



# *What I Wish My Pastor Knew About ...* **Same-Sex Desire**



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Heather Looy is a Professor of Psychology in Edmonton, Alberta, who studies the biopsychology of human sexuality and gender. She is the co-author (with Heidi Campbell) of *A Science and Religion Primer* (Baker, 2009).

As I crossed the stage at my high school graduation, my biology teacher leaned forward and whispered loudly, “Don’t drop your stethoscope!” Twelve years later I was a doctor, but without the stethoscope—I ended up with a Ph.D. in biopsychology. Life journeys rarely take us where we expected to go; instead we may travel where we needed to go.

My dream of becoming a medical doctor was born of my fascination with human bodies and especially with how embodiment and experience are intertwined. I saw medicine as a means to bring healing to the whole person, to acknowledge and work with the intimate relationships between mind, soul, and body. I knew that Western medicine tended to take a very mechanistic view of bodies and health, but in my youthful enthusiasm and naïveté I believed I could navigate the years of training untainted by such reductive views. It may seem strange that a then-18 year old would think this way, but I was born with a questing and questioning spirit and raised in a family that encouraged this kind of thought and analysis. I was a rather serious young adult!

During my first two undergraduate years I studied at King’s, a small Christian liberal arts university, and in that context my confidence in my dreams grew. Once I transferred to the large secular Queen’s University to finish my pre-med degree, this confidence waned. I worked daily with classmates who were motivated by the status of medicine and were fiercely competitive, to the point of stealing answer keys and library books to prevent others from succeeding. Some of my professors fueled the competitive fires by grading on a curve and apparently deliberately teaching to produce high failure rates. Also, one of my faculty mentors from King’s gave me as a farewell gift a book telling the story of a woman in medicine who ultimately quit the field because of her discouragement with the unwillingness of the medical establishment to think holistically about health and healing. I began to wonder whether pursuing medicine would result in me either compromising my principles and vision or becoming deeply disillusioned.

At the same time, I took a course in biological psychology, and discovered that here was an entire field focused on understanding the meaning of embodiment for the whole person! While biopsychology wouldn’t allow me to work on the ‘front lines’ with people seeking healing, it would enable deep explorations that might challenge the medical status quo.

It was not an easy decision to change directions, but I knew that I was flourishing in biopsychology and fretting—even though I was doing well academically—in my pre-med courses. If I were to make that decision today, I probably would have chosen medicine because in the 25 years since that fork in my road medical training has, in many places, changed significantly for the better. However at the time it seemed that the Spirit was nudging me in a new direction. And I did—and still do—love biopsychology.

Early in my graduate studies I discovered a passion for the biopsychology of human gender and sexuality. How fascinating to learn how genes, hormones, intrauterine environments, and socialization after birth literally weave us into gendered and sexual beings! What profoundly embodied gifts, tugging us into deep relationship, fruitful, and modeling faithfulness and grace. And how deeply limited, distorted, and broken is our vision and experience of gender and sexuality. Here was a place where my studies in biopsychology could provide serviceable insight into a core aspect of our being that is powerful and deeply mysterious.

One great mystery is how we come to desire particular people. Our culture has framed this question in terms of the *gender* of the one who desires and the one who is desired. Thus we speak of people who desire women and those who desire men. We refer to this as a person’s *sexual orientation*. The question I address in this article is whether it is ethical to suggest or promote therapy to assist people who would like to—or feel they must—change their particular sexual orientation.

It seems on the surface a very simple question. Why *not* offer therapy to those who desire change? However pursuit of an answer leads into a labyrinth of complexly interconnected observations, science, politics and worldviews. I cannot offer here an exhaustive examination of all the relevant aspects of this story. Instead I will focus on a few elements I believe to be central: The context, the science, and especially the complexity hidden behind our gender categories. Be warned: There are no easy answers.

I come to this topic not only as a biological psychologist interested in human sexuality and gender, but as a professor and friend who has walked with and listened to students, family members, colleagues, and friends who encounter same-sex attraction in themselves or people they are close to. I believe it is vitally important that we recognize and remember that we are not speaking merely of abstract concepts, but about real human beings, with names and communities, commitments and questions. We are speaking of ourselves, of our families, co-workers, friends, neighbors, and sisters and brothers in Christ. Even if we don't have tidy answers, we can still seek increased understanding and translate that understanding into effective ministry.

### **The Context and the Story**

Why not offer treatments to help people with conditions that they find distressing? Many people seek therapy for various psychological and neurological conditions, going to psychologists or psychiatrists and being treated with anything from drugs to exercise to talk therapy. We trust these professionals to tell us what is wrong, and what options are available to deal with the problem.

Imagine then Sam, a young man, 19 years old, who comes to a psychologist and confesses that, despite trying very hard for many years, he just isn't sexually attracted to women. It's other men who really turn him on. As far as he knows, no-one else in his community has this experience. His parents have started pressuring him to bring home a 'nice young woman,' and all their expectations for the future center around his

marrying and eventually starting a family. Yet he has absolutely no desire to do so if it involves being intimate with a woman. He doesn't know what to do with these feelings, and he comes to you, asking "What is wrong with me?"

Until about 40 years ago, any North American mental health professional would have answered this question by saying that the problem *is* the same-sex erotic desires. They would have diagnosed Sam with a type of 'sexual deviation' called homosexuality<sup>1</sup>. The goal of therapy would be both to reduce the same-sex erotic attractions and also to increase hetero-erotic desires...or at least, enable Sam to 'function heterosexually.'

Between 1971 and 1975, the major professional mental health organizations such as the American Psychiatric Association and the American Psychological Association dramatically and officially altered their view of same-sex attractions<sup>2</sup>. They removed homosexuality as a diagnosable mental disorder after being pressured to get past unquestioned assumptions and to pay close attention to the data<sup>3</sup>. These data consistently show that having homosexual desires, in contrast with genuine mental disorders, "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."

Today the received view is that (a) homosexuality is not a mental illness, (b) people who experience distress at their same-sex attractions are actually experiencing an internalized homophobia or live in a context hostile to homosexuality, and (c) sexual orientation is a stable trait, not amenable to change. One 'discovers' one's sexual orientation, one does not choose it. These organizations work hard to encourage all countries to repeal laws that criminalize homosexual behavior between consenting adults, and to remove the stigma associated with same-sex desires.

If our young man Sam came to a mental health professional today, he would most likely be told that he did not have a mental disorder. The only problem Sam has is his distress, depression, or anxiety about his same-sex desires, not the desires

themselves. Therapy would focus on helping him fully discover his sexual orientation, accept his sexuality, and find ways to live with integrity. There would be no suggestion that Sam should attempt to alter his attractions.

But let's imagine that Sam is a devout and committed member of a religious community that happens to have a clear and strong position that same-sex desires are inherently or objectively disordered,<sup>4</sup> and that it is sinful to engage in same-sex fantasies or behaviors. Sam shares these views<sup>5</sup>. Yet Sam's desires are very strong. He aches for intimate relationships, but with other men. He despairingly pictures a future of deep loneliness and isolation.

He could simply admit to himself and his community that he has these same-sex desires, and, like the alcoholic, pledge and seek support to remain forever celibate, meeting his relational needs through nonsexual friendships. This is much easier said than done, as the longing for intimate physical connection is powerful, and we also live in a culture in which real intimacy outside of sexual relationships is difficult to achieve. Celibacy has also generally been considered, for those who have the physical capacity to engage in sexual behavior, a calling or gift, not a prescription or treatment. But Sam also longs to fulfill his own and his community's expectations that he marry and have a family. He wants to want these things, and yet the thought of heterosexual intimacy leaves him cold. He doesn't think this would be fair to any woman he married.

What is a young man in this situation to do? Where does he go for help?

He may turn to organizations such as Exodus International (<http://exodusinternational.org>) or NARTH (National Association for Research and Therapy of Homosexuality, [www.narth.com/](http://www.narth.com/)), or to therapists such as Joseph Nicolosi at the Thomas Aquinas Psychological Clinic (<http://www.josephnicolosi.com>), that provide support for people in this dilemma. These and many similar organizations are run and supported

primarily by evangelical Christian Protestants in the U.S.

Exodus and NARTH offer support to people with same-sex desires who live in and embrace the values of communities that view these desires, or their expression, as immoral. They help them to "make peace with, and decisions about, their irreconcilably conflicting life choices and chances" (Diamond, 2003, p.430).

However, these organizations go further than offering ways to cope: they offer hope that same-sex desires can be changed. For example, the headline on Joseph Nicolosi's page reads: "You don't have to be gay."

Several multi-modal types of therapy are offered to help people change their sexual orientation, collectively known as 'reorientation' or 'conversion' therapies. Both APAs and many other organizations are concerned that these therapies may be unethical because they offer a promise that cannot be kept. They argue that there is no good scientific evidence that such therapies work, that they can result in despair, shame, and self-blame when clients fail to experience real change, and that simply advertising such therapies contributes to a climate of negativity about same-sex desires.

On the other hand, proponents of reorientation or conversion therapies counter by claiming that literally thousands of clients have not only come to peace with their same-sex desires, but have experienced a reduction in those desires, and that many have gone on to maintain successful heterosexual marriages.

What are we to make of these apparently conflicting claims? The answers are critical, because before we can consider whether a therapy is *ethical*, we need to know whether or not it is *effective*. While efficacy is not a sufficient condition for declaring a therapy ethical, it is certainly a necessary one.

**Current Scientific Evidence and Understanding about Conversion Therapies**

So what does the scientific evidence tell us? As it turns out, the answers are actually not very clear.

***Do they pose a risk of harm?***

Let’s start with research examining whether conversion therapies present a significant risk of harm to clients. Strong supporters of conversion therapies have conducted studies that examine both the retrospective reports of clients after they have completed therapy, and also the perspective of therapists who administer such therapies. They conclude that whether or not clients experience actual change in same-sex desires, clients are generally better off in many ways post-therapy (Byrd, Nicolosi, & Potts, 2008; Nicolosi, Byrd, & Potts, 2000). A study conducted by researchers more skeptical of such therapies also reports, on the positive side, that even when clients fail to experience a change in same-sex attractions, some report increased “feelings of fitting in, strengthened emotional (nonsexual) same-sex relationships, congruence between sexual feelings and personal values, and improved gender identity” (Cramer, Golom, LoPresto, & Kirkley, 2008, p. 99). However, Cramer et al. also reviewed a wide range of studies on this question, and concluded that despite some positive results, overall there is strong evidence of numerous disturbing negative outcomes. They include: long-term sexual dysfunction, lowered self-esteem, elevated self-hatred, loss of family and religiosity or anger at family and community, elevated depression and anxiety, suicide attempts, spiritual crises, phobic anxiety of attractive same-sex persons, increased aggression/hostility, and frustration at wasted time and resources (see review by Cramer, et al., 2008).

***Do they effectively alter sexual orientation?***

The central tenet of conversion therapy is the claim that it can produce significant shifts in sexual orientation, moving a person from a primarily homosexual to a primarily heterosexual orientation. Is there any evidence that this is possible?

Such therapies have been around for a long time, and were particularly widely-used in the 1940s through the 1970s, especially before the 1973 APA decision to declassify homosexuality as a mental disorder. They include everything from surgery to hormone injections, psychoanalysis, and behavior therapies. Behavior therapies include aversion conditioning and covert sensitization. Aversion conditioning involves pairing aversive stimuli, such as painful electric shock or nausea-inducing drugs, with homoerotic stimuli. Covert sensitization is a little less direct; here the client imagines the undesirable behavior and also imagines a negative consequence (such as being publicly humiliated). Both techniques have long been popular for the treatment of sex offenders so their application to same-sex desires was a natural extension. While surgery and hormone treatment are no longer used, psychoanalytic and behavior therapies continue to be offered under the umbrella of conversion therapy.

*Reparative therapy* is the most well-known and widespread form of conversion therapy. Clinical psychologist Joseph Nicolosi developed this therapy out of his theory of the cause of male same-sex attraction. In brief, working from a psychoanalytic perspective, he argues that young boys who do not behave in gender-typical ways are often rejected or ridiculed by parents and peers, and come to feel inferior to other boys. They internalize the belief that they are not ‘real boys’ and thus engage even further in ‘gender inappropriate’ behavior. These boys develop same-sex attractions because they are seeking “from other males the masculine qualities [they] believe are lacking in [themselves]” (Nicolosi & Byrd, 2002, p.939). “Repairing” this internalized sense of failure as a male should, according to Nicolosi, result in the disappearance of same-sex attractions .

Not all conversion therapies assume this particular developmental path toward male same-sex attraction, but they all do assume that there is something disordered about a person’s gender identity and/or relationships with same and other-sex parents.

There is a small academic literature assessing the success of conversion therapies in changing sexual orientation. Reviews of this literature (Adams & Sturgis, 1977; Cramer, et al., 2008) show that there is such diversity of sampling, methodology, and measurement that it is actually difficult to determine whether any of it was really successful.

In the research, “success” is defined in various ways: Some reduction in same-sex attractions, desires, fantasies, or behaviors; increases of interest in the other sex; an ability to engage in heterosexual sex. And even when “success” is achieved, its meaning can be ambiguous. A decrease in same-sex erotic desires does not necessarily reflect a shift toward heterosexuality: it may simply reflect an overall reduction in libido. When shifts are obtained in the heterosexual direction, stressful events can trigger a shift back in the homosexual direction, in some cases threatening marriages and families that were formed as a result of encouragement by the therapist (Borowich, 2008).

Studies also varied in how long after therapy the changes were assessed—in most it was immediately after therapy concluded; in some, it was a few months. None reported on effects a year or more later. Only one recent study focused solely on individuals who reported a change lasting at least five years (Spitzer, 2003).

A very few studies used physiological measures, where sexual response to homoerotic and heteroerotic stimuli was assessed. Most of them used retrospective self-report measures. Data from retrospective and self-report techniques are notoriously difficult to interpret, because people who have invested time, money, and emotional energy into a particular therapy are highly motivated to perceive and report significant changes as a result of treatment.

Not surprisingly, uncontrolled studies report higher success rates than controlled studies. These uncontrolled studies include one retrospective survey of nearly 900 clients of

reparative therapy, in which a significant percentage reported a perception that their same-sex desires had diminished over the course of the therapy (Nicolosi, et al., 2000). Another recent and widely publicized study of the efficacy of conversion therapy was by Robert Spitzer, the psychiatrist who led the movement to remove homosexuality as a mental disorder back in 1973. He recruited only those individuals who *had* experienced a change in sexual orientation, mainly from reparative therapy and ‘ex-gay’ organizations. He managed to find 200 individuals who retrospectively reported that their same-sex attractions were reduced, and had remained reduced for at least five years, over the course of what was, on average, 5 years of therapy (Spitzer, 2003). It should be noted that it took Spitzer several years and persistent effort to find his participants, and that the majority (78%) were strong and outspoken advocates of the value of reparative therapy.

One early group of reviewers concluded that “although sexual reorientation techniques have achieved moderately positive results, research is sorely needed on ways to improve the efficacy of the procedures. The procedures involved do not yet operate at a level of sophistication and validity that will allow clinicians to place much faith in the procedures and use them in a competent manner, assured of the potential for success” (Adams & Sturgis, 1977, p. 1186). Things have not improved since that review. Current American Psychological Association’s ethical standards and guidelines for therapists require that therapies meet the criteria for ‘Empirically Supported Treatments’ (EST) and another more recent set of reviewers, who included the studies by Nicolosi and Spitzer noted above, concluded that “[conversion therapy] appears to... lack an empirical basis as a treatment option” (Cramer, et al., 2008, p. 102). Spitzer himself concluded that while some strongly motivated individuals appear to have successfully shifted their desires toward the heterosexual end of the spectrum, none reported a complete loss of same-sex attractions, and more important, he believed that his sample represented an unusual subset of the many

thousands of individuals who have been sought change through conversion therapies.

In other words, there is no good evidence that conversion therapy works reliably to change sexual orientation, and considerable evidence that it can cause harm.

What then are we to do with studies and anecdotes and other claims that some people do experience changes in their sexual orientation? Are they all lying?

That seems unlikely. Something else must be going on.

### What is “Sexual Orientation”?

In order to explore this question, we need to press more deeply into what exactly we mean by ‘sexual orientation.’

The usual definition, promoted by the American Psychological Association, is that “sexual orientation refers to an enduring pattern of emotional, romantic, and/or sexual attractions to men, women, or both sexes. Sexual orientation also refers to a person’s sense of identity based on those attractions, related behaviors, and membership in a community of others who share those attractions.”

While the APA asserts that sexual orientation is an enduring characteristic of a person, it acknowledges that recognizing, integrating, and expressing one’s sexual orientation is a lifelong developmental process.

As a scientist, I find this definition problematic, because it seems overly complex, and to conflate several different aspects of identity and behavior.

Let’s unpack it a bit.

This definition of sexual orientation draws together sexual and romantic/affectional feelings, gender identity and role, sexual behavior, and social identity. The assumption is that all of these things are normally wrapped up in a singular

package, so that if you know something about one of them, you can predict all the others. The expected combination is that, if you are female, you will have a female gender identity and role, be sexually attracted to men, only fall in love with men and interact sexually with them, and identify as heterosexual (straight). Alternatively, if you are a man who is sexually attracted to men, it is assumed that you will also be invariably affectionally attracted to men, engage in homoerotic behavior, and identify as gay.

Recent research challenges this package and suggests that it makes more sense to view these dimensions as somewhat interconnected, but also somewhat independent.

To clarify this, let’s start with identifying the diversity of sexuality we know is present among people. The relative proportion of same-sex to other-sex desires, fantasies, and behaviors varies along a continuum (sometimes called the Kinsey Scale). Although we tend to categorize people into three groups—homosexual, bisexual, and heterosexual—for convenience and research purposes, it’s important to recognize that these categories don’t really exist in nature.

While there is evidence that some people shift along this continuum over their lifetime—women more often than men—it’s very important to distinguish between something that can change and something that can be changed. In other words, these shifts in sexual desire may not be amenable to deliberate, conscious efforts.

It’s also important to recognize that even the Kinsey Scale conflates sexual *feelings* with sexual *behaviors*.

These sexual *feelings* may be more stable than any other aspect of sexual orientation. This is certainly the view based on current research. Whatever else changes, your core desires or core capacities for erotic arousal/attraction are viewed as unchangeable, part of your essential makeup. While this may make intuitive sense, it does reflect a rather reductive view of erotic desire—as if it is something that wells up within us, not as

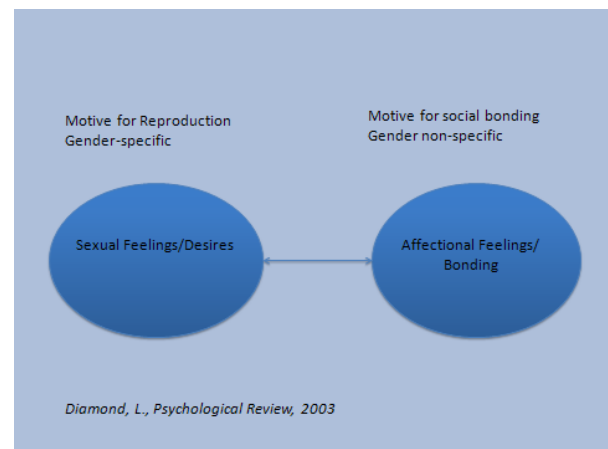
something that might be somewhat amenable to social influence. Nevertheless, this position is consistent with research that shows that erotic desires are experienced as emerging sometimes even despite conscious choice and socialization, as happened with Sam.

Yet, despite a huge literature on this question, nobody really knows how a person comes to have particular sexual desires. Nicolosi's 'reparative-drive' theory is only one of many theories. There is evidence for a role for genetic factors and prenatal hormones or antibodies, in interaction with various subtle and complex processes during development and socialization, and a growing consensus that there is more than one path through which a person might develop same-sex attractions (Bailey, Dunne, & Martin, 2000; Diamond & Savin-Williams, 2000; Looy, 1995).

The very definition of sexual orientation assumes that people can be clearly categorized in terms of gender (woman or man) and that sexual desires are gender-specific. But both assumptions are problematic (Looy, 2005). Gender identities are not neatly divided into female or male, but show diversity within and overlap across categories. Further, people are not automatically sexually attracted to any and every member of a particular gender, but to specific individuals. Sometimes people are sexually or romantically or affectionally attracted to individuals who happen to be of the other gender and at other times, people of their own gender (Diamond, 2003).

As well, the relationship between having same-sex desires and one's *sexual identity* is not linear. Sexual identities are social categories that people adopt based on a complex range of factors (Yarhouse & Tan, 2004). Some with strong same-sex desires never identify as gay or lesbian; some with a mixture of same-sex and other-sex desires may identify as bisexual, gay or straight. People also occasionally *change* their sexual identity over their adult life, whether or not their basic desires change. This is particularly true for women, but can also occur for some men.

These observations have led to a distinction between sexual and affectional feelings (Diamond, 2003). *Sexual desire* is the basic motivational state facilitating reproductive behavior. It is usually gender-specific—one can, after all, only reproduce with a member of the other sex. *Affectional feelings* are understood as rooted in the infant-caregiver bonding process that is so essential for the human infant to survive and thrive, and serve throughout the lifespan to motivate the social alliances and networks we need to function in community. Affectional bonding is *not* gender-specific. We can “fall in love” or “fall in friendship” with people of either gender.



Because these somewhat independent processes are interconnected, however, it is possible for sexual attraction to precede, accompany, or follow such “falling in love.” Thus, one might “fall in friendship” with someone of one’s own gender and then, especially in a person whose core sexuality includes the possibility of same-sex desire, trigger a sexual dimension to the friendship. However, sexual desire is by no means a necessary component of a loving relationship.

In light of all of these observations, it seems far too simplistic to equate love with sex and to reduce sexual orientation, broadly speaking, to two categories of gender (Diamond, 2003; Looy, 2005). There is evidence that, for example, a woman who thinks of herself as ‘straight’ may for

a period find herself in love with, and sexually attracted to, another woman; while a man who identifies as ‘gay’ might happen to fall for a woman. Despite changes in behavior, these individuals may not change their sexual identity. Human romantic/sexual relationships and friendships are nuanced and complicated, involving many dimensions of the person and of behavior and experience.

Thus it is perhaps not too surprising that reports keep surfacing of people changing some aspects of their sexual orientation. When people report changes in their sexual orientation they may be reporting changes in their fantasies (which are under conscious control), their behavior, their affectional ties, or their social identity—whether or not the core erotic desires have been altered. It may also be the case that many who report successful experiences with conversion therapies have sexual desires that lie somewhere between the extremes on the Kinsey continuum, and have managed to focus on or develop the heteroerotic aspect of those desires. Further, the discovery and acceptance of the idea that love doesn’t always include sexual attraction may enable some people to engage in fulfilling committed relationships despite a lack of sexual interest. Finally, it may even be the case that Nicolosi’s reparative drive theory accurately captures the history of *some* men.

The key conclusion here, however, is that any account of sexual orientation that claims to explain *everyone’s* story and provide the solution—whether full acceptance or reorientation—for *all* should be treated as suspiciously oversimplified.

### **Ethics of ‘Reorientation’ Therapies**

Let us return now to the original question: Is it ever ethical to offer therapy to support someone wishing to change his or her sexual orientation?

On the one hand, we have the mainstream psychological establishment arguing that sexual desires are a stable, immutable component of the personality, not unhealthy in and of themselves.

Based on these premises, offering therapy that promises to change healthy and immutable desires is logically viewed as unethical. However, this same establishment recognizes that sexuality is experienced in context, and that people may need support to find ways to integrate their sexual desires with their beliefs, values, and commitments. The guidelines for practitioners almost exclusively support ‘gay-affirmative’ therapies. Building on a fairly individualistic idea of psychological well-being, the goal is usually to help the client affirm their same-sex desires and if necessary, change, escape, or reject their stigmatizing communities.

On the other hand, we have the reorientation or conversion therapy organizations arguing that same-sex desires are objectively disordered, a sign of developmental wounding that cries out for healing. These organizations offer hope for genuine change of sexual desires. This is something the research suggests is occasionally possible, but rare, and even more rarely complete, and probably not amenable to deliberate change attempts. However, these organizations also offer support to people seeking ways to integrate their sexual desires with their beliefs, values and commitments. Further, they actually understand and agree with belief systems that view same-sex desires as problematic. For clients who share those belief systems, this can be an important aspect of the support they seek. Conversion therapists are not going to encourage clients to affirm their same-sex desires (though many do claim to be supportive if that is what clients ultimately choose). Rather they focus on a more communitarian idea that the individual’s desires are less important than the community’s values. For them, it is the better path to affirm the faith community’s values and if necessary, deny, control, or change the same-sex desires.

Which is the ethical choice?

The science isn’t going to help us here. No data about about sexual desires, identities, and behaviors can compel a particular set of moral and ethical conclusions. The controversy over the ethics of reparative versus gay-affirming therapies

necessarily draws on sources of knowledge and authority beyond scientific data.

Mainstream psychology works within an individualist worldview that affirms absolutely the values of autonomy and self-determination. More subtly, it expresses the belief that individual happiness is more important than, and can be attained apart from, one's family or community. The more marginal, explicitly faith-based reorientation organizations work within a more communitarian, authoritarian, and theocentric worldview that suggests that happiness and flourishing are best found when people live in obedience to commands presented as having divine authority.

Interestingly, however, these faith-based organizations use the language of autonomy and self-determination to argue for their right to offer their conversion therapies and the clients' rights to seek them out (Yarhouse & Throckmorton, 2002). And the major mental health organizations use the language of community, culture, and context to argue that the very fact that conversion therapies are offered creates an environment within which stigmatization and pressure on people with same-sex attractions to change continues, causing untold harm.

One thing the science tells us, however, is that presuming simple male/female, gay/straight categorical distinctions is inappropriate. Yet at this point in history, neither mainstream psychology nor conservative evangelical Christian organizations seem comfortable or prepared to deal with complexity in human sexuality and relationships. For both, love equals intimacy equals sex equals sexual identity. And yet, embedded in the approaches and statements of both is a recognition that loving, intimate relationships can come in many forms, and that sexual expression is but one facet of such relationships.

My own suggestions about what to do when the need to respond to issues of sexuality arises are based on having perused the research extensively, listened to arguments from many perspectives,

and talked intimately with many who deal with same-sex desires in themselves or their communities, including pastors.

1. Discussions about sexuality must occur in a context that acknowledges that the heart of the gospel message, the core Christian faith, is not being questioned. This is a place of agreement for everyone in the congregation.
2. Another element of the context is an acknowledgement that "it's complicated, so let's discuss it." The complexity of the science of gender and sexuality is echoed in the complexity of scriptural interpretation. Together, as sinful and limited human beings, we are called to humbly explore how best to live out the gospel in our time and place. We all love the Lord, and we all love the scriptures...let's figure out where we go from there.
3. Conversations need to be respectful, loving, and validate people's real concerns without requiring that everyone must agree. Discussion leaders need to model a sincere effort to listen to all perspectives.
4. All of the above suggestions actually apply to any issue, challenge or concern facing a congregation, not just those related to sexuality. Creating a climate within a congregation, community, or family within which many things are discussed with respect and grace means that when very difficult issues emerge, there is already a context and an understood culture.
5. *Listen.* Try to create safe spaces where people can speak of their experiences of sexuality and ask their questions without fear of shame or stigma. Be slow to judge or draw conclusions. Be honest about your own questions, and seek support and good information from those who have experience and wisdom on these topics. A wonderful resource is the Gay Christian Network (<http://www.gaychristian.net>), and its Canadian sister organization, New Directions (<http://www.newdirection.ca>). Catholics can seek support from Courage

(<http://couragerc.net>). These organizations make no promises about change in sexual desires, and focus entirely on support, friendship, spiritual growth, and integration of sexuality with other aspects of a person's identity. These are things that anyone, regardless of their sexual desires, could benefit from. They also provide materials to help families and congregations.

6. Be very wary of anyone or any organization who promises that one's sexual desires can be deliberately changed, and extremely cautious in suggesting that if a person only tries hard enough, or has sufficient faith, they will change. The evidence simply does not support this. Be further wary of anyone who claims to know *the* reason why people, or a particular person, has same-sex desires. The paths to such desires are complex and truly not understood.
7. Therapy and community support to assist people struggling with *conflicts* between sexual desires and faith commitments may be very helpful. The pain of one is the pain of all; try to avoid making same-sex desires simply one person's problem. As well, consider the extent to which this support might involve the community or congregation examining its own (often unquestioned) attitudes and beliefs about same-sex desires and relationships.
8. Remember that our North American culture too directly connects love and sex, reserves intimacy for sexual relationships, and views most touching between adults as sexual. In such a context, demanding celibacy of persons with same-sex desires can lead to deep isolation, and drive them into unhealthy sexual subcultures in an effort to alleviate loneliness. Consider ways in which you, or your congregation, can create spaces for deep friendships and warm touch in a nonsexual manner, if same-sex expression is not an option within your community.
9. Finally, keep in mind that gender and sexuality are only *part* of who we are. Nobody wants to be "the transgendered

person" or "the gay guy," nor do they wish to be treated as a mere means for sincere Christians to exercise charity. We are all whole, multi-faceted people with unique stories, and we are called to journey *together* in relationships characterized by mutual accountability, humility, forgiveness, and grace.

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<sup>1</sup> The Diagnostic and Statistical Manual of Mental Disorders (DSM), 2<sup>nd</sup> edition, published in 1968, listed homosexuality as a diagnostic category (302.0) under 'sexual deviation' (302) which in turn was classified under 'personality disorders not otherwise specified.'

<sup>2</sup> Position of the American Psychiatric Association: <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/Position-Statement-on-Homosexuality.aspx>. Position of the American Psychological Association: <http://www.apa.org/topics/sexuality/orientation.pdf>

<sup>3</sup> The story of how homosexuality was declassified as a mental disorder is described in detail in Ronald Bayer's book *Homosexuality and American Psychiatry*, and at [http://www.aglp.org/gap/1\\_history/#declassification](http://www.aglp.org/gap/1_history/#declassification). While the process was begun as a result of political pressure by gay and lesbian activists, the APA did not, as some today assert, simply declassify based on opinion and majority vote; the political pressure caused the organization to question previously unquestioned assumptions about the deviance of homosexuality and to examine, and conduct, the scientific studies needed to address this assumption. It is also important to remember that *all* mental disorders in the DSM are there as a result of ongoing science, accumulated knowledge, and scientific consensus, which changes as our understanding and theories about mental health change. In other words, what gets designated as a mental disorder is not merely an 'objective' decision based on 'the facts' but emerges as a result of historical, cultural, and philosophical dynamics in conjunction with scientific knowledge.

<sup>4</sup> <http://www.usccb.org/doctrine/Ministry.pdf>, and see also the Catechism of the Catholic Church, 2357-2359 for statements that are agreed-upon by many, though not all, Christian churches (<http://www.vatican.va/archive/ENGO015/P85.HT>)

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<sup>5</sup>Often, people like Sam actively question whether these desires *are* wrong, but for present purposes I'd like to keep the story simpler.