The Linacre Quarterly

Volume 64 | Number 3 Article 2

August 1997

Ethical Considerations in Counselling the Homosexually-Oriented Client

Mark Kahabka

Ethical Considerations in Counselling the Homosexually-Oriented Client

by

Mr. Mark Kahabka

The author, a graduate from the Master's program in Pastoral Counseling at Saint Paul University in Ottawa, Canada, is currently proprietor of The Open Door, a professional counseling agency in Windsor, Ontario.

The counselling of homosexually-oriented clients has become a "hot potato" of sorts in recent years, involving not only socio-political factors but ethical ones as well. On the one side are those who endorse and support what has come to be known as "Gay Affirmative Therapy" (G.A.T.), a counselling model of therapy developed specifically to help homosexually-oriented clients achieve a goal of understanding and self-acceptance of themselves as well as their sexual orientation. According to supporters of G.A.T., homosexuality, "despite being nonproductive in nature, is as biologically natural as heterosexuality...'Like left- and right-handedness, the two are expressions of a single human nature that can be expressed differently in different individuals...'"[1] As such, the counsellor must take precautions never to devalue the homosexual condition in any way, as, for, example, by implying the inferiority of homosexuality in regards to heterosexuality, or even worse, by actually attempting to "convert" or "reorient" the client to a heterosexual lifestyle, even when requested to do so by the client him or her self.

On the other side are those who, for the most part, tend to view

homosexual orientation as the consequence of a developmental deficit, usually resulting from some childhood trauma or another, and thereby in need of healing and correction. Most theorists and practitioners on this side of the debate now seem to favor the work of Elizabeth Moberly, whose research suggests that homosexual orientation is the result of incomplete gender identity, the cause of which can be traced to a defensive detachment from the same-sex parent in the early years of the prehomosexually-oriented person's life. Supporters of this model believe, for the most part, in the practitioner's responsibility to try to heal or repair this developmental deficit if/when a client expresses dissatisfaction with his/her homosexual condition and as such, are willing to employ reparative therapy methods within that percentage of homosexually-oriented clientele who experience their sexual orientation as ego-dystonic and who indicate a desire to change.[2]

Eventually, the question of morality inevitably enters into the picture as well. While avoiding debate as to the actual causes of homosexual orientation, the Roman Catholic Church, along with various other Christian denominations, holds to a very clear position as to the intrinsically disordered nature of the homosexual orientation and to the sinfulness of homosexual genital acts.[3] Because of the Church's moral influence over the years, it has been able to defend its teaching on the unnaturalness of homosexual acts by pointing to both Scripture and "natural law", claiming that "according to the objective moral order, homosexual relations are acts which lack an essential and indispensable finality."[4] As such, to "choose someone of the same sex for one's sexual activity is to annul the rich symbolism and meaning, not to mention the goals, of the Creator's sexual design. Homosexual activity is not a complementary union able to transmit life..."[5] The strength and conviction by which this "traditional" Christian understanding of homosexuality once prevailed, however, has been diluted to a large degree by a number of factors. Such factors include empirical findings suggesting that homosexual orientation may be, at least in some cases, an in-born condition; and a mutual desire on the part of both professional and church communities to put an end to the social discrimination faced by persons merely on the grounds of their sexual orientation.[6]

Origins of Homosexuality

As for the theories regarding the causes and origins of homosexual orientation, they are both numerous and varied. Some theorists have focused their attention on biological-genetic determinants., while others have pointed to developmental factors. While acknowledging that most theorists seem able to point to at least some degree of empirical verification to support their positions, I have decided, in order to familiarize the reader with at least one model which is morally acceptable from a Christian perspective, to focus primarily on Moberly's developmental deficit theory as well as on the socio-political and ethical consequences of the American Psychiatric Association's (APA) gradual shift from its early categorizing of homosexual orientation as a sociopathic disorder to its present day de-classification of homosexuality.

In brief, then: according to Moberly's theory, a person's homosexual orientation has its primary origin neither in a genetic dispositional hormonal imbalance nor in defective learning processes but rather, in unfulfilled attachment needs involving the same-sex parent.[7] She refers to this unfilled need as a "Deficit" in that there has been a disruption in the normal attachment process and which leaves the child "unfilled in its need for the same-sex attachment."[8] As the child develops, s/he begins to unconsciously seek to repair this deficit "through the medium of same-sex or homosexual relationships."[9] This is, in essence, says Moberly, the principle motivation underlying the homosexual impulse.

Yet, for the most part, Moberly's approach to her developmental model is a radical departure from the more traditional understanding of same-sex love as pathological and deviant in that it affirms the need for same-sex affectional love as a pre-ccondition for healing and growth. Since "this valid and universal love-need has not been fulfilled on the usual developmental time-table" any theory which hopes to repair the damage must focus primarily "on same-sex relational needs and difficulties."[10] In short,

> "What the male homosexual seeks," says Moberly, "is what he should have received from his relationship to his father. What the female homosexual seeks is what she should have received from her relationship to her mother. What is sought is the fulfillment of

> attachment needs which are a normal part of the developmental process, but which have abnormally been left unmet in the process of growth."[11]

Or in other words, "same-sex love is not an obstacle to development, but is itself the drive to resume and further the developmental process."[12]

Complicating the situation, however, is the evidence of hostility found in many homosexually-oriented persons towards members of the same sex.[13] Although such inner conflict is often unconscious, it frequently surfaces within the context of same-sex social and/or sexual relationships.[14] The hostility and subsequent ambivalence underlying such same-sex relationships is the result, says Moberly, of a "defensive detachment" from the same-sex parent, "coupled with the urge for renewed attachment."[15] Thus, the central task for the therapist is to focus not only on resolving the emotional wounds from which this defensive detachment arises but also to nurture "the capacity for same-sex relating so that these legitimate developmental needs for same-sex love may be fulfilled."[16]

In light of the above, it probably comes as no surprise that Moberly advocates gender-specific therapy (i.e., male client/male therapist; female client/female therapist) for the homosexually-oriented client, seeking thereby to "coordinate thesolution with the nature of the problem."[17] In fact, Moberly goes so far as to say that increased opposite-sex contact, at least initially, is entirely inappropriate for such a client, "Since increased opposite-sex contact can do nothing to fulfill same-sex deficits relationships with the opposite sex are, literally, by definition irrelevant to a problem of this nature."[18] This is not to say that Moberly trivializes the goal of a genuine heterosexual orientation for those who wish to attain it; on the contrary, what Moberly makes all too clear is that the road leading to such attainment paradoxically depends upon the successful resolution and fulfillment of the client's same-sex developmental needs - needs, by the way, which Moberly sees as existing prior to, and independently of, any sexual activity, since homosexual orientation is viewed by Moberly specifically as a "gender-identity problem rather than a sexual-genital one."[19] As such, the needs involved also "can and should be met independently of any sexual activity."[20]

Having reviewed Moberly's theory, the question as to its validity remains. Unfortunately, as will be noted later in this article, the database required to empirically validate the theory is minuscule at best, in part because of the lack of research presently being done in this particular area. At the same time, if there is a general conclusion to be drawn from Moberly's work, it would seem to be that psychotherapy, having traditionally focused on eliminating the need for same-sex love, inadvertently misinterpreted the solution for the problem. What eventually led to widespread pessimism among professionals regarding reparative therapy with homosexual clients, therefore, if Moberly is correct, might have been due less to the lack of success than to a lack of understanding of the basic relational needs of the homosexually-oriented client.[21]

As for socio-political factors, as recently as 1991, the APA Task Force on Bias in Psychotherapy with Lesbian and Gay Men conducted a survey in order to determine the views and attitudes of over 2,500 licensed psychologists in order to set some guidelines as to what did and did not constitute ethical or exemplary practice in the counselling and treatment of gay and lesbian clients. Some of the exemplary practices included :

> -not attempting to change the sexual orientation of a client without evidence that the client desires this change
> -recognizing that gay and lesbian people can live happy and fulfilled lives
> -recognizing the importance of educating professionals, students, supervisees, and others about gay and lesbian issues and attempting to counter bias and misinformation
> -recognizing the ways in which societal prejudices and discrimination create problems for clients and dealing with these concerns in therapy[22]

while some of the practices considered biased or unethical were:

> -automatically attributing a client's problems to his or her sexual orientation
> -discouraging lesbian or gay clients from having or adopting a child
> -expressing attitudes or beliefs that trivialize or demean gay and lesbian individuals or their experience

-showing insensitivity to the impact of prejudice and discrimination on gay and lesbian parents and their children
-providing or teaching inaccurate or biased information about lesbians or gay men[23]

Although the present policies of the APA are not necessarily identical with the philosophical views of the supporters of G.A.T., a major shift over the last 30 years has had a definitive effect on the way homosexuality is viewed by a large number of practitioners today. For example, for years homosexuality was considered to be a pathological condition, and as far back as 1952 the APA's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) had labeled it among the various sociopathic personality disorders.[24] In 1968, with the advent of DSM-II, homosexuality was removed from the sociopathic category and was instead placed on a list with other sexual disorders such as pedophilia, fetishism, and sadism.[25] Here it remained through five more revisions of DSM-II until 1973, when the board of trustees of the APA voted to drop homosexuality from the list and to place it under the somewhat oblique category of "ego-dystonic homosexuality disorder," a reference to those "individuals who themselves reject their sexual inclinations and wish to become exclusively heterosexual."[26] Continued pressures by gay rights activists as well as by those within the mental health profession eventually led to another change in which homosexuality was dropped from DSM-III-R and placed into yet another new category, "Sexual Disorder Not Otherwise Specified" where it is characterized by "persistent and marked distress about one's sexual orientation"[27] and where it can still be found in the 1994 edition of DSM-IV.

Political Pressures

What were the grounds for such rapid changes and which were the events that helped to bring them about? Furthermore, how can the social and political issues involved be separated from the ethical ones, if indeed, they can be sifted out at all? That there were political factors at work is beyond doubt.[28] Over and beyond the political pressures were genuine humanitarian concerns in that the profession had "hoped to eliminate social discrimination by removing the stigma of sickness

attributed to homosexual people."[29] The argument presented by both mental health professionals as well as by gay rights lobbyists was that "homosexuals who reject their own homosexuality do so because they have internalized negative stereotypes; by labeling their sexual orientation a psychological disorder, the mental health establishment reinforced those stereotypes."[30] In fact, this argument has been expanded in recent years as to include any form of counselling or therapy which fails to recognize and accept the homosexual condition and lifestyle on a par with that of heterosexuality. As a result, G.A.T. practitioners will often present the underlying philosophy of gay affirmative therapy as the only ethical guidelines by which professionals should be allowed to work.

In short, according to Haldeman, such ethicists and practitioners "object to conversion therapy on two grounds: first, that it constitutes a cure for a condition that has been judged not to be an illness, and second, that it reinforces a prejudicial and unjustified devaluation of homosexuality.[31] Haldeman supports Davison's claim that "the devaluation and pathologizing of homosexuality" is implied whenever conversion treatments and methods are offered or employed.[32] Over and above these objections are Haldeman's concerns regarding the lack of empirical evidence testifying to the efficacy of conversion treatments,[33] as well as his anxiety over the negative effects which failed attempts at reorientation may have on the client.[34] Added to these is the overriding concern of whether a client who comes of her/his own free will to seek out reparative therapy can truly be said to be acting in a "voluntary" manner.[35] This issue is an important one, since it is the grounds on which arguments are made to justify the continued use of reparative therapy methods despite the present APA policies.

Murphy would seem to accurately surmise the stance of those who offer reparative therapy when he writes that "What differentiates contemporary approaches to reorientation therapy from their predecessors, therefore, is that they do not usually avail themselves of the language of disease, disorder, and cure...They speak instead of wishes and preferences, of rights and duties."[36] Sturgis and Adams, for example, have argued that to deny "the right to modification of sexual orientation violates the right of the individual to treatment and imposes arbitrary values of the clinician in the same manner as the clinician who assumes that all homosexuals should receive treatment for sexual

reorientation."[37] In order to protect the client from being unduly influenced by the values of the clinician, Sturgis and Adams recommend that following

> the assessment and formulation of any problem behavior regardless of its nature, therapists consult with clients, inform them of their opinions about the problem, discuss possible treatment alternatives, and discuss implications of the alternatives. Included should be a clear statement of the therapists's values that the client can evaluate in accepting or rejecting treatment alternatives. Such an approach decreases the likelihood that a client would unknowingly be influenced by the value systems of the therapist and also allows the individual to exercise greater personal control over possible consequences of treatment procedures.[38]

While acknowledging the contribution and influence of social discrimination as a motivating factor in the homosexually-oriented client's request for therapy, Sturgis and Adams dispute the claim that gay and lesbian clients are subject to more discrimination than others who violate societal norms.[39] Nor do they view social discrimination and prejudice as the primary motivation for change in all cases: "there are clients who may actually wish to alter their preference to be congruent with their values rather than changing their value system."[40] In fact, Nicolosi has argued that one of the effects of the attempt of the mental health population has been the unintended occurrence of reverse discrimination against those "whose social and moral values and sense of self cannot incorporate their homosexuality,"[41] and in the process, "has cast doubt on the validity of this group's struggle."[42]

> ...Society now views this group with a certain derision, and psychology perceives him as self-hating and misguided. His identity is lost between the cracks of popular ideology. The straight world shuns him, and the gay world considers him not their own.[43]

Having examined the theoretical base for and against the use of reparative therapy methods along with some of the socio-political and ethical implications which submerge the issue in its present climate of

controversy, at least one question remains which has yet to be explored: can those on the opposing sides of the continuing debate allow each other the freedom and respect to hold and practice conflicting beliefs in order to peacefully coexist? The question is a compelling one since recent indications suggest attempts to seek an end to the employment of reparative treatment methods for homosexually-oriented clients will continue.[44] Perhaps the only short-term solution to the problem at present is, as Nicolosi says, "to 'agree to disagree' by allowing the debate to continue, rather than putting an end to the discussion through political intimidation."[45]

As for the Christian communities: they, for their part, must work at upbuilding their own credibility by disproving the claim - so often conveyed through the media - that they are indifferent to the plight of homosexually-oriented persons. This can be done by undertaking the humble task of establishing spiritual support groups for such members struggling to live in accordance with their church's teachings. While the existence of several such groups at present testifies both to the sincerity and commitment of these same churches to minister to a marginalized group of people within their own denominations,[46] there remains, as yet, much to be done for the future.

References

1. Douglas C. Haldeman, "The Practice and Ethics of Sexual Orientation Conversion therapy," *Journal of Consulting and Clinical Psychology,* Vol. 62, No. 2, 1994, p. 225.

2. The term "reparative" is used here in place of the more conventional terms "conversion" or "reorientation" therapy, since the latter terms suggest a changing, rather than a healing or completion of a gender identity developmental deficit. Some psychotherapists, such as Joseph Nicolosi, prefer this term and have standardized it in their writings, arguing that homosexuality in psychiatric literature "has long been explained as an attempt to 'repair' a deficit in masculine identity." (Joseph Nicolosi, *Reparative Therapy of Male Homosexuality,* Northvale, NJ, 1991, p.70).

3. For example, in the 1987 Vatican document, *The Pastoral Care of Homosexuals,* we read that "Although the particular inclination of the homosexual person is not a sin, it is a more or less strong tendency ordered toward an intrinsic evil and thus the inclination itself must be seen as an objective disorder." (Cardinal Joseph Ratzinger,

The Pastoral Care of Homosexuals, Battleford, Saskatchewan, 1987, p.2).

4. Cardinal Franjo Seper, *Declaration on Certain Questions Concerning Sexual Ethics*, Boston, MA, 1975, p.13.

5. Ratzinger, p.4.

6. In *Pastoral Care of Homosexuals*, the document, while stating that the "intrinsic dignity of each person must always be respected in word, in action, and in law," also cautions that in "assessing proposed legislation, the bishops should keep as their uppermost concern the responsibility to defend and promote family life." (Ibid, pp.6, 10).

7. "A review of the physiological literature demonstrates that genetic and hormonal factors do not seem to play a predetermining role in homosexual development. However some predisposing factors may make some boys more vulnerable to gender-identity injury." (Nicolosi, *Reparative Therapy of Male Homosexuality*, p.xvi) "In *Three Essays on Sexuality*, Freud rejected as too crude to be credible the view that an individual could be born with object choices already determined, that is, prior to psychodevelopmental experience (Freud, 1905/1953)." (Timothy F. Murphy, "Freud and Sexual Reorientation Therapy," *Journal of Homosexuality,* Vol. 23(3), 1992, p.25) According to Michael Saia, "genetic and hormonal explanations are two variations on the same theme. Behind both of these theories lies the basic idea that a person's physical body predisposes him to homosexual tendencies. The practical out-working of this idea is that the affected person must live out what he is physically, and so must live a homosexual lifetsyle. Some adherents to the theory claim that the person maintains no responsibility whatever for his actions, while others claim that the person can control how he expresses his homosexuality, but he must behave in a homosexual fashion. After all, they say, that is what he is." (Michael R. Saia, *Counseling the Homosexual*, Minneapolis, MN, 1988, p.40).

8. John F. Harvey, *The Homosexual Person,* San Francisco, CA, 1987, p. 28. "According to Moberly's data, the homosexual person - whether male or female - has been unable to meet the normal developmental need for attachment to the parent of the same sex." (Ibid., p.38).

9. Ibid., p. 28. Not every child, of course, who has been deprived of the presence of a same-sex parental figure will go on to develop a homosexual orientation. Says Nicolosi: "Even if the father is absent through death, divorce or a work situation, the child is not at risk if the mother really values masculinity. If he hasn't been hurt emotionally, he will still find a model. The hurt of parental rejection is more significant than a father's absence." (John Paul Arnerich, "Dialogue: Joseph Nicolosi on Therapy for Homosexuals", *National Catholic Register,* October 20, 1991, p. 12).

10. Harvey, *The Homosexual Person*, p.38. "As a result of early difficulties in relating to the parent of the same sex, the attachment-need is repressed and remains unfulfilled. Hence the child's normal needs for love, dependency, and identification remain unfulfilled, since their fulfillment depends on an uninterrupted attachment. However, the attachment-need may well emerge from repression and seek further fulfillment. When this occurs, a renewed same-sex relationship is established. This means that a so-called homosexual relationship is not deviant but based on the drive to fulfill a legitimate developmental need." (Ibid., pp.38-9).

11. Ibid., p. 39. " 'What were you looking for when you had your first homosexual experience?' I have asked gay men this question and have received many and varied responses. But there is one answer I have never heard: 'sex.' Each was seeking affection, companionship, communication, identity, or security - but never sex. This curious silence made me wonder about the relationship of sex to human needs in the homosexual's life." (Saia, *Counseling the Homosexual,* p. 55). "Some youngsters, feeling unaffirmed and deprived of affection, come to look for acceptance on any terms. They may drift to homosexuality hoping for affirmation and may thereby solidify homosexual leanings." (Jeffrey Keefe, "A Sharper Focus on Homosexuality," in Harvey, *The Homosexual Person,* P. 73) "As Moberly explains, 'Homoerotic feelings must be reinterpreted as emerging from the legitimate need for same-sex intimacy.' " (Nicolosi, *Reparative Therapy of Male Homosexuality,* p. 21).

12. Harvey, p. 39.

13. "Clinical as well as empirical studies have found (male) homosexuals to be more likely than heterosexuals to have had distant, hostile, or rejecting childhood relationships with father..." (Nicolosi, *Reparative Therapy of Male Homosexuality,* pp.43-4).

14. "Not all the structures of same-sex ambivalence are visible in all cases or at all times. Many of them remain latent on the unconscious level. Either side of the ambivalence may be predominant. The homosexual love-need may often be the only conscious manifestation of this total structure. What often happens is that the person forms a renewed attachment while defensiveness toward the same sex remains repressed. Unfortunately, the reparative attempt may be thwarted by this defensiveness from the unconscious level. The relationship may be subject to instability and disruption. This happens frequently in homosexual relationships." (Harvey, *The Homosexual Person*, P. 45) "The perennial problem of the homosexual ambivalence is that the reparative attempt may at any time be thwarted by the reemergence of the defensive barrier. The tendency toward renewal of loss through renewal of detachment is inherent in the very structure of homosexuality. This is the reason why active homosexual relationships are unable to fulfill developmental deficits." (Ibid, pp.46-7).

15. Ibid., p.28. "These negative signs of ambivalence are not really adult behavior, although they may be manifested in adult life. They represent the reemergence of the child's repressed defensive response." (Ibid., p.44) Nicolosi considers the primary cause of homosexuality in males as resulting not so much from the absence of a father figure as from "the boy's defensive detachment against male rejection." (Nicolosi, *Reparative Therapy of Male Homosexuality,* p. 34) "Defensive detachment also prevents the homosexual from internalizing the missing masculinity that would allow him to grow in heterosexual identity. It is his healthy desire to take in the masculine - which is blocked by defensive detachment - that binds him into a frustrating predicament." (Ibid., P. 106) "Clients often report this sense of isolation and frustration leads them to the impulsive pursuit of anonymous sex, which brings them the sense of an infusion of masculinity and of connectedness with themselves." (Ibid., p. 107).

16. Harvey, *The Homosexual Person*, p. 40. "...therapy should aim at undoing the defensive detachment from the same-sex love source and in bringing the reparative drive to its fulfillment...As long as the defensive barrier is a dynamic force within the personality (and this holds for the adult as well as for the child), he or she will block the capacity for the fulfillment of the love-need. One will not be capable of receiving love from the mistreated love-source." (Ibid., p.43) Nicolosi believes it was Moberly's concept of defensive detachment which finally laid the groundwork for treatment based on a causal model. Says Nicolosi: "Moberly identified defensive detachment as the primary block to healing, thus isolating a basic resistance in treatment." (Nicolosi, *Reparative Therapy of Male Homosexuality,* pp.19-20).

17. Harvey, *The Homosexual Person,* p. 40. Nicolosi views the classical psychoanalytic practice of remaining "emotionally distant" from the client as just one more basic error in previous attempts to work with the homosexually-oriented client. "Withholding personal involvement merely frustrates the homosexual client who particularly needs intimate male connectedness, and whose healing comes primarily though the therapeutic relationship. The emotionally detached therapist reactivates old memories of earlier frustration from the cold and critical father. To correct this error, Moberly explains that the therapist must be more emotionally involved and, within therapeutic guidelines, permit dependency. The therapist must be of the same sex as the client to allow him to work through developmental blocks with the same-sex parent. In reparative therapy the therapeutic relationship is the central factor in treatment. Not only is the relationship with the primary therapist important, but also with members of a like-minded psychotherapy group. Mutual, trusting, and intimate nonerotic relationships with males will further the therapeutic process." (Nicolosi, *Reparative Therapy of Male Homosexuality,* p. 20) "The female clinician can play a role in reparative therapy (with males), but ultimately she must be prepared to surrender the client to work with a male therapist," (Ibid., p. xviii) since "only a male can stimulate reenactment of the conflictual feelings experienced with males, particularly problems with trust and the need for male acceptance. Only through men can masculine identity be found." (Ibid., p.179) It is important to note here that Moberly is not putting emphasis on the physical aspects of same-sex attraction, but

rather on the process of gender specific therapy.

18. Harvey, *The Homosexual Person,* p. 40. "Romantic relationships with women have actually little or no value in therapy until the latter stages. When I encouraged (male) clients to develop these relationships before they were ready, they came back reporting that they felt uncomfortable, artificial, and dishonest. They saw themselves as having used the woman in an experiment. Because their feelings could not match their behavior, they believed the relationship was exploitative, and universally they returned with a sense of failure. Not only did these clinical attempts to encourage dating prove fruitless and frustrating, but the pressure they created eroded my relationship with the client. These men invariably talked about male relationships as more significant, more intense, more satisfying, and more relevant." (Nicolosi, *Reparative Therapy of Male Homosexuality,* pp. 202-3) "Behavioural programmes based on the premise that confusion around sexual orientation results from faulty learning tend to disagree with this position. Goff, for example, argues that having failed in an attempt to establish an intimate relationship with the opposite sex, a young male may feel "that he is faced with the prospect of being homosexual even though he does not have sexual feelings toward same-sex partners. This poses a dilemma for which he is unprepared: sexual feelings with no acceptable or desired sex object, which results in confusion." (J. Larry Goff, "Sexual Confusion Among Certain College Males," *Adolescence*, Vol. XXV, No. 99, Fall, 1990, p.609. See also, W. Ralph Layland, "In Search of a Loving Father," *International Journal of Psycho-Analysis,* Vol. 62 (2), 1981, P.220.

19. Harvey, *The Homosexual Person,* P. 28. According to Nicolosi, "male homosexuality has long been understood to be a reflection of gender-identity deficit. Recently, this gender deficit has also been empirically demonstrated. However, no consistently successful treatment has followed from that understanding. This may be due to the fact that traditional psychoanalysis made the error of emphasizing overcoming an assumed 'fear of females'." (Nicolosi, *Reparative Therapy of Male Homosexuality,* pp.17-8) Nicolosi views this gender-identity deficit as having a specific causality: "In the course of a child's life, every significant developmental lesson has its critical periods of receptivity. These periods of heightened awareness appear to have a biological basis. There is a particular period of openness to language, which is best taught during the first three years, after which time it is exceedingly difficult to acquire. Receptivity to gender identity also has a critical period, after which the lesson will not be easily learned. Most researchers agree that the critical period for gender identification occurs before the third year...Within that period, the time of greatest receptivity appears to be the second half of the second year." (Ibid., p.26) According to Nicolosi, the higher ratio of male to female homosexuality may also have a specific causality: "As very young infants, both boys and girls are first identified with the mother, who is the first and primary source of nurturance and care. However, whereas the girl maintains primary identification with the mother, the boy later has the additional developmental task of shifting identification from the mother to the 'second other' (Greenspan 1982). It is through his relationship with father that the boy will change to a masculine identification,

which is necessary if he is to develop a normally masculine personality (Sears, et al. 1957) This additional developmental task for boys explains why they have more difficulty than girls in developing gender identity (LaTorre 1979)..." (Ibid., pp.25-6) While in agreement with Moberly that homosexuality has its roots in a gender-identity deficit, Nicolosi believes there does come a time when this deprivation eventually becomes sexualized: "Because needs for affection, affirmation, and identification remain unmet from the early relationship with father, the prehomosexual boy feels an intensely painful deprivation. At a certain age, there eventually occurs a transitional phase, when the affectional hunger for male attention transforms into a sexual striving. The exact developmental timing of this transitional phase depends upon the boy's emotional development and sexual experience. For most boys it occurs in early adolescence (13-15 years of age). During this phase these unmet affectional, affirmation, and identification needs take on an intense sexual aspect." (Ibid., pp.68-9) In speaking of gender-identity, Nicolosi distinguishes between it and what he refers to as "core gender-identity, the basic awareness that one is a male. Confusion in core gender-identity may result in transsexualism. For most homosexuals, core gender-identity is intact, but there remains a private and subjective sense of simply not feeling fully male-identified." (Ibid., p. 94) Jeffrey Keefe distinguishes between the two by using the terms "core gender identity" and "gender role identity." (Jeffrey Keefe, "A Sharper Focus on Homosexuality", in Harvey, *The Homosexual Person,* P. 65.

20. Harvey, *The Homosexual Person*, p. 28. "It is really an attempt to complete the process of identification....The homosexual love-need is essentially a search for parenting, but this does not mean that the same-sex partner must be an overt parent figure. It should be remembered also that we are here concerned with the homosexual condition and not with its translation into sexual activity. While the psychological needs of the homosexual person are often expressed sexually, these needs exist independently of sexual expression, according to Moberly. They can be fulfilled by a good non-sexual relationship with a member of the same sex." (Ibid., pp.44-5) In short, "an uninterrupted relationship will itself guarantee basic gender identity." (Ibid., P.47) "Male bonding is an especially important goal through the development of mutuality in nonerotic same-sex friendships." (Nicolosi, *Reparative Therapy of Male Homosexuality*, p.xviii).

21. Nicolosi claims that the recent changes in the de-classification of homosexuality as a pathological condition in the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) "had the effect of discouraging treatment and research." (Ibid., P. 10) Nicolosi, in focusing specifically upon therapeutic work with the male homosexually-oriented client, has made a considerable contribution to the expansion and further development of Moberly's theories and claims the "gender-deficit model is appropriate for about 90 percent" of the clients with whom he works. (Arnerich, "Dialogue: Joseph Nicolosi on Therapy for Homosexuals," p. 12).

22. Gerald Corey, Marianne Schneider Corey and Patrick Callanan, *Issues and Ethics in the Helping Professions*, Belmont, CA, 1993 P. 271.

23. Ibid.

24. "While for centuries same-gender sexual activity has been punished, it is only in the last century or so that such behaviour changed in the ways it was perceived, in this country from being 'deeds' which anyone might commit, to being the behaviour of a particular type of person - 'the homosexual' - ....In the nineteenth century the newly emerging discipline of sexology played a significant part in pathologizing homosexuality by locating its origins within the biology or psychology of particular individuals. However in so doing, it also created opportunities for resistance to such labelling, and inadvertently paved the way for the emergence of a more positive identity as 'gay' or 'lesbian'....(Peter Gordon, "The Politics of Homosexuality", *Sexual and Marital Therapy*, Vol. 5, (1), 1990, p. 7) "Vern Bullough dates the beginning of the medicalization of homoeroticism with the work of German physician Carl Westphal (1833-1890) who believed 'contrary sexual feeling' to be mostly a congenital condition (Bullough, 1989). For many of the early sexologists, part of the incentive to discover a biological basis for homoeroticism (it being a separate question whether it was a disorder) was to shield persons from harsh criminal judgments which assumed the voluntary nature of homeroticism. In many cases, the development of reorientation techniques followed developments in scientific progress elsewhere." (Timothy F. Murphy, "Redirecting Sexual Orientation: Techniques and Justifications", *The Journal of Sex Research,* Vol. 29, No. 4, 1992, p.516).

25. Evelyn Hooker "was among the first to point out the degree to which the 'pathology' of homoeroticism might belong to its social circumstances rather than to its inherent psychological features." (Ibid., p. 518) According to Dunkle, in the years preceding the removal of homosexuality from DSM-II in 1973, the majority of clinicians focused mainly on attempts to "convert" homosexually-oriented clients to heterosexuality - thus, the term "conversion" or "reorientation" therapy. (John H. Dunkle, "Counseling Gay Male Clients: A Review of Treatment Efficacy Research: 1975-Present," *Journal of Gay & Lesbian Psychotherapy*, Vol. 2 (2), 1994, pp. 2-3).

26. Richard R. Bootzin, Joan Ross Acocella, Lauren B. Aloy, *Abnormal Psychology*, New York, NY, 1993, p.357. "The resolutions of the board of trustees in December, 1973, led to a referendum of the members of the APA, in which the majority supported the trustees' statement, but a minority of roughly forty percent did not support it (5,854 members approved; 3,810 opposed; 367 abstained; *The Washington Post*, April 9, 1974, confirmed by the APA Public Relations Department, November 11, 1976)." (Fr. John Harvey, "Changes in Nomenclature and Their Probable Effect," from John R. Cavanagh, *Counseling the Homosexual*, Huntington, IN, 1977, p. 31) "This decision, which erased a hundred-year-old psychological definition, was confirmed by a referendum among the membership, who voted approximately six to four." (Harvey, *The Homosexual Person*, p. 74) Sturgis and Adams have argued that the "abnormality of homosexual behavior, like the classification of any behavior pattern, is an issue to be resolved empirically rather than through verbal discourse or through the vote of a professional body...." (Ellie T. Sturgis and Henry E. Adams, "The Right to Treatment: Issues in the Treatment of Homosexuality," *Journal of*

Consulting and Clinical Psychology, Vol. 46, No. 1, 1978, p.166) "According to the social and professional standards of a number of nations, however, homoeroticism per se remains a pathological state or psychological disorder." (Murphy, "Redirecting Sexual Orientation: Techniques and Justification," p. 518).

27. Nicolosi, p. 9.

28. "The current controversy regarding the classification and modification of homosexual behavior appears to have been stimulated by pressures on professional organizations exerted by groups such as the Gay Liberation Movement." (Sturgis and Adams, "The Right to Treatment: Issues in the Treatment of Homosexuality," p. 165) "In his scholarly analysis of the American Psychiatric Association's reversal of the diagnostic classification of homosexuality, Bayer (1981) states: 'The result was not a conclusion based upon an approximation of the scientific truth as dictated by reason, but was instead an action demanded by the ideological temper of the times'...The combined effects of the sexual revolution and the 'rights' movements - civil rights, minority rights, feminist rights' have resulted in an intimidating effect upon psychology. Some writers have even questioned whether 'straights' are capable of doing research on homosexuality...." (Nicolosi, *Reparative Therapy of Male Homosexuality,* p. 9) "Psychiatrist Ruth Barnhouse observed that many members felt caught between either upholding an appraisal based on scientific evidence or contributing to discrimination - a dilemma, she says, born of muddy thinking. Interestingly, in a medical journal survey four years later, 69% of responding psychiatrists agreed that 'homosexuality is usually a pathological adaptation, as opposed to a normal variation.' " (Harvey, *The Homosexual Person,* pp. 74-5).

29. Nicolosi, *Reparative Therapy of Male Homosexuality*, p. 11. "In the past , homosexuals have been denied civil rights in many areas of life on the score that they suffer from a mental illness, and that it is necessary for them to demonstrate their competence and reliability in spite of their homosexuality." (Harvey, "Changes in Nomenclature and Their Probable Effect," from Cavanagh, *Counseling the Homosexual*, p. 31).

30. Bootzin, Acocella, Alloy, *Abnormal Psychology*, p. 357. The APA explained its controversial decision in DSM-III-R (1980) in the following manner: " 'The crucial issue in determining whether or not homosexuality per se is to be regarded as a mental disorder is not the etiology of the condition, but its consequences and the definition of mental disorder. A significant proportion of homosexuals are apparently satisfied with their sexual orientation, show no significant signs of manifest psychopathology (unless homosexuality, by itself, is considered psychopathology), and are able to function socially and occupationally with no impairment. If one uses the criteria of distress or disability, homosexuality per se is not a mental disorder. If one uses the criterion of inherent disadvantage, it is not at all clear that homosexuality is a disadvantage in all cultures or subcultures.' (Harvey, *The Homosexual Person*, p. 75) Harvey believes that by disregarding the etiology of homosexuality as a criterion of disorder, the APA has simply ignored "the accumulated literature on psychodynamics

that has demonstrated the connection between unresolved unconscious conflict and disordered functioning. This literature, wrought from clinical experience, sees compulsive and symptomatic homosexuality as a sexualized resolution of conflict in which the particular experiences of an individual became interwoven with psychosexual development. Episodic homosexuality usually is not psychologically disordered, because its motives are accessible to consciousness." (Ibid., p.76).

31. Haldeman, "The Practice and Ethics of Sexual Orientation Conversion Therapy," p. 225. Haldeman finds support for this position in the 1975 APA resolution urging " 'all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations.' " (Ibid.) "Martin (1984) stated that 'a clinician's implicit acceptance of the homosexual orientation as the cause of ego-dystonic reactions, and the concomitant agreement to attempt sexual orientation change, exacerbates the ego-dystonic reactions and reinforces and confirms the internalized homophobia that lies at their root'..." (Ibid., p.226).

32. Ibid., p. 225. Haldeman further claims that "gay men and lesbians do not differ significantly from heterosexual men and women on measures of psychological stability, social or vocational adjustment, or capacity for decision making. In fact, psychological adjustment among gay men and lesbians seems to be directly correlated to the degree that they have accepted their sexual orientation...." (Ibid.).

33. According to Haldeman, "Evidence for the efficacy of sexual conversion programs is less than compelling. All research in this area has evolved from unproven hypothetical formulations about the pathological nature of homosexuality. The illness model has never been empirically validated; to the contrary, a broad literature validates the nonpathological view of homosexuality, leading to its declassification as a mental disorder....In short, no consistency emerges from the extant database, which suggest that sexual orientation is amenable to redirection or significant influence from psychological intervention." (Ibid., pp. 223-4) "At the present time, it is unclear whether there is any known treatment of homoeroticism in the sense that there is a reliable, replicated method offering a 'cure' or reorientation to randomly selected groups. Virtually every study mentioned above failed to establish any control mechanism for the intervention being tested. It is thus impossible to tell whether the 'successes' reported belong to the charm of the therapist or to the technique, were the result of psychosexual developmental changes occurring for reasons unrelated to the therapy, were the consequence of the psychologically powerful placebo effect....In many cases, moreover, the subjects under study had bisexual histories, and it is therefore unclear whether the interventions were in fact replacing homoerotic dispositions with heteroerotic ones or resolving a conflict between competing, already existent erotic interests (Mondy, 1988). And certainly, since these studies lack long-term follow-ups, it is unclear that the success of reorientation is any enduring one...These observations do not, of course, rule out the possibility of the development of a successful, empirically confirmed treatment. Even the skeptics acknowledge this possibility." (Murphy, "Redirecting Sexual Orientation: Techniques and Justification," pp. 515-6) Harvey counters the above by arguing that while it is correct

to say that "many clinical research findings do not apply to all homosexuals," their "lack of universal application" does not invalidate them since "various dynamics may contribute to homosexual orientation, some more in one person than another. Every person has a unique, rich, and dramatic psychic history." (Harvey, *The Homosexual Person*, p.71) The argument, according to Ruth Barnhouse, " 'that because it cannot be demonstrated the "x" factor always causes homosexuality' " does not invalidate in any way earlier findings suggesting the reparative nature of homosexual behavior. (Nicolosi, *Reparative Therapy of Male Homosexuality*, p. 76) For a review of behavioral, psychodynamic, hormonal, pharmaceutical and surgical attempts to alter sexual orientation, see Murphy, "Redirecting Sexual Orientation: Techniques and Justifications," pp. 502-514.

34. "...subjects who have undergone failed attempts at conversion therapy often report increased guilt, anxiety, and low self-esteem. Some flee into heterosexual marriages that are doomed to problems inevitably involving spouses, and often children as well. Not one investigator has ever raised the possibility that conversion treatments may harm some participants, even in a field where a 30% success rate is seen as high. The research question, 'What is being accomplished by conversion treatments?' may well be replaced by, 'What harm has been done in the name of sexual reorientation?' At present, no data are extant." (Haldeman, "The Practice and Ethics of Sexual Orientation Conversion Therapy," p. 225).

35. "Stephen L. Halleck, for example, has said that by reason of the considerable pressures from parents, spouses, and the law, by reason of years of struggle with self-loathing, by reason of fatigue in facing daily indignities, by reason of the powerful feelings of deprivation of acceptance, marriage, and family, he doubts that men and women requesting reorientation do so in a truly voluntary way...." (Murphy, "Redirecting Sexual Orientation: Techniques and Justifications," p.519).

36. "...reorientation therapy is now defended as a matter belonging to the domain of individual conscience: if a person would like to have a sexual orientation other than the one he or she does have, then therapy ought to be pursued and provided. Sexual orientation is thus no different from the other products consumers may find on the shelves of medical practitioners....While there are still those who interpret homoeroticism as pathological or otherwise fundamentally disordered, most of their professional colleagues maintain that reorientation is a legitimate goal of therapy even if homoeroticism is no pathology, psychological disorder, or even any necessary disability in social life." (Ibid., pp. 518-9).

37. Sturgis and Adams, "The Right to Treatment: Issues in the Treatment of Homosexuality," p. 165. "Many individuals who seek the aid of a psychologist are normally functioning individuals who experience difficulties in some respects of their lives. Should the issue of treating individuals who report dissatisfaction with their pattern of sexual preferences be different from treating individuals who are dissatisfied with behavior patterns in nonsexual response systems? When clinicians respond differently to homosexuality than to other problems, are we not reacting to

social or political pressures rather than to the basic issue of treatment? (Ibid., p. 166).

38. Ibid.

39. "....to assume that homosexuals experience more prejudice than others do is questionable. The role of social prejudice in specific deviations (positive or negative) can be more appropriately answered through empirical investigation than through armchair speculation. Until such evidence is available one cannot conclude that social pressure is the critical factor in the development of distress and desire for change in the homosexual but not in the development of distress and the desire for change in other patterns of behavior." (Ibid., p. 167).

40. Ibid., p. 168. Nicolosi has coined the term "non-gay homosexual" as someone "who experiences a split between his value system and his sexual orientation." (Nicolosi, *Reparative Therapy of Male Homosexuality*, p. 4) Such clients "experience their homosexual orientation and behavior as at odds with who they really are. For these men, their values, ethics, and traditions carry more weight in defining their personal identity than their sexual feelings. Sexual behavior is just one aspect of a man's identity, an identity that continually deepens, grows - even changes - through his relationship with others." (Ibid., p. 13) In his 1976 pastoral letter on human sexuality, Brooklyn's Catholic bishop, the late J. Mugavero, urged " 'homosexual men and women to avoid identifying their personhood with their sexual orientation. They are so much more as persons than this single aspect of their personality. That richness must not be lost.' " (Harvey, *The Homosexual Person*, p. 163) Nicolosi laments the fact that "reacculturation into the gay subculture" is being encouraged "as a fundamental second step of the coming-out process. This means alienation from the culture at large, as well as separation from family, friends, and loved ones with whom the homosexual man formerly identified." (Nicolosi, p. 145) According to Nicolosi, reacculturation "merely reinforces the original childhood response of defensive detachment, in which the prehomosexual boy's solution was to split his identity from a rejecting father. In reacculturation, this intrapsychic split is projected onto society - for reacculturation is actually defensive detachment on a social scale." (Ibid.) Nicolosi labels as "tragic" the attempt "to build a new identity - worse yet an entire culture - around one's gender-identity incompleteness." (Ibid.)

41. Ibid., P. 12.

42. Ibid., p. 6, "Forgotten is the homosexual who, out of a different vision of personal wholeness, legitimately seeks growth and change through the help of psychotherapy. Unfortunately, these men have been labeled victims of psychological oppression rather than the courageous men they are, committed to an authentic vision." (Ibid., p. 12).

43. Ibid., pp. 5-6.

44. For example, Haldeman writes that "state psychological associations have started to address the issue of conversion therapy, to provide reasonable guidelines to consumer and practitioner. In 1991, the Washington State Psychological Association adopted an advisory policy on sexual orientation conversion therapy. Here, this policy is stated in part: 'Psychologists do not provide or sanction cures for that which has been judged not to be an illness. Individuals seeking to change their sexual orientation do so as the result of internalized stigma and homophobia, given the consistent scientific demonstration that there is nothing about homosexuality per se that undermines psychological adjustment. It is therefore our objective as psychologists to educate and change the intolerant social context, not the individual who is victimized by it. Conversion treatments, by their very existence, exacerbate the homophobia which psychology seeks to combat.' (Washington State Psychological Association, 1991)" (Haldeman, "The Practice and Ethics of Sexual Orientation Conversion Therapy," p. 226) According to Murphy, "There would be no reorientation techniques where there was no interpretation that homoeroticism is an inferior state, an interpretation that in many ways continues to be medically defined, criminally enforced, socially sanctioned, and religiously justified. And it is in this moral interpretation, more than in the reigning medical theory of the day, that all programs of sexual reorientation have their common origins and justifications." (Murphy, "Redirecting Sexual Orientation: Techniques and Justifications," p. 520) The National Association of Research and Therapy of Homosexuality (NARTH) recently reported that the American Psychological Association remains active in its attempt to gain support for a resolution aimed at discouraging conversion therapy. (E. Mark Stern, "Results of the A.P.A. Meeting; A Personal Report," *NARTH Bulletin,* Vol. III, No. 2, 1995, p. 1).

45. Arnerich, "Dialogue: Joseph Nicolosi on Therapy for Homosexuals," p. 12.

46. Some of these groups include Exodus International, Metanoia Ministries, Outpost, Homosexuals Anonymous, Regeneration, and the Roman Catholic Organization, Courage. (Harvey, *The Homosexual Person,* p. 126.).

Bibliography

Arnerich, John Paul
"Dialogue: Joseph Nicolosi of Therapy for Homosexuals," *National Catholic Register*, Studio City, CA: Circle Media Inc., October 20, 1991, p. 12

Bootzin, Richard R.; Acocella, Joan Ross; Alloy, Lauren B.

Abnormal Psychology, New York, NY: McGraw-Hill, Inc., 1993.

Cavanagh, John R.
Counseling the Homosexual, Huntington, IN: Our Sunday Visitor, Inc., 1977.

Dunkle, John H.
"Counseling Gay Male Clients: A Review of Treatment Efficacy Research: 1975-Present," *Journal of Gay & Lesbian Psychotherapy,* Vol. 2 (2), Binghamton, NY: The Haworth Press, Inc., 1994, pp. 1-19.

Garanzini, Michael J.
"Psychodynamic Theory and Pastoral Theology: An Integrated Model", *Journal of Homosexuality,* Vol. 18 (3), New York, NY: The Haworth Press, Inc., 1989, pp. 175-94.

Goff, J. Larry
"Sexual Confusion Among Certain College Males", *Adolescence,* Vol. XXV, No. 99, San Diego, CA: Libra Publishers, Inc., Fall, 1990, pp. 599-614.

Gordon, Peter
"The Politics of Homosexuality", *Sexual and Marital Therapy,* Vol. 5, (1), Oxfordshire, England: Carfax Publishing Company, 1990, pp. 7-8.

Haldeman, Douglas C.
"The Practice and Ethics of Sexual Orientation Conversion Therapy", *Journal of Consulting and Clinical Psychology,* Vol. 62, No. 2, Washington, D.C.: American Psychological Association, 1994, pp. 221-227.

Harvey, John F.
The Homosexual Person, San Francisco, CA: Ignatius Press, 1987.
"The Impact of Gay Propaganda Upon Adolescent Boys and Girls", *The Priest,* Vol. 36, No. 3, Huntington, IN: Our Sunday Visitor, Inc., March 1980, pp. 15-24.

Layland, W. Ralph
"In Search of a Loving Father," *International Journal Psycho-Analysis*, Vol. 62 (2), London, England, Institute of Psycho-Analysis, 1981, pp. 215-223.

Murphy, Timothy F.
"Freud and Sexual Reorientation Therapy", *Journal of Homosexuality*, Vol. 23 (3), New York, NY: The Haworth Press, Inc., 1992, pp. 21-38.
"Redirecting Sexual Orientation: Techniques and Justifications", *The Journal of Sex Research*, Vol. 29, No. 4, Mount Vernon, IA: The Society for the Scientific Study of Sex, Inc., 1992, pp. 501-523.

Myers, Michael F.
"Counseling the Parents of Young Homosexual Male Patients," *Journal of Homosexuality*, Vol. 7 (3), New York, NY: The Haworth Press, Inc., 1982, pp. 131-43.

Nicolosi, Joseph
Reparative Therapy of Male Homosexuality, Northvale, NJ: Jason Aronson, Inc., 1991.

Ratzinger, Cardinal Joseph
The Pastoral Care of Homosexuals, Battleford, Saskatchewan: Marian Press, 1987.

Saia, Michael R.
Counseling the Homosexual, Minneapolis, MN: Bethany House Publishers, 1988.

Seper, Cardinal Franjo
Declaration on Certain Questions Concerning Sexual Ethics, Boston, MA: St. Paul Books & Media, 1975.

Shannon, Joseph W. and Woods, William J.
"Affirmative Psychotherapy for Gay Men," *Counseling Psychologist*,

Vol. 19, No. 2, Newbury Park, CA: Sage Periodicals Press, 1991, pp. 197-215.

Sobocinski, Michael R.
"Ethical Principles in the Counseling of Gay and Lesbian Adolescents: Issues of Autonomy, Competence, and Confidentiality," *Professional Psychology: Research and Practice*, Vol. 21, No. 4, Arlington, VA: American Psychological Association, Inc., 1990, pp. 240-247.

Stern, E. Mark
"Results of the A.P.A. Meeting; A Personal Report", *NARTH Bulletin*, Vol. III, No. 2, Encino, CA: National Association of Research and Therapy of Homosexuality, 1995, pp. 1,3.

Sturgis, Ellie T. and Adams, Henry E.
"The Right to Treatment: Issues in the Treatment of Homosexuality," *Journal of Consulting and Clinical Psychology*, Vol. 46, No. 1, Washington, D.C.: American Psychological Association, 1978, pp. 165-169.