (including dream analysis), spiritual health, and meditation (including positive imagery). Six destructive mental attitudes are mentioned: (1) “I want to be liked by everyone”; (2) “How can I be happy in a world like this?”; (3) “It is better to be safe than sorry”; (4) “What’s done is done”; (5) “The cards are stacked against me”; and (6) “The people around me are my problem” (pp. 184–185).

He spends a whole chapter (14) on opposition to societal discrimination against homosexuals, which was the original purpose behind removing homosexuality from the DSM. He still believes homosexuality is a disorder, however, when he says, “When the gays proclaim that homosexuality is no more peculiar or unusual or abnormal than, say, being color-blind, I feel they are making an egregious error” (p. 219). He advocates for acceptance yet does not hold much hope for happiness for gays. “People whose lives are fraught with deep inner conflict and are antithetical to the rest of society must necessarily lose much of the joy of being in tune with the universe—the joy of being alive” (p. 220).

Kronemeyer’s book gives us a picture of what talk psychotherapy for clients with unwanted same-sex attractions was like in the 1970s. His motivation would seem not only to be to help what at the time was considered a difficult class of hurting people, but also to promote a particular branding of psychotherapy, which has been the norm for psychotherapists since Freud. Only a few of these, such as cognitive behavioral therapy and EMDR, have enjoyed scientifically reproducible confirmation. In this regard Kronemeyer’s message might best be summarized as good psychotherapy can help motivated same-sex attracted people attain their own life goals, which includes happiness as well as heterosexual functioning.

References

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual (DSM-5).* Arlington, VA: APA Publishing.

Fosha, D. (2000). *The Transforming Power of Affect: A Model for Accelerated Change.* New York: Basic Books.

Practice guidelines for the treatment of unwanted same sex attraction and behavior. Retrieved from https://www.scribd.com/doc/115508811/NARTH-Institute-Practice-Guidelines

Janov, A. (1970; 1999). *The Primal Scream. Primal Therapy: The Cure for Neurosis.* New York: Dell.

Kronemeyer, R. (1980). *Overcoming Homosexuality.* New York: Macmillian Publishing Co., Inc.

Kronemeyer, R. (1994). *Syntonics: A Dynamic New Program for Total Health & Happiness.* Upper Saddle River, NY: Prentice Hall Trade.

Nicolosi, J. (2016). *Shame and Attachment Loss: The Practical Work of Reparative Therapy.* Downers Grove, IL: IVP Academic.

Van Den Aardweg, G. (1985). *Homosexuality & Hope: A Psychologist Talks About Treatment and Change.* Ann Arbor, MI: Servant Books.

A Review and Summary of the Documentary:
Voices of the Silenced: Experts, Evidences and Ideology
(Directed by Michael R. Davidson)

Silke Edelmann, EdD
Deutsches Institut für Jugend und Gesellschaft, Germany

Two groups of people, living at different times in history and under different circumstances, yet sharing the same sexual ethics and a similar fate: being silenced by the societies of their time. In his remarkable documentary, *Voices of the Silenced*, Michael R. Davidson compares the story of the Jewish people living under captivity in ancient Roman society, with the story of a contemporary group of people whose sexual ethics are deeply rooted in their biblical faith and worldview. After their deportation to Rome, Jews and Christians were supposed to be silenced forever—and so are the voices of those who follow their footsteps today, in the midst of a society that is turning away from its Judeo-Christian roots, looking instead more and more like the ancient Roman pansexual society. Yet, while the Roman empire crumbled, the attendants of the Mosaic Law were still there, back in the nation which was supposedly destroyed forever. Their voices were heard again, and so, we hope, will the voices of those who are being silenced today.

Voices of the Silenced begins with a powerful soundtrack and moving pictures, retelling the story of the Jewish people being deported from Israel. Their march of humiliation has been commemorated by the Arch of Titus. With pictures of an erupting volcano, a reminder of the Vesuvius eruption, which some thought to be an act of judgment, the viewer is introduced to the second group: "*Today many, like the Jewish slaves, are being forced to march into a similar captivity—this time under a rainbow arch. Those who refuse are silenced. This is their story. . . .*"

Subsequent to the first scenes, the viewer is introduced to the people who are telling their story: women and men who struggle with or have overcome their unwanted same-sex attractions and those who are helping them in their processes. This is followed by some expert comments on the topic. From then on, the documentary goes back and forth between direct and indirect interviews with experts, therapists, the persons concerned, and scenes of ancient places. Throughout the documentary the film director is actively involved in the different scenes, making comments and guiding the content with his questions.

Historical background information is gained from archaeological places in Pompeii and Rome. Archaeological findings bring to light artifacts, which confirm the presence of Jews and Christians living

as slaves in ancient Rome and Pompeii. While most of the artifacts only tell the story of the lives of the free Roman citizens, in the end Judeo-Christian ethics and values superseded the ancient pansexual way of life.

Included in the historical background information are arguments about biblical references concerning homosexuality. One of the arguments is the supposed silence of the New Testament on the topic. However, even if that would be a correct observation, Christian ethics of sexuality are deeply rooted in Jewish ethics, which is very clear on that topic. Another argument is that Paul had no knowledge of the complex sexual practices of the Roman culture. This view cannot be supported, as he lived for several years outside of Israel in other parts of the Roman empire. Therefore, the expert interviewed in the film concludes that it is quite implausible for Paul not to have known anything about the common sexual practices and relationships in Roman culture.

Experts express concern about how massively the homosexual agenda is pushed forward through new sexual politics, unsound reasoning, false claims, and new court orders. Professor Stephen Baskerville argues that journalists and academic professions are under pressure not to explore contemporary sexual ethics in a critical manner anymore. In regards to scientific research, Dr Peter May and Dermot O'Callaghan challenged the statement the Royal College of Psychiatrists gave to the Church of England, which claims that sexual orientation is essentially inborn and cannot be changed. May and O'Callaghan asked the Royal College to provide them with evidence for this statement—and after a long time merely received the unscientific reply, "*I do not propose to enter into a discussion about sexuality but wish to make the following points.*" On the legal front, the film gives an example from New Jersey about a law that makes it illegal for therapists to help minors who struggle with unwanted same-sex attractions and seek to diminish them. Even though there was clear evidence that one of the witnesses provided false information, the law was passed.

Therapists and counselors report on how they are treated by society and even by the church. Some are not invited anymore to speak at conferences or at Christian events, as the organizers are afraid of being labeled as "homophobe." Those who have found help describe the numerous obstacles they experienced

before receiving appropriate support and their difficulty to find people who respect their self-determined life goals.

Even churches are less willing or able to offer support, as Michael R. Davidson states: *"There is a danger of the Christian church, in seeking to contribute positively to society as it should and as the apostles encouraged them to do; it capitulates the values, betraying the Jewish foundation upon which the church is built."*

Finally, the question arises of the church's stance in the midst of competing ideologies and worldviews: *"Where do we now stand as people conscientious about our history and our destiny?"* Some pastors are already too intimidated to speak up when it comes to fornication, divorce, and adultery. On the cusp of the normalization of transsexuality, another step is taken towards a pansexual society. To appeal against this is the command of the hour, as the Irish pastor Mathew Brennan put it: "*Churches should not be nervous, I think we have a gospel that will bear up to scrutiny. . . . There is a remedy in the wonder of Christ."*

Compared with the beginning triumphant ethos of the documentary, the ending is rather sober and quiet. One would have expected it to end as it began. However, the ending is well fitting for the moment in history we find ourselves in. Silencing those who have experienced deep changes in their life, and who we got to know in the documentary will continue. There is no end of the marginalisation in sight, also not for others, who like them, are being silenced; children who suffer from broken families, the unborn killed through abortion, mothers who would rather care for their children than for the profit of their employers, and those trapped in sexual addictions, to name just a few. They are not mentioned in the film, but I believe their voices should be heard as well. The final plea of the documentary are words of hope for all who are silenced in a civilization captured increasingly by a pansexual ideology:

> *It is time to say that those ideologies, that force men, women and children to accept a reality they do not wish to own, are damaging and hurtful. It is time to respect difference, to accommodate those individuals, who choose as a matter of conscience, belief and free will, not to embrace doctrines of sexuality that will surely pass!*