

# **Holistic Therapy: A Comprehensive, Clinical Approach to the Treatment of SSA**

by  
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## **I. Definitions**

- A. Holistic – Comes from the word Holism (from a Greek word meaning all, entire, total); is the idea that all the properties of a given system (physical, biological, chemical, social, economic, mental, etc.) cannot be determined or explained by its component parts alone. Instead, the system as a whole determines in an important way how the parts behave.
- B. Reductionism - Is often seen as the opposite of holism. Reductionism in science says that a complex system can be explained by reduction to its fundamental parts. Reductionists focus on discrete details as opposed to the whole picture. Holistic clinicians resist reductionistic thinking and emphasize the focus on the larger whole.
- C. Comprehensive – Wide in scope or contact; broad, extensive, not limited to one aspect.
- D. Clinical – Objective, not distorted by emotion, personal, or professional bias; based on observable phenomena; “an objective appraisal;” “objective evidence.”

## **II. Principles Underlying Holistic Therapy**

- A. Humans are complex, multi-dimensional beings, rather than unidimensional and simplistic. Holistic therapy posits that to describe clients as simply “SSA” limits our understanding of the overall dynamic of the person’s personality and overall clinical picture.
- B. Holistic therapy focuses on the whole person, as opposed to one aspect.
- C. The concept of individuality is essential in avoiding inappropriate “typing” or simplistic categorizing, as well as emphasizing the uniqueness of each human being.
- D. SSA is most often a component of an overall clinical picture, without which a complete understanding of the individual is not possible.
- E. Importance of case conceptualization is emphasized, as well as treatment that is driven by empirical data and not just intuition.

- F. A clinical holistic approach to treatment focuses on the need for both informal clinical as well as formal psychodiagnostic assessment.
- G. Carefully orchestrated treatment planning is essential, as is the need to be mindful of the importance of sequencing treatment strategies based on clinical priorities and interdependent dynamics of comorbid conditions.
- H. Holistic therapy usually requires an interdisciplinary team that deals with a wide range of conditions, utilizing a broad array of treatment approaches and strategies, as well as a well-developed resource network.
- I. Holistic therapy emphasizes the need for goals and ongoing assessment of goal attainment.
- J. Of paramount importance is an emphasis on hope, recovery, and the innate drive to heal.

### **III. Holistic Perspectives on Human Nature**

- A. Complexity – Personality, emotions, and sexuality are all complex issues and cannot be distilled into discrete unitary concepts. Specifically, to identify anyone as “gay” or “SSA” or “straight” is entirely too absolute and does not at all capture the complexity of the human experience.
- B. Multi-Dimensionality – People exist within multiple dimensions, of which some can exist in consonance or in conflict with others. In order to fully understand an individual, there needs to be a more complete understanding of these dimensions and how they interact with each other.
- C. Focus on the Whole Person – “The sum is much greater than its parts.” One cannot understand an individual in a comprehensive way by focusing on just one or even two aspects of the person’s psychology. We are a composite of the many parts of our selves – our personalities, behavior, biology, genetic history, interpersonal lives, spirituality, and sexuality. In order to fully appreciate an individual, we must integrate these discrete “parts” into an integrate, unitary “whole.”
- D. Individuality/Uniqueness – Each person has his/her own unique individuality – there are no two person who are exactly alike. Two people with SSA can be completely different in every other aspect of their lives and psychological makeup and cannot be grouped solely based on their common challenge. Similarly, OCD can manifest itself in countless different variations, subtypes, and combinations. Describing a group of individuals only in terms of OCD compromises and distorts the comprehensive and accurate clinical picture of each individual.

## ***Required Reading:***

### **What is Holistic Psychology?**

**By Daniel T. Moore**

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Sometimes a term is used without fully understanding what is implied by the term. Some people may use the same term but have different meanings associated with the concept. This is often the case when using the term Holistic Psychology. Below is an attempt to define Holistic Psychology in the way that Your Family Clinic uses the term. Several implications of using this term and recommendations for scientific inquiry will also be presented.

#### **Definition**

A whole is always greater than the sum of its parts. This is especially true when dealing with living organisms. Something alive and moving is infinitely different than the same organism dead. No matter what you do to a dissected frog, it will never be the same as when that frog was alive. Much of science today is trying to break down complex phenomena into simplistic explanations. When this is done, like the frog, the essence of the whole is often lost.

Psychology, a branch of science, faces the same dilemma. Current Psychology is limited to the study of mind, thought, and behaviors that are observable, measurable and objective. Science often attempts to reduce phenomenon or examine parts of behavior as opposed to looking at the whole as the object of study. The fact that objects of scientific study are always greater than a sum of its parts is often ignored.

It is difficult at best to account for all the factors that influence human behaviors. If we could add up all these factors, it still may be different than considering the phenomenon as a whole. Holistic Psychology attempts to consider human behavior in relationship to the organism as a whole. In this attempt, it incorporates other scientific disciplines (e.g., nutrition, medicine, neuro-biology, neuro-chemistry). It even considers scientific inquiry considered outside the realm of traditional science. Spirituality, intuition, health, social and economical influences, and even birth order may be important considerations when observing human behavior.

Applied Holistic Psychology attempts to apply knowledge from a variety of disciplines to accomplish parsimonious delivery of effective services to accomplish the client's goals. While it may never reach to goal of considering the individual as a whole, Holistic Psychology includes a variety of techniques and procedures that approximate that condition. It is believed that application of a holistic perspective will lead to better and more efficient forms of treatment than the way Psychology is practiced today.

#### **Limitations to the current system of Psychology**

Holistic Psychology probably developed as a reaction to the limitations of the

current system of Psychology. The American Psychological Association is probably the foremost authority on the current practice of Psychology and influences psychological endeavors throughout the world. It sets the standards of practice, ethical guidelines, and regulates the practice of Psychology. It also attempts to limit and restrict several areas related to the application of Holistic Psychology. The three major limitations of the current study of Psychology include: limited scope of study, forming biases to certain specialty areas within psychology, and a relatively slow dissemination of psychological discoveries. These three points will now be explained in further detail.

**Limited Scope of Study.** Psychology attempts to study phenomena that can be observed, measured, and quantified. There are many things that exist that are beyond our current ability to perceive, measure, and quantify. In reference to our frog analogy stated above, some of the “parts” that exist are not currently measurable given the status of today’s technology. When applied to human behavior, there currently exists unperceivable factors that may affect our mind, thought, behaviors, and intentions. To ignore them is to limit the effectiveness of psychology. To include them and to study them, theoretically should expand the effectiveness of Psychology. To include them is the essence of Holistic Psychology. Holistic Psychology is a term that was developed to broaden the science to include looking at the whole of human behavior and to consider some “parts” that have been overlooked or deemed as outside the realm of scientific inquiry for Psychology. Holistic Psychology integrates the current knowledge of psychology with the theoretical aspects of psychology that are considered outside the mainstream of scientific study. Researchers of Holistic Psychology are not adverse to scientific inquiry, it is that holistic psychology researchers consider the limitations of our current methods and use creative methods that are designed to consider the human being as a whole, operating on a number of factors that interplay with each other. They also look for new methods that can quantify previously unmeasurable phenomena that went beyond detection.

For example, some scientists feel that there is a wide range of matter that comprises the electro-magnetic spectrum. They theorize that if this spectrum were to stretch across the United States from Los Angeles to New York, the amount of that spectrum that humans are able to see, hear, feel and measure would be the width of an arm chair. They postulate that there exists much of the electro-magnetic spectrum that is still undiscovered. How much of this undiscovered electro-magnetic spectrum effects human behavior is totally unknown. However, some scientists are exploring the role of electro-magnetic energies or subtle energies on human behavior. The American Psychological Association (APA) does not recognize the use of subtle energies as within the realm of Psychology. Psychologists cannot receive APA approved continuing education units if they attend a conference or workshop on the use of subtle energies (e.g., Emotional Freedom Technique). While the American Psychological Association does not officially recognize this body of research and application, Holistic Psychology does.

Holistic Psychology does not limit itself to the study of subtle energies. It seeks to utilize all areas of discovery that affects human behaviors and/or the mind. There

may be factors of behavior that are currently undiscovered or have been ignored. These factors may be important to the healing of emotional and psychological problems.

For another example, under current Psychology, the placebo effect is viewed as a negative phenomenon. Studies of effectiveness are compared against a placebo. A researcher and/or practitioner utilizing principles of Holistic Psychology may choose to embrace the placebo effect, attempting to form models explaining the effect, or attempt to enhance the effect. In theory the practitioner could utilize the placebo effect to enhance the effectiveness of a currently demonstrated effective behavioral approach. The goal of such a practice would be to increase the effectiveness of that treatment approach to a wider variety of people and circumstances by maximizing the placebo phenomenon. This can be accomplished by expanding objects or phenomena to study, investigate and apply them for the betterment of the human condition.

**Biases.** There are several reasons why research is biased against the practice of Holistic Psychology. People who work in Universities have the time and resources to do research. Practitioners of psychology generally do not have the time and resources to do research. Often professors in an academic setting depend on the amount of research they do for their continual employment. For the advancement of alternative techniques, this is often more of an obstacle than a advantage because people tend to research what is in vogue so they can obtain grant money and have their research approved through the peer review system. Bias is created when only projects that are popular get funded. Funding sources are usually extremely limited in their scope of what is deemed worthy of funding. Currently, cognitive behavioral approaches appear to be easily funded. Even the "peer review" process is biased towards academia and the current theories that are popular at the time. Reviewers have preconceived attitudes about alternative approaches and can disdain an approach without knowing much about the technique.

For example, the leading expert in child attention deficit disorders makes negative comments about EEG neurofeedback for the treatment of ADHD. In spite of the many journal articles that show effectiveness of neurofeedback in ADHD treatment, he continues to state that the research is inadequate. When other scientists in the field are called upon to give evaluations about the merits of neurofeedback for the treatment of ADHD, they are biased about what they have read from the expert. Instead of taking the time to conduct experiments themselves, they do not. They simply parrot the biases of the expert. Even if they wanted to conduct the research, they would have a difficult time finding funding resources to do the work. If their work was completed and positive results obtained, they would have to overcome the biases of the reviewers who read the same statements from the expert in the field. Thus the advancement of neurofeedback techniques become delayed due to bias. Research could have been placed in making neurofeedback more effective and less time consuming or enhancing the techniques instead of trying to prove to bias people that it works. In the area of attention deficit disorders the current popular techniques are medication combined with cognitive behavioral approaches. There exists much money for research on these popular techniques. Almost no funding

exists for research on alternative methods for ADHD treatment.

Too much of psychological research is influenced or biased by the medical model. The medical model is backed by pharmaceutical companies which is an industry with one of America's highest profit margins. Even psychological journals display major advertisements by the pharmaceutical companies, a practice that was not common a decade ago. Many psychologists conduct their research in medical centers that are heavily funded by pharmaceutical companies. It could be argued that methods and treatments that are not in the best interest of pharmaceutical companies are lacking in representation of the spectrum of research currently being funded. To researchers of Holistic Psychology, this is a violation of ethics. Holistic Psychologists encourage medical research, but not at the expense of other research. Methods should be developed to broaden the types of research that receive funding.

This practice of funding often creates a double standard. Some APA members are stating that unproven techniques should not be used. If the technique has not been adequately researched, it should not be used on paying customers. Cognitive behavioral techniques and medical techniques have a strong research base. These areas of discipline wish that all theories and methods be held to this principle of research based treatment. Research is the foundation for getting many medications approved. However, many medicines used with children have not been approved by the FDA. Many medications that are commonly given to children have not been researched with children. Lack of research does not stop their use. Medications are even used for conditions that have not been researched in adults (e.g., Tenex to treat aggressiveness in children). Though this is a common practice, the same people condemn other professionals for using alternative techniques that have not been thoroughly researched. This hypocritical practice becomes ludicrous when one compares the possible side effects of medication with the possible side effects of benign alternative techniques (e.g., Emotional Freedom Technique to treat aggressiveness in children).

If we only utilized techniques that have been researched we assume that we have all the knowledge that we need to treat mental illness. If we look at our effect sizes, a statistical measure that helps determine treatment effectiveness, we can see that our treatments do not work for everyone. For example, antidepressant medications are not that much more effective than a placebo for treating depression. Yet individuals hooked on the medical model feels that anti-depressants combined with cognitive behavioral approaches is the only way to treat depression. Even with the combined psychotherapy, the effect size is not that great. Many people will still be depressed after the best researched treatment is given. Do we consider them hopeless or do we look for other methods to treat their depression. Holistic Psychology encourages an examination of the whole individual within the environment and treat the depression accordingly. This may necessitate the use of alternative treatments as well as traditional forms of therapy.

Most medical practitioners do not give up on depression if the first attempt fails. They will try a different type of antidepressant or even a different type of class of

medication to treat the depression, even those who have yet to be “proven” effective for depression. They will also run tests to see if the thyroid could explain the depressive symptoms. They usually will not include alternative models of healing, but they look for other ways to treat if they were unsuccessful the first time. Holistic Psychologists stress the importance of going a little bit further to consider alternative models early in the treatment planning. Not having biases towards treatments allows more options for consideration and hopefully a more effective delivery system that will increase treatment effect sizes.

**Slow dissemination of information.** Too often the distribution of useful scientific information is too lengthy. When new information is developed, the information takes too much time to reach the practitioners who use the information with individuals. Significant advances often take years to be implemented. Easy access to the results of scientific inquiry is limited to memberships and payment of fees. These practices may have been necessary in the past, but with the current availability of information, these practices slow down the advancement of knowledge. The cost of disseminating information has greatly decreased yet membership fees remain expensive and usually outside the reach of many practitioners. Much of the information obtained through psychological research is kept out of the public domain. This limits the advancement of Psychology.

### **Applied Holistic Psychology**

To further the advancement of Psychology, Holistic Psychology attempts to increase the scope of practice and study of psychology, attempts to cease the turf battles amongst practitioners, parsimoniously applies techniques from a variety of disciplines, and attempts to use modern techniques to disseminate knowledge and experiences related to Psychology.

**Increasing the scope of practice and study.** As mentioned previously, Holistic Psychology accepts all types of scientific endeavors. The aim of scientific inquiry is to learn truth. Truth is defined as the way things are, were, and are to come. Our understanding or belief about the truth does not change truth. Our understanding of truth may be limited or incomplete. Truth will continue to be as it is regardless of our understanding of it. For example, the science of chemistry has changed over the last twenty years. Most of the periodic chart has remained the same. Chemistry was able to keep the part of the understanding that was truth (the periodic table) and has added more truth as the science has become more advanced. The science of chemistry will continue to change as more scientific discoveries are made. The truth of chemistry did not change, only our understanding of the truth changed.

Psychology is not as advanced as chemistry. There is much more that we do not know about human behavior than what we do know. We have few evidences of truth advanced as far as the periodic table. Even Neuropsychology is at its infant stage. While we probably have a good description of brain anatomy, the knowledge of how the brain functions continues to elude scientific inquiry. The exact nature of brain waves and their benefit to the body is not completely understood. The relationship of the myofascial system with the nervous system has not been adequately illuminated or explored. How some people report memories during near

death experiences even when monitors display zero brain activity during the time of the memories is completely baffling. It is obvious that there is much that remains unexplored or unexplained.

Even though the amount of knowledge from a given scientific field is limited, Holistic Psychology attempts to apply the knowledge from many sources of scientific discovery. Nutritional sciences are often embraced within the realm of Holistic Psychology. Other sciences include medicine, homeopathy, acupuncture, and most of the other healing arts. Applied Holistic Psychologists often have to choose which sciences they consider important in their practice and which to exclude in their practice. Applied Holistic Psychologists often make referrals to a variety of healing art specialists.

**Reduction of biases and turf battles.** In an ideal world all theories and topics should have an equal chance at being studied. We feel we should work toward an ideal situation. Funding sources should broaden their perspectives to widen the scope of research. A relatively easy source of research is through Doctoral dissertations. Many of these dissertations go unfunded. Unfortunately, most doctoral students follow what is in vogue by the University or the chair of the student's dissertation committee. Encouragement should be given to explore outcomes of alternative treatments as well as traditional treatments.

The results of much outcome research suggest that research outcomes are often biased or influenced by the theoretical orientation of the researcher. A cognitive behavioral researcher will often find that their methods are superior to the medical model while a medical researcher will often find that medicine is superior to a cognitive behavioral approach. When orientation of the researcher is factored out, outcome research consistently demonstrates that most treatment approaches are equally effective for most mental health disorders.

For this reason, practitioners of alternative techniques should be involved in the design of the research. For example, a study may be overly biased if a cognitive behavioral researcher designed an outcome study on the effects of Energy Freedom Technique (EFT) on phobia. The practitioner of EFT should design the study that would ensure the true treatment effects are being isolated and not washed out due to a faulty experimental design. Additional research should examine specific factors that are necessary for a particular method or technique to be successful. Research should include the use of several techniques simultaneously on individuals and compare the outcomes with clients who had some of the treatments excluded. This type of research has been successfully performed with medicine and cognitive behavioral treatments. These techniques can be applied to alternative techniques as well. Even when such research is conducted, the individuals applying the research results must consider that when you study parts of something, it may be far different than considering the whole. Discovering what parts of a treatment approach will always come short of studying that treatment approach in the context of the whole.

**Parsimonious.** Parsimony means that treatment is to be provided through the



least restrictive method, the least evasive, the most conservative treatment, the treatment with the least amount of side effects, and the most cost effective. If a short behavioral treatment will accomplish the same objective as an extensive holistic procedure, then the short behavioral treatment would be preferred. A more intensive treatment should only be considered if less intensive treatments have failed and there is a clear theoretical rationale to use that treatment. For example, in the treatment of most children with Attention Deficit Hyperactivity Disorder symptoms, medications should be employed after the Stein Model (a parenting approach that uses behavioral principles) has failed. There may be certain environmental conditions, that may make medications the first line of treatment (a child in an home that the parents are unwilling or unable to apply the Stein Model). If the child's background demonstrates that the child has allergies and it is known that the child is much more hyperactive following the intake of a particular food, then a treatment model that accounts for allergies should be employed before using a parenting approach or prescribing stimulant medications. In the treatment of bipolar disorders with psychotic features, medication may need to be applied first until an alternative technique is identified that can be as responsive as medicine in controlling the manic symptoms. Efforts should then be made to reduce the amount of medication needed over time for that individual because of the severe long term side effects from mood stabilizing medications. Parsimony should be an important concept when applying treatment.

**Dissemination of information.** A better dissemination of research and information is currently utilized by the practitioners of electronic technology. With a few exceptions, we are currently under a free market economy for technology. While there exists a peer review process, this process does not significantly inhibit the change process for technological advancement. The process is driven by what works and what will be purchased by the consumer.

Similar models exist in Psychology but are not supported by the current establishment of psychology and are even seen in disdain. For example, Emotion Freedom Technique, EFT is viewed by American Psychological Association as not scientifically validated and unworthy of continuing education credits for Psychologists. Though the roots of EFT have existed for over thirty years, there continues to be a lack of research base for this technique. Still because of loss of sanction, many psychologists feel that their license is placed at risk for utilizing these techniques because these techniques could be viewed as falling outside the realm of a standard of practice. While they fear they are being unethical, it could be that it is unethical to continue to utilize techniques that are considered within the standard of practice that are less effective and more restrictive than the techniques offered by EFT and related theories. While their techniques have been shown effective on television programs, no formal research has been applied to their techniques. Advocates of EFT disseminate their findings through list serves, web sites, instructional CD videos and electronic newsletters. Their information can be found in the public domain and can be experienced by everyone.

This method of dissemination could work for other techniques and theories as well. A better way is to have a forum of what appears to be working. Psychologists could

report on what they do in their practice. Communication via list serves can help stimulate this development. Effective communication among practitioners and researchers and better dissemination could advance Psychology as fast as technology.

Efforts should be made to reduce the amount of political wars and territorial battles that exist in the current therapeutic community. When these systems are developed, participants can report significant changes and techniques that are effective under particular circumstances. As specific modalities gain in usage, more formal types of research can be applied. The people from academia with the assistance of a practitioner could then validate what is being used in the therapy session. This is the way that real advances are made in Psychology. Freud, who was trained in research, developed psychological principles and applied them, then the research came later. Many of today's academic researchers feel that the process should be reversed. They feel that only validated techniques should be applied in the clinical setting. This type of thinking only leads to stagnation and impedes creative discovery and development of better techniques. It assumes that our current knowledge is best and there is not much left to discover. Effective dissemination of useful information could significantly advance the practice of psychology and improve the human condition.

### **Summary and Conclusions**

Holistic Psychology rejects the reductionist point of view about the human condition. Holistic Psychology accepts the notion that the whole is greater than the sum of its parts. Theoretically there exist many factors about the human condition that are yet unmeasurable that influence our behaviors (e.g., subtle energies, components of the electro-magnetic spectrum, spirits, and faith). This phenomenon goes beyond superstition and may have more of an impact on behavior than is currently held by most individuals in professional practice, academia and research.

Even though there is probably more we do not know about Psychology than what we do know, we should still apply the knowledge that we have. Not to do so would result in the continual emotional suffering of millions of people. However, we should apply our knowledge with an open mind, open to the possibility of better and more efficient methods. We should also look for methods that are comprehensive. Service delivery should be done in the most parsimonious manner.

To increase effectiveness and comprehensiveness, Holistic Psychology attempts to combine the knowledge of other health related sciences such as nutrition, medicine, psycho-immunology, etc. Holistic Psychology attempts to further the development and application of Psychology by developing methods for the study of such phenomena and the dissemination of information. Holistic Psychology does not reject the advances of scientific research or any theory but graciously incorporates such knowledge into practice.

Currently, the progress of Psychology is too slow. It is inhibited by bias, politics, protectionism and ineffective dissemination of information. It is hoped that by embracing principles of Holistic Psychology within research and practice, more

effective advancements can occur that would significantly improve the condition of mankind.

#### **IV. Gender Disruption Theory**

Gender disruption theory is a comprehensive theory that attempts to explain the causes of same-sex attraction and homosexuality in all cases. At present, gender disruption theory (GDT) explains only male homosexuality. A corresponding theory for female homosexuality needs to be articulated.

Theoretical explanations and treatments of homosexuality date back to the work of Sigmund Freud, and much has been written on the subject over the years. Profiles of the most typical homosexual presentations have been amply articulated. The current prevailing theories and treatment models and applications are suited to these typical presentations.

However, the homosexual population is more diverse than common theory and treatment models account for in terms of life history and etiology, underlying personality structure, the nature of sexual impulses and attractions, and co-morbidity. A few examples of unexplained or poorly explained phenomena are outlined below.

- The object of any given individual's sexual attraction ranges from much younger (pedophilia, hebephilia, ephebophilia) to much older (gerontophilia) than the individual. This variety may be indicative of important etiological diversity and may require diverse treatment approaches.
- The interplay between same-sex and opposite-sex attractions has received insufficient attention. Many men with same-sex attraction have also experienced opposite-sex attraction at some point in their lives. On the other hand, some men in treatment experience a diminishing of same-sex attraction but do not experience subsequent development or increase in opposite-sex attraction.
- Some evidence suggests that obsessive-compulsive traits co-exist with homosexuality in a large percentage of cases. An unpublished in-house April 2009 review of cases in the author's (Matheson) own practice showed that 25% exhibited diagnosable OCD or OCPD with an additional 42.5% manifesting significant though sub-clinical obsessive-compulsive features. Together these represent two-thirds of those surveyed (N=40). Current theories and treatment models do not explain the role of OCD and OCPD in homosexuality. This may be leading to under-treatment.
- A small percentage of males with same-sex attraction report life histories or family structures that do not match prevailing etiological theories. Their

stories suggest a stronger role for associative learning in the development of homosexuality. This warrants further exploration.

- Co-morbidity is the rule, not the exception. In addition to obsessive-compulsive tendencies (mentioned above), mood and anxiety disorders, sexual and chemical addictions, post-traumatic disturbance, dissociation and Axis II disorders are quite common. This requires careful sequencing of treatments. Current treatment models do not properly account for this reality.

While each of the aforementioned phenomena have been observed by others, no one has yet developed a complete and unified theory of homosexuality that is capable of accounting for such a range of variables.

Furthermore, no one has yet created a unified system of assessment, diagnosing, treatment planning, and treating the full diverse population of those with unwanted homosexuality. Gender disruption theory attempts to provide such a system.

The theory presented here attempts to account for these and other factors within a single system. It proposes an interactive biopsychosocial model for the development of homosexuality and the blocking of heterosexuality. And it proposes a model for typing homosexuality according to a system that considers the assumed underlying causes, the object of sexual focus, and the nature of the sexual intention (e.g., to enjoy the body, experience connection, punish, etc.).

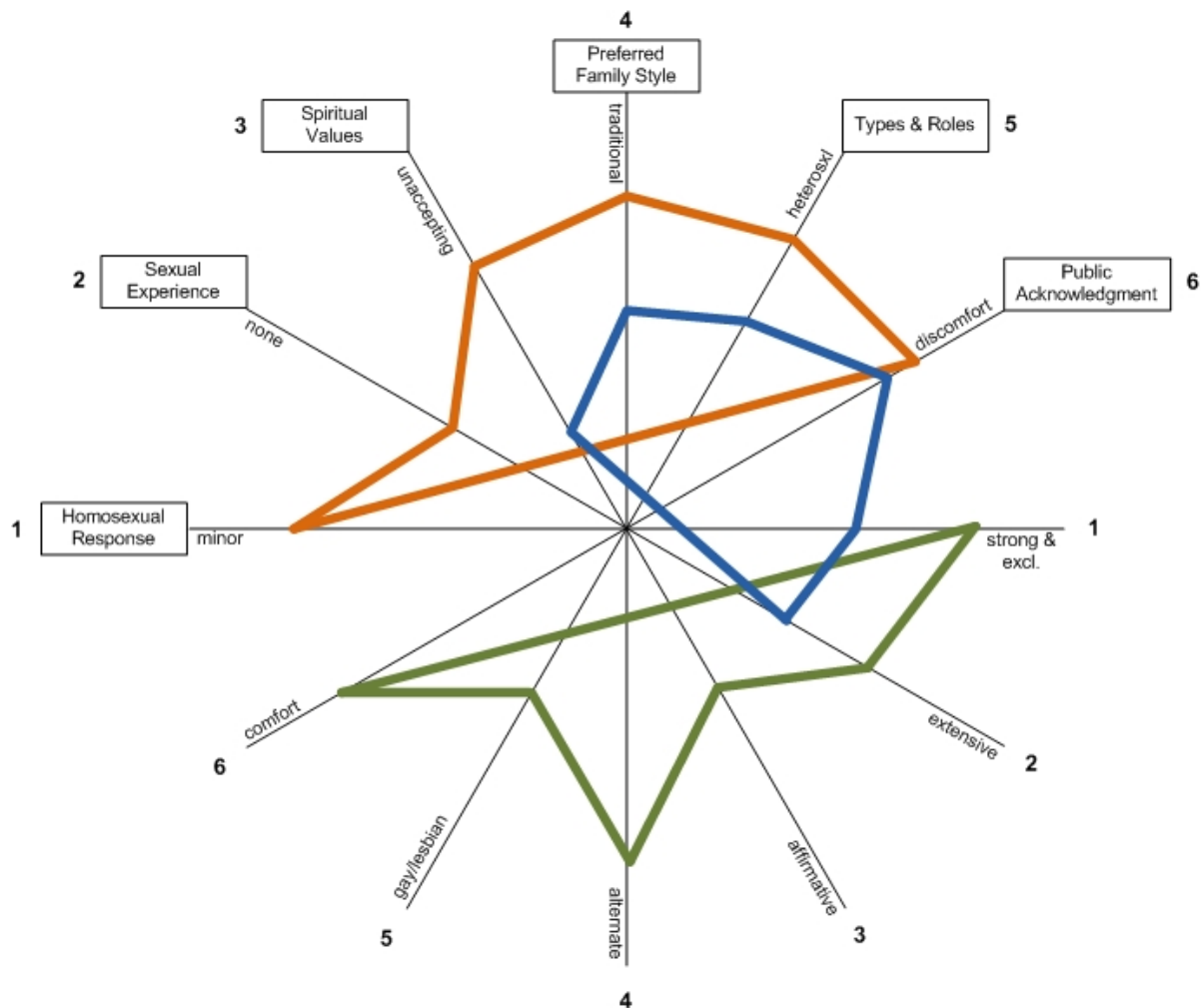
#### A. Recognition of Diversity

The population of individuals with homosexuality is extremely diverse. An understanding of this diversity is important before working with individuals who present with this issue. Several factors may be considered:

1. Degree of homosexual response
2. Extent of sexual experience
3. Spiritual values
4. Their preferred family style
5. Types and roles with which they resonate
6. Their comfort or discomfort with public acknowledgment

The hypothetical instrument on the next page uses a multi-axial display to graph these factors.

(Hypothetical Instrument)  
**Six Personality Factors for Same-Sex Attracted Men (6PF-SSAM)**  
 Multi-axial Display



**Hypothetical Case 1**—homosexual response (strong and exclusive), sexual experience (extensive), spiritual values (somewhat affirmative), preferred family style (strongly alternative), identification with types and roles (mostly gay/lesbian), and comfort with public acknowledgement (comfort). This person may be openly gay or lesbian, involved in a significant same-sex relationship, active in gay rights efforts, and fairly comfortable in his/her lifestyle although possibly experiencing social discrimination.

**Hypothetical Case 2**—homosexual response (low), sexual experience (minor), spiritual values (mostly unaccepting), preferred family style (strongly traditional), identification with types and roles (strongly heterosexual), and comfort with public acknowledgement (discomfort). This person may be in a heterosexual marriage or currently celibate, closed about his/her sexual orientation, involved in an organized religion which does not accept homosexual behavior, and mostly comfortable with his/her life situation although occasionally disturbed by intrusive homosexual interests.

**Hypothetical Case 3**—homosexual response (strong), sexual experience (much), spiritual values (ambivalent), preferred family style (moderately traditional), identification with types and roles (moderately heterosexual), and comfort with public acknowledgement (discomfort). This person may be single or in a heterosexual marriage, homosexually active, closed about his/her sexual orientation, confused about his/her spiritual beliefs, and highly conflicted about his/her lifestyle.

## B. Risk Factors

This section considers factors that may combine together within individuals, leading to the development and continuation of SSA. It also considers factors that may derail heterosexual development, leading to either no opposite-sex attraction (NOSA) or diminished opposite-sex attraction (DOSA).

1. Disruptions in one's internal experience of gender, leading to gender incongruity or ambiguity.
  - a. Self-concept
    - (1) Gender non-conformity

### ***Required Reading:***

#### **Pathways into Male Homosexuality**

**By David Matheson**

[www.genderwholeness.com](http://www.genderwholeness.com)

#### **Boyhood Manifestations**

This section will describe traits that are common among pre-homosexual boys. These include emotional traits, atypical behaviors, and peer relationship problems. Problems in peer relationships may involve a tendency to isolate, feel inferior, perceive rejection from peers, and a resulting lack of masculine initiation.

#### **EMOTIONAL TRAITS**

Dependency is a common trait of pre-homosexual boys. Bieber writes that the family and peer situations described in chapter 3 can result in pathological dependence on mother, among other things. 17(p316-317) In his study, he and his colleagues found that about half of the homosexual group showed this type of dependency. Their findings related dependency to infantile treatment and interference with heterosexual activity by mothers and an excessive fear of injury in the sons. 17(p205) A related trait revealed by their study is *clinginess*. Half of the individuals in the homosexual group were rated as "a clinging child," while only 25% of the control group was rated as such. 17(p175)

Pre-homosexual boys may also see themselves as weak and passive in their relationships with other males. 14(p59) This weakness was reflected in the Bieber study as "Frailty." About 44% of the homosexuals considered themselves to have been frail in childhood. However, the health records of this group were very good, which leads Bieber to conclude that the self-assessment of frailty was not based on actual health concerns. Additionally, only a few of the homosexuals were considered to have been athletic or well coordinated as children. Bieber assumes that the lack of coordination comes from being anxious and tense out of fear of participating in competitive sports with other boys. 17(p205)

Joe Dallas agrees. 4(p173) Nicolosi describes another problem that many homosexuals experience in relation to their body. He says that "excessive modesty" begins in childhood and continues into adulthood. This physical shyness may be compensated for by exhibitionism or the desire to show off one's body. Both of these traits represent an alienation from—or lack of natural acceptance of—the body. He writes that most homosexuals experience their bodies as an object, something somehow separate from them, rather than as a natural part of themselves. 14(p65-67)

Another common trait among the homosexuals in the Bieber study was fearfulness, particularly fearfulness of being injured physically. Seventy-five percent of the homosexual group were considered "excessively fearful of physical injury in childhood," compared to only 46% of the control group. 17(p174-175) These boys are not inclined to participate in activities that they believe might be dangerous, though usually they grossly overestimate the danger. 17(p316) Bieber related this fear of physical injury in childhood (in both the homosexual and control groups) with "mothers who were over-concerned about health and injury . . . [and] were socially restrictive and interfered with self-assertiveness and heterosexuality." The fathers of these individuals "were mostly hostile and rejecting." 17(p204)

Joe Dallas suggests a fourth emotional trait of pre-homosexual boys. "The pain of growing up homosexual is the pain of being different," he says. This sense of being different impacts the person's development. They grow up convinced that they are different, that they are not on par with or not as valuable as their peers. 5(Tape 1) Jeff Konrad adds that "the deepest root of homosexuality is lack of a sense of belonging." 15(p214-215) Bieber described such boys as "beset by feelings of inadequacy." 17(p316) In addition to feeling different, separate, and inadequate, pre-homosexual boys may see themselves as being without certain important assets that would come from a closer bond with other males, such as approval, attention, and someone to identify with. 4(p111)

#### ATYPICAL INTERESTS AND BEHAVIOR

Two of the most widely acknowledged childhood patterns among pre-homosexual boys are non-masculine behavior and problems in relationships with male peers. 14(pXVI) Peer relationships will be the subject of the next section. Researchers have demonstrated that some behaviors that are considered male-typical (such as rough-and-tumble play) are affected by prenatal hormones. 1(p928) One reason for considering such a relationship between prenatal hormones and childhood behaviors is that the differences in childhood behaviors between pre-heterosexual and pre-homosexual boys begin very early in life. However, Byne and Parsons point out that boys and girls are treated differently from the moment they are born. Children establish gender identity by age three and gender constancy—which determines what sex they will use as a model for their behavior—soon after. Gender identity and constancy are determined mostly by social factors, which suggests that gender typical behavior, as well as gender-atypical behavior, could be the result of social input even at age three or four. 9(p236)

*Gender non-conformity* is the term most commonly used to describe a higher than normal interest in opposite-gender activities and lower than normal interest in activities of one's own gender. Gender non-conformity in childhood is considered to be the most reliable predictor of adult homosexuality, 9(p236) or at least to be "a very strong predictor" of this. 18(p76) In their major study, researchers Bell, Weinberg, and Hammersmith found that gender non-conformity ranks as the most significant factor in the development of homosexuality among the 15 developmental variables they studied. Their research and hypotheses suggest that boys who feel they are different from other boys with regard to their degree of masculinity and their playtime interests (in other words, boys that show gender non-conformity) are more likely to "Feel Sexually Different from other boys," to "experience Homosexual Arousal" in childhood or adolescence, to have "Homosexual Genital Activities in Childhood," and to "have more extensive involvement in Homosexual Activities in Adolescence." They also state that gender non-conformity in adolescence tends to cause individuals to feel alienated from their peers. All of the factors listed increase the probability of adult homosexual behavior. 18(p76-77)

As mentioned above, gender non-conformity also includes interest in activities that are typical of the opposite gender. For boys this may include interest in dolls, dressing up like a girl, preferring the company of girls in game playing, preferring the company of older women rather than men, and having a greater sexual interest in boys than girls in sex play. 14(p61) It may also include aesthetic and intellectual interests, 1(p926) physical effeminacy, 17(p205) and even the desire to be a woman. <sup>1</sup>17(p194)

Gender non-conformity also includes a relative absence of typically masculine interests. Researchers Hockenberry and Billingham concluded that this second aspect of gender non-conformity (absence of male interests) predicts adult homosexuality more strongly than the first aspect (interest in feminine activities). They listed five factors that effectively discriminated between pre-heterosexual and pre-homosexual boys. They were: 1) "whether he plays with boys or girls," 2) "his preference for boys' or girls' games," 3) "whether he imagines himself as a sports figure," 4) "whether he reads adventure and sports stories," and 5) "whether or not he is considered a sissy." 19(p60) Other researchers have noted that pre-homosexual boys often avoid "activities thought to be injurious" 17(p316) as well as "play that involves fighting and rough-and-tumble team sports." 1(p928) Bieber's study provides a comparison between boyhood characteristics of homosexuals versus heterosexuals (see table below). 17(p175)

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<sup>1</sup>This was reported in 40% of the homosexual group in Bieber's study, compared to only 8% of the control group.



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b. Male gender concept

Gender concept defined:

Most broadly, gender concept refers to the entire set of beliefs and expectations that define "male" or "female" for any individual. It is basically a person's very complex answer to the questions, "What is a man?" and "What is a woman?" It is normal for all people to have a gender concept regarding both males and females.

Gender concepts begin with awareness of distinguishing biological factors. Beyond that, one's gender concept might include beliefs and expectations about personality, thinking style, preferences and values, emotionality, dress and grooming, interests and career, and many other variables.

Individuals likely categorize the beliefs and expectations comprising their gender concepts into various categories, such as givens, ideals, neutrals, negatives, undesirables, and taboos. People are most typically unaware of their own categorizations.

A person's gender concepts can be broad or narrow, flexible or rigid, adaptable or fixed. Gender concepts exist on various levels of awareness and consciousness. You may be well aware of aspects of your gender concepts on some levels and completely unaware of the concepts that exist on other levels.

c. Gender Imperatives

Gender imperative defined:

- (1) The trait is considered to be necessary in order to be whole as a male—truly masculine, attractive, desirable, good, valuable, loveable, or complete.
- (2) At some point in life the man experienced some degree of fixation or obsession about the trait.
- (3) The fixation began in childhood or adolescence at which time the man saw this trait as something significant that he was lacking in. He believed this differentiated him from other boys and he probably felt shame about lacking this trait.
- (4) When the man thinks about the trait or sees it in another man he feels longing, curiosity, envy, or lust.

***Required Reading:***

From *Coordinates*, by David Matheson (unpublished manuscript)  
Chapter 8—Male Gender Concept

**Gender Imperatives**

Before going further, we need to introduce you to the idea of “gender imperatives.” Sometimes men become fixated or obsessed with certain male traits. They consider these attributes to be necessary in order to be truly masculine or to be considered attractive, desirable, good, valuable, loveable, or complete as a man. When the man sees someone with this trait (or when he thinks about the trait) he usually feels powerful feelings of pain, longing, curiosity, envy, or lust. The awareness of gender imperatives may begin in childhood—though it often begins in adolescence—and tends to be inflexible and unrealistic, remaining unchanged for many years.

Gender imperatives form around significant masculine traits that boys see in other males around them but consider themselves to be lacking in. These dissimilarities become a critical factor differentiating the boy from the males around him. Typically, the boy tells himself the story that these differences make him inferior, which creates his pain and longing. These boys may tell themselves that, in order to be truly worthy or whole as a boy or man, they must possess those qualities. But they also see themselves as incapable of obtaining the required traits.

Gender imperatives can develop around specific body traits, such as muscularity, chest hair, facial features, or a large penis. They can form around personality traits

such as aggression, athleticism, or confidence. They can even be based on socioeconomic factors such as education and wealth. And they are often focused on a mysterious and vague quality that might be best described as “the male mystique.”

Gender imperatives can function on a very conscious level, such as the conscious belief that men must be good at sports. But they can exist on far less conscious levels, showing up only in our spontaneous responses to the men around us—most typically in our attractions. You might notice your own gender imperatives by noticing your reactions to the men around you. For example, you might find yourself drawn again and again to a certain type of man or to specific masculine traits. These may be evidence of a gender imperative you carry. If you look more carefully, you might find that these types or traits are aspects of masculinity that you felt different from in boyhood even though you have obtained those traits for yourself in adulthood.

- d) Gender incongruity or ambiguity—perceived critical mismatch between gender concept and self-concept. Gender incongruity exists on the level of core identity and is purely internal. It is different from gender non-conformity, which describes sex role and behavior.

This is different from gender nonconformity (get definition)

It is also different from gender identity disorder (get definition)

### ***Required Reading:***

#### **Pathways into Male Homosexuality**

**By David Matheson**

[www.genderwholeness.com](http://www.genderwholeness.com)

#### **Chapter 1**

### **Identity Development in Males**

In order to understand how a man develops a homosexual identity, it is helpful to first understand the general process of identity development in males. This chapter presents basic principles related to identity development, including the discovery and acceptance of gender, masculine identification, and the acquisition of gender role. Learning about these concepts will provide a background of understanding for the information given in later chapters.

A man's identity develops from infancy onward. All aspects of life influence this development. Psychologist Erik Erikson wrote that a person's identity unfolds as an ever-changing pattern. This pattern is formed and reformed as new elements are introduced and old elements are rearranged. The “ego” is conceived of as a part of the human mind that arranges and integrates these elements. Some of the

elements that must be integrated are biologically determined traits, personal preferences among one's various abilities, significant roles one takes on, effective emotional and psychological defenses, individual ways of satisfying sexual interests, and ways of channeling energies into socially accepted activities. 1(p162-163)

But a person's identity is not just a combination of these elements. Nor is it simply one's values, beliefs, or behaviors. The outward manifestations of all these things could be called "personality." But one's identity is an inward awareness of all these things—in others words, the thoughts and feelings one has about all of these elements. So identity could be described as an integrated accumulation of thoughts and feelings one has about oneself. 2(p95-96)

The thoughts and feelings we have about ourselves begin to form shortly after we are born and continue to develop throughout life. Many basic patterns are laid down by the time we are just a few years old. These early patterns influence the way we see ourselves and the world and become more elaborate through life. These patterns tend to persist, but may change as a result of new experiences or if specific efforts are made to alter them.

### **Developmental Processes**

This section will deal with three key concepts. They are *gender identity*, *masculine identification*, and *gender role*. Gender identity is a person's awareness of being either male or female. This is usually established by age three. Most homosexual persons do not experience difficulty with gender identity. 3(p185) Masculine identification could be described as a sense of belonging, or mutuality, with men. It seems to begin with a sense of being like father and being accepted by father, 4(p27) which is later generalized into an ability to attach to other same-sex models. 4(p29, 34) Gender role (also called social sex-role 3(p185) and sex-role identity 6(p6) ) is the behaviors that are expected of individuals because of their gender. These include "physical attributes, mannerisms, speech, interests, and personality traits." 3(p185)

#### **GENDER IDENTITY**

Gender identity begins with a young child's most rudimentary recognition of categories. They become aware early on that there are two types of people—boys and girls—and they have been told that they are one or the other. But their comprehension of the fact that gender is a constant thing that does not change—for example, if a boy puts on a dress or a girl gets a hair cut—does not develop until later. 5(p92) Between the ages of five and seven years most children become able to maintain stable categorizations of things. It is during these years that children acquire a constant sense of their own and others' gender. 5(p119)

#### **MASCULINE IDENTIFICATION**

Children begin life primarily identified with their mother, who is usually the main

source of care and nurturance. For boys to gain a masculine identification it is necessary for them to shift their primary identification from mother to father, or some other adult male. 4(p26) The most receptive time for this identification appears to be before the age of five years. Joseph Nicolosi considers the time between the ages of two and a half and three years old to be especially crucial. 4(p26) The boy has some natural sense within him that he is not like his mother. Nicolosi describes this as "an intense intuition based on a bodily sense" that tells him he is different from his mother, but like his father. This is accompanied by an interest and desire to grow up to be like his father. 4(p27) Masculine traits are established and reinforced largely due to identification with, and encouragement from, the father. 6(p115) The mother's reactions to the father, to other males, and to the boy are also important in this regard. This initial identification with the father prepares the boy for identification with other males 4(p29, 34) who will reinforce and add to his growing sense of himself as a masculine individual.

## GENDER ROLE

Children begin to perceive role difference in infancy and associate certain roles with certain people. For example, mothers are associated with comfort and fathers with play. 5(p93) By the age of two, children begin to sex-type items such as lawn mowers, tools, ties, purses, irons, and clothes dryers. 5(p94) Younger children (through approximately age five) typically view the roles of their parents differently and according to stereotypes. 5(p163-169) During middle childhood a number of influences outside the family contribute to the development of gender role, including schools, television, advertisements, and peers. 5(p181-204) Cultural gender expectations, practices of the social institutions they are exposed to (such as family, school, and church), and their acquired individual attitudes and beliefs form the basis for gender role development in children. 5(p6)

Robert Stoller wrote: "The first order of business in being a man is: don't be a woman." 7(p29) In infancy and early childhood the mind distinguishes and separates things into different categories. With regard to gender, children create two categories, girl and boy, based on cultural prescriptions of masculinity and femininity. Part of knowing how to say and do "boy" things may be knowing how to *not* say and do "girl" things. 8(p244) There can be significant consequences to openly disregarding socially accepted gender roles, such as being labeled deviant. 3(p185)

For adult males, gender role includes all of their concepts of what "good" men are supposed to be and do. A man's gender role definition may include such things as acceptable physical attributes, ways of self expression, ways of relating to women and children, athletic abilities, social class, sexual prowess, level of education, spirituality, and profession. A man's gender role definition can have profound implications on his self-esteem. If his definition of gender role matches what he actually is, then he is likely to have a fair amount of self-confidence. But if he does not match his concept of gender role he will probably feel inferior to, and perhaps envious of, those men who are more like his definition.

## Role of the Father

### "FATHER SALIENCE"

The personal qualities of the father impact this process of masculine identification. Nicolosi uses the term "father salience" to describe a balance of dominance and nurturance, which are traits he considers necessary in a father to elicit masculine identification in his son. 4(p32) Nicolosi cites the work of Ross in describing these two traits: dominance is the father's "presence as a strong influence within the household," and nurturance is "his warmth, availability, and empathy." 9(p32) Nicolosi also cites studies by Sears 10(p31) and by Mussen and Distler, 11(p32) which conclude that boys are more likely to identify with fathers who are affectionate, nurturant, and rewarding than with fathers who are cold. Because the small boy's relationship with his mother is typically safe and emotionally rewarding, the father must possess this combination of dominance and nurturance in order to attract the attention of the boy and win his identification. 4(p33)

### ATTACHMENT TO FATHER

At the same time the boy is developing an interest in becoming like his father, he is also developing a desire to be accepted by his father. This has been described as a dependence on the father receiving the boy and validating his maleness. 4(p27) The boy longs for this type of union with his father, which has been described as "father hunger," 12(p30-31) and if he is received, will emulate his father. But if he feels unaccepted by his father, or unwelcomed by him, he will avoid identifying with him. 13(p101) Obviously, this is a simplified view of what actually takes place in families. There are likely many heterosexual-identified men who were rejected or abused by their fathers. Similarly, there are certainly homosexually-identified men who had loving, nurturing fathers. Such exceptions will be dealt with later in this chapter.

Elizabeth Moberly points out that "it is not the availability of same-sex models but the ability to be attached to such persons that is crucial in the acquisition of a same-sex identity." 14(p48) In other words, the boy has to initiate and carry through this identification with maleness from within himself. A rejecting father can discourage the boy from doing so, but some boys will accomplish it anyway. Likewise, a kind father may invite the boy's identification, but the boy may still never initiate the process. The mother's influence is also vital in this shifting of identification. She must allow the change to occur by letting the boy go, accepting and affirming the boy's masculinity, and respecting the masculinity of the father. 4(p84-85)

In addition to facilitating the process of masculine identification, a strong relationship between a boy and his father fills the boy's needs for love and acceptance from this stronger male figure and gives him someone he can depend upon. 14(p5) Furthermore, a good relationship between father and son provides the boy with personal confidence, the ability to be independent, assertiveness, and a sense of personal power. 4(p44) Joe Dallas states that if a young boy's perception

of the father's attitude is favorable, the boy will gain confidence, which allows him to relate easily to the various males who will come into his life in the future, including brothers, mentors, teachers, and male friends. Dallas calls this "an emotional baton [that] is passed between the significant males in a boy's life." 13(p158)

Boys learn how men do things from their fathers. Physical activity, or doing things together, seems to be the basis of father-son relationships. According to Nicolosi, this results in a "behavioral, bodily phenomenon of identification" that is carried into adult same-gender relationships that are also based on "doing." Part of what the boy learns about masculine activities from "doing" with his father is that "danger can be fun and exciting." 4(p38-39) This becomes an important trait later as the boy begins to compete with other boys.

Nicolosi describes fathers as "the reality principle." The father is the first influence or intrusion of the outside world in the exclusive relationship between mother and son. The father represents "strength, independence, and mastery of the environment." 4(p37) During infancy, most boys receive unconditional warmth and nurturance from the adults around them. But later in childhood, during the time boys are beginning to identify with their father, expectations and demands are being placed upon the child. Many of the activities boys do with their fathers require the boy's conformance. He must "keep up with daddy," or "throw the ball," or "hold the hammer." These are the requirements for relating with dad and they teach the boy to balance his own needs and desires with the expectations and demands of the outside world. They bring the boy into reality. This ability to balance internal needs with external expectations seems central to masculinity. 4(p37-38, 40-41)

A related developmental task is that of achieving autonomy. Autonomy simply means independence, or being directed from within yourself. For autonomy to be learned it must be allowed, encouraged, and reinforced by both parents. The formation of an autonomous identity and the formation of gender identity occur at about the same time and are considered highly inter-related. 4(p33)

### **Initiation and Competition**

Numerous cultures have various initiation rites, or rites of passage into manhood. Most of these involve doing acts that demonstrate to other men the boy's ability to meet external expectations through bravery, strength, endurance, or cunning. Nicolosi states: "Where there is a good fight [together] with the experience of acknowledgement, we have full masculinity and heterosexuality." 4(p41) One arena where a sort of initiation takes place is adolescent PEER GROUPS. Through the combination of *putting down* and *building up*, which is common in these groups, boys learn how to trust and respond to other men and to develop a resilience to peer aggressions and lack of consideration. 4(p63)

In modern western culture competition in all of its forms is a significant part of acquiring masculinity. 4(p31) It is not necessary that a boy win at everything he competes in but rather that he gains a sense of having competed sufficiently and



that his efforts have been recognized and validated by other men as sufficient. Part of the importance of physical competition through games or sports is that the boy must engage his body in his relationship with other boys. Doing this over and over during childhood and adolescence provides the boy a stable way of perceiving his body in terms of its physical capabilities—which is the typically masculine way of viewing the body—and teaches him how to use his body in doing things with other men. 4(p39)

The keen interest and curiosity that pre-adolescent boys have in their own bodies may sometimes be expressed in pseudo-sexual behaviors, occasionally among groups of boys. According to one study, at least 20% of adult males have experienced sex at least once with another male. However, this study reports that only about 3.3% of adult males engage in homosexual behavior with much frequency after age 20. 15(p338, 346-47) The majority of the pre-adult homosexual behavior may be viewed as an exploration of sexuality, rather than as expressions of homosexual attraction. However, some adolescents may assume that because they enjoyed these experiences they must be homosexual. This assumption may result from over-simplistic societal explanations of sexual orientation and demonstrates the importance of the ways in which individuals explain their experiences 16(p101) But such male/male sexual exploratory behaviors are more accurately described as pre-heterosexual, meaning that the boys have sexual interest but have not yet discovered the eventual object of that interest.

The activities and tasks described above form the central psychological tasks of boys from early childhood through pre-adolescence. During this time their energies are spent on bonding with their same-gender peers. It is not until the boy has developed a sufficiently firm identity for himself, based on having attached sufficiently, that he is ready to take interest in the opposite sex. 13(p105)

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From *Coordinates*, by David Matheson (unpublished manuscript)  
Chapter 8—Male Gender Concept

## Messages about Maleness

In Chapters 4 and 5 you wrote about experiences with your parents, siblings, other children, and adults that may have given you messages about men and masculinity. These messages may have come verbally or nonverbally, directly or indirectly. You also described messages you may have received from institutions and the media.

Institutional messages can come from religion or from organizations such as the Boy Scouts or the military. These messages are based in the expectations these

institutions place upon males and the way those expectations are communicated publicly. For example, certain religions expect men to marry and produce children. The Boy Scout handbook teaches men to be honest and brave. The military requires men to be tough and function in unfavorable circumstances. All of these produce unmistakable messages about masculinity.

Some of the most powerful and lasting messages we get about maleness come from the media. Advertisements, television shows, movies, and magazines provide powerful images and stories of masculinity. These messages tend to emphasize ideals and to devalue men with undesirable traits. Such messages can be subtle, but are often very direct. It is important to note that the constant presence of the media in our society—and the intensity of these messages about maleness—encourages the formation of gender imperatives.

Messages about maleness can come in many ways. Consider the following sources of these messages.

### **Verbal Statements**

Words spoken by people you have direct contact with as well as people in the media. For example:

- Mom or dad says, "Boys don't cry."
- Someone in a movie says, "Take it like a man."
- Your mother says, "Your father is a big brute."
- The TV says, "Gentlemen prefer blondes."

### **Characterizations**

These are positive and negative depictions of men. You might see or hear these stories through real-life conversations, from the media, or from scripture. For example:

- The depictions of men as unintelligent and bumbling through characters like Homer Simpson, Al Bundy, Ray Romano, or Archie Bunker.
- The idealized characterization of men like Superman, Riddick, Indiana Jones, and Luke Skywalker.
- Biblical stories of men like Moses, the Pharaoh of Egypt, or King David.

### **The Examples of Others**

Traits and behaviors we observe in real-life people who are significant to us, such as:

- Father's appearance, personality, behaviors, and relationships.
- The relationship between father and mother.
- The appearance, personalities, and behaviors of the boys around us.

### **Interactions with Others**

First-hand experiences with other males, both positive and negative. For example:

- Play with other boys or men, in or out of the family.
- Discipline from older males including father, teachers and others.

- Abuse and cruelty.

## Images

Pictures of men in movies, TV shows, magazines and advertisements, such as:

- Abercrombie & Fitch models.
- Movie stars and rock stars.
- Athletes.

## Formation of Gender Concept

We are all exposed to messages about maleness throughout our lives. We accumulate those messages in our minds and feelings—some are conscious, others are outside our awareness. Gender concept is not a simple accumulation of these messages, however. Many messages are simply ignored while other messages take on tremendous significance because of the feelings that accompany them.

The messages that remain with us form the basis for our stories about what makes males masculine; they form our gender concept. Just as with self-concept, we choose the stories that make up our gender concept. These choices about what makes a boy or a man masculine are strongly biased by life events and environmental influences. They are also biased by our own innate traits, such as our temperaments, that influence the way we view what happens in our environment.

Gender concept is not always coherent. Concepts on one level may directly contradict concepts on another level. For example, on the most conscious level we might carry around a list of “shoulds” such as, “men should be religious and obedient” or “men should play sports and like to go hunting.” But these shoulds might be contradicted on a less conscious level by “shadow ideals,” which are negative traits that are seen as desirable and attractive, such as rebelliousness, roguishness, sexual promiscuity, or disrespectfulness.

From *Coordinates*, by David Matheson (unpublished manuscript)  
Chapter 13—Gender Disruption

## Gender Incongruity

When a boy views himself (self-concept) as being at odds with his beliefs about what it means to be male (gender concept) he will likely experience a sense of being strange, out of sync, or not like other boys. I have created the term “gender incongruity” to describe this state, which can be quite uncomfortable or even painful.

Gender imperatives, negative imperatives and same-gender repulsion (all of which you learned about in Chapter 6) are core to the sense of gender incongruity

because they create a sense that “I am different.” Typically those differences cause the boy developing gender incongruity to see himself as inferior to other males. But same-gender repulsion can leave a boy feeling superior to other males—though still incongruent.

Problems with thinking—like those discussed in Chapter 3—make matters worse by clouding the boy’s view of himself and other males. Distortions, illusions and thinking errors can badly skew a boy’s perspective or blow things way out of proportion. Differences between the boy and the males around him can be greatly exaggerated or might take on far more emotional significance than is appropriate. Obsessive thinking can fixate the boy’s mind on his situation, acting like a pressure cooker intensifying his sense of incongruity and creating powerful emotional reactions to it.

Let me provide an example to illustrate these concepts from my own life. One day when I was a sophomore in high school I was walking toward the playing fields for gym class. Another young man was leaving the playing field at the same time, walking toward me. This young man was one of the athletic, cool, and intimidating guys in my school. He was wearing red gym shorts—and nothing else.

My illusions about him were that his physique was perfect and that he had absolute confidence. I believed that his body and athleticism made him superior and more worthy than I. My distortions about my own body were that being tall, thin, and uncoordinated made me gangly and unattractive. And my own obsessive-compulsive personality kept these ideas rigidly fixed in my brain. I believed that I was inferior, unworthy, and less than masculine.

I envied everything about this boy—his body, his athleticism, and perhaps most of all the confidence he had about his body that allowed him to walk around in public nearly naked. His image contributed to an already developing gender imperative, which had me convinced that a man had to be like him in order to be truly masculine or to be attractive, desirable, good, valuable, loveable, or complete as a man. This gender imperative was central to my male gender concept.

## 2. Same-sex disaffiliation

It is natural and normal for people to want to relate to others of their own gender. When these needs are not met, problems can result.

***Required Reading:***

**Pathways into Male Homosexuality**

**By David Matheson**

[www.genderwholeness.com](http://www.genderwholeness.com)

**Chapter 3**

**The Role of Relationships in Homosexual Development**

In essence, adult male heterosexuality begins with a boy's willingness to use his father, his peers, and/or some other male figures as role models in developing his own masculine identity. Successful role modeling requires trust, attachment, and identification from a boy toward his role model(s). It also requires presence, bonding, and willingness to encourage autonomy from the role model(s) toward the boy.

This chapter considers factors within the various relationships a boy encounters that can prevent or derail successful role modeling. These relationship problems may be influenced by other things, such as biologic predisposing factors or abuse (which were discussed in the preceding chapter) or they may be sufficient in themselves to lead to a homosexual orientation.

A great deal of research over the past 50 years has shown a correlation between relationship problems in childhood and adolescence and homosexuality in adulthood. Although the evidence is plentiful and well documented, there is much it does not explain. Most importantly, it does not explain *how* childhood relationship problems contribute—if at all—to adult homosexuality.

Richard Friedman makes this point in his critical overview of the literature on the role of family interactions in the development of homosexuality. Friedman determined that a certain pattern of strained family interactions (similar to what will be presented below) was implicated in the development of men who become homosexual. In fact, he concludes that few, if any, homosexual men grew up in households characterized as "emotionally secure, non-traumatic, warm and supportive." 1(p73) Yet he acknowledges that "a big leap is necessary in order to conclude that homosexuality is likely to be *caused* by exposure to this type of family situation" since such family situations also exist in the histories of many heterosexual men. 1(p71)

Much of what this chapter presents is the theories of experienced clinicians who attempt to make the "big leap" Friedman refers to through anecdotal evidence and inductive reasoning. These theories are not presented as a simple linear explanation for the development of homosexuality since evidence does not show that there is such an explanation. Nor do these theories provide concepts broad enough to apply in every case. But they do help us to sketch a plausible outline for

a large puzzle to which many of the pieces are still missing.

### **Perception and Interpretation**

Joe Dallas has stressed the importance of the child's perception of his early relationships and the meaning which the boy attributes to what he perceives. Dallas wrote that it is not what actually happens in the parent-child relationship that contributes to homosexual development, but how the boy perceives the relationships and how he responds emotionally to those perceptions 3(p92, 98) The conclusions we draw from our circumstances, and not what actually happens to us, is what develops our personalities. 4(Tape 4) Jeff Konrad agrees: "What *actually* transpired in our childhood wasn't as important as what we *thought* was happening. The development of our identity is dependent upon how we *interpret* reality, how we *perceive* the manner in which others treat us, and not necessarily on reality itself." 5(p71)

Furthermore, the fact that a disruption has occurred in the relationship between parent and child does not mean that the parent has willfully done something to cause the disruption. Moberly speaks of the relationship problems between pre-homosexuals and their parents as a disruption in the normal attachment that should exist between parent and child. She states that "no parents of a homosexual should necessarily blame him/herself for the disruption in attachment." The hurt underlying this disruption may be accidental or unintentional. Situations such as divorce, separation, or anything else that results in parental absence during a critical period, even if it is unavoidable or for good reasons, can put a strain on the relationship between child and same-sex parent. "The human situation is such that hurt may sometimes occur without it being a matter for blaming anyone." 6(p2-3)

"If we must blame anything," Dallas suggest, "it should be the chain of events beginning from infancy that shape a boy's attitude toward father, men, and himself." Dallas adds that some boys may be born with a sensitive nature that disposes them to perceive as rejecting a father who is actually both available and accepting. There may also be miscommunication between father and son, causing the boy to misinterpret the father's intentions. 3(p158)

### **Father and Son**

As stated above, adult male heterosexuality essentially begins with a boy's willingness to trust, attach to, and identify with his father, his peers, and/or some other male figures, and use them as role models in developing his own autonomous masculine identity. Conversely, the boy's unwillingness to engage in such a process is typical of the pathway leading to a homosexual identity. 6(p44-46) Nicolosi and Moberly place most of the blame for homosexual development on the relationship between father and son, probably because this is the earliest and most profound same-gender relationship for most boys. Nicolosi states that the most commonly seen pattern of homosexual development results from problems in the relationship between father and son. The failure of this relationship prevents the boy from fully internalizing a masculine identity. 7(p25) In her book *Homosexuality: A New*

*Christian Ethic*, Elizabeth Moberly repeatedly makes the point that homosexuals experienced some type of deficit in their relationship with the same-sex parent. This deficit created a drive within them to repair the deficit through homosexual relationships. 6(p2) Dallas reminds us to avoid blaming by referring to an "unsatisfactory relationship" between father and son. 3(p157)

But whatever it is called, the relationship between pre-homosexual sons and their fathers is problematic with few exceptions. In these relationships boys do not experience or learn how to experience attachment to other males. Therefore, identification—which normally comes out of attachment and to which children are normally inclined—does not occur. 6(p48), 3(p101) Instead, negative feelings toward the father grow and become transferred to the qualities that the father represents and then to other men with these same qualities. 3(p161, 6(p45) The sections below will describe some of the factors that may cause boys to withdraw trust and attachment from their fathers. Abuse, which is potentially the most damaging factor in a father-son relationship, was described in detail in chapter 2 and will not be included here.

#### GENERAL RELATIONSHIP PROBLEMS

In general, it seems that problems are worse than normal in relationships between pre-homosexual sons and their fathers. In their extensive study, Bieber and his colleagues found problems in the relationships between fathers and sons in both their homosexual group and their control group.<sup>1</sup> However, the problems were far worse among the homosexual sample. Bieber states that "*profound interpersonal disturbance is unrelenting in the [homosexual group] father-son relationships.*" And they note that "the outstanding attitudes of homosexuals toward their fathers were hatred and fear." 8(p114) The findings of this study were so overwhelming that Bieber remarked: "We have come to the conclusion that a constructive, supportive, warmly related father *precludes* the possibility of a homosexual son." 8(p311)

Nicolosi describes a particular and pronounced negativism from homosexuals to their fathers, characterized by "qualities of festering resentment, hurt, disappointment, and inability to understand what their father is about." Heterosexual men may give unfavorable descriptions of their fathers, but in Nicolosi's experience "homosexual men are strong in their *rejection of their father as a model.*" It must be recognized, however, that not all homosexuals report problems in their relationships with their fathers, although strained relationships are predominant among the cases studied. 7(p45-46) Possibly the damage done by a poor relationship with a father might be undone through a good relationship with another significant male. It is equally possible that a good relationship with father might be undone by particularly painful rejection from other males. 3(p158-159)

<sup>1</sup>The control group in the study by Bieber, et al, was comprised of men who were in psychoanalytical treatment for problems other than homosexuality. 8(pXXV) Thus, they were not a cross section of men in society and we might expect higher levels of parent-child



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relationship difficulty than would be typical of a group of men who were not in treatment.

#### TRAITS OF FATHERS

According to Nicolosi, "fathers of homosexuals are often described as detached, helpless, pouting, avoidant, uninvolved in family affairs except to interject criticism." Some of the obvious personality problems seen in these fathers are "egocentrism, narcissism, criticalness, and coldness." Even when some of these fathers are warm and concerned about their sons, they still do not accept the son in a genuine way. 7(p51-52)

Bieber described specific details regarding the attitudes of these fathers toward their pre-homosexual sons. They found that such a father was likely to have "a specifically negative attitude toward his homosexual son as contrasted with his attitude toward his other children."

They also found that the homosexual son was rarely the preferred child, in fact he is usually the least preferred. Fathers of homosexuals have the capacity for affection but do not exhibit this toward their homosexual sons. The authors do not explain whether this negative attitude from fathers to their homosexual sons began before the father learned of his son's homosexuality or whether it may have been caused by his knowledge of the son's sexual orientation. 8(p137) Nicolosi suggests what may have been missing in these fathers: "the father's capacity to be genuinely 'for' his son rather than requiring the son to meet specific expectations in exchange for acceptance." 7(p52)

The descriptions of fathers of homosexuals just given are highly critical. Remember though that most of these descriptions represent the way the homosexual son perceived his father and their relationship. For example, what a small boy perceives as "hostile" may actually be either a father who regularly and intentionally inflicts brutal physical abuse or one who—though he loves his family—has a temper with his children, or anything in between. We are probably safe to assume that fathers of homosexuals cover nearly a full range of actual behaviors and attitudes. At the same time, we can probably also assume that none of these fathers fully met the definition of salience given by Nicolosi (see chapter 1).

Remember that the definition of salience is "dominance plus nurturance." 7(p32) We might assume that there must be a balance in the application of these two traits. We might also consider that for boys who are temperamentally sensitive or who have not developed a high degree of trust, a little dominance would go a long way while a lot of nurturance might still not be enough. For such a boy, a father who is slightly under-nurturing and a little over-dominant may not be an attractive enough alternative to the safe and warm relationship with his mother. This could lead to the boy failing to make the necessary identification with his father. 7(p50) This suggests that when we talk about balance, we do not mean balance in the opinion of the father but balance in the opinion of the boy's emotions.

The types of situations that could create a lack of salience might include "the normal, 'nice guy,' emotionally distant, and detached type of father," 9(p46) a father's ambivalent or contradictory attitude toward his son, a father's lack of security in his own masculinity which might cause him to feel in some way threatened by his son, a father feeling rejected by his son and responding by pulling away, or a situational influence that causes the father to be absent or emotionally overburdened. 7(p50) The two main traits that typified fathers of the homosexuals in Bieber's study were detachment (75%) and absence (12%). 8(p88) Each of these contributes to a lack of salience in ways we will describe below.

#### DETACHED FATHERS

The detached fathers in Bieber's study were classified as being detached in various ways. Fifty-five percent were considered detached and "hostile." These fathers were contemptuous and humiliating toward their sons, who generally responded by hating and fearing their fathers. Twenty-three percent of the detached fathers were considered "indifferent." These fathers interacted very little with their sons, leading to emotionally shallow relationships. Eighteen percent of the detached fathers were ambivalent. These fathers were sometimes affectionate and rarely contemptuous or humiliating, but they spent little time with their sons. The last four percent of the detached fathers were considered "dominating" and exploitative." These fathers were puritanical, demanding of their son's attention, and unaffectionate. Their sons were fearful and submissive. 8(p91-102)

A detail from the Bieber study suggests that the father's detachment may be a particularly significant component of homosexuality. The sons of those fathers who were not detached or absent—although their fathers manifested a range of other problems—showed higher probability of change in therapeutic treatment. Seven of the 13 men (54%) with non-detached fathers became heterosexual through treatment. This was the highest rate of change in sexual orientation seen in any of the sub-groups considered. Bieber suggests that, even when the father has other problems, if he is not detached he still introduces something into the father-son relationship that favors recovery from homosexuality. 8(p117)

More than half (54%) of the men in Bieber's non-homosexual control group also reported having detached fathers. Why did these men not become homosexual? It appears that the problems in these father-son relationships may have contributed to other psychological problems (all were receiving psychoanalysis) although not to homosexuality. Bieber states that close comparisons between the fathers of homosexuals and those of the control group shows "consistently less detachment and hostility among the [control group] fathers." They conclude that "the extent of detachment and the intensity of hostility apparently play a determining role in the sexually adaptive outcome." 8(p116)

Sons of detached fathers may react to the unfulfilling relationship in various ways. They may be consciously aware of the lack of affection and interest, they may feel rejected, or they may simply feel an indistinct yearning for something they can't explain. But however they experience it, the relationship will be traumatic. 8(p114)

W. Fairbairn wrote the following regarding sons of rejecting fathers: "frustration of his desire to be loved and to have his love accepted is the greatest trauma that a child can experience; and indeed this is the only trauma that really matters from a developmental standpoint." 10(p83)

In response to this traumatic lack of need fulfillment, the boy may search elsewhere for attachments, 8(p114) or he may simply withdraw into himself. Perhaps those boys with detached fathers who grow up heterosexual differ from their homosexual counterparts mostly in their ability to find attachments with males other than their father where their needs can be fulfilled nonsexually. Moberly's statement that "the homosexual condition does not involve abnormal needs, but normal needs that have, abnormally, been left unmet in the ordinary process of growth" 6(p18) makes a great deal of sense in this context.

#### ABSENT FATHERS

In our society, most men must go to a location away from the home to work. Many men spend long hours or even days at a time away from home and away from their sons. In addition, a large percentage of households today consist of a single mother raising children. To some degree the absence of fathers from the home is a societal norm. Bieber states that a father spending little time with his son "contributes to the failure to provide the son with an adequate male model for identification." 8(p115) Nicolosi cites numerous studies showing a connection between the father's absence and "dependency, lack of assertion, and/or weaker masculine identity" in boys. 7(p34)

Moberly suggests that when a child is separated from a parent, a process of mourning may ensue. First the child protests the separation in some way. Next the child experiences despair when the parent does not return. Finally, the child detaches from the parent. If the parent does return, a process of resolving the detachment is required to restore the original attachment. If this process does not take place, or if the parent never returns, the detachment remains and the need to receive love from that parent is never met. 6(p15)

If absence of the father is so damaging and if the frequency of absent fathers is so high in our society, why isn't a large percentage of the population homosexual? Nicolosi answers this question succinctly by stating that "the primary cause of homosexuality is not the absence of a father figure, but the boy's defensive detachment against male rejection." 7(p34)

Based on this statement we might imagine any number of hypothetical cases where boys with absent fathers acquire a masculine identification and heterosexuality. One such case, suggested by Bieber, might include a father who is frequently absent. If the father and the son have a good relationship and the mother is affectionate and admiring of her husband, the son may retain a positive image of his father despite his absence, allowing for attachment and identification. 8(p310-311) One could also imagine a case where a father leaves the home permanently at any time during his son's early childhood. If the separation does not destroy the

child's willingness to trust adult males (either by father's cruel actions or by mother's angry devaluation of father), the son could identify with other men in his environment (real or fantasized) and use them as role models.

In this case, much would depend on the boy's temperamental sensitivity, his perception of the situation, and the meaning he makes of what he perceives. It is possible that in the course of the separation the boy could perceive his father as cruel and frightening. As long as the hurt he receives from his father does not come to mean to him that *all* men are hurtful or that being a man is bad, he will be able to attach to and identify with other men at some point in the future. He may develop low self-esteem, deep insecurities and excessive guilt, but "as long as the boy remains open to masculine influence, he will eventually encounter some father-figure who will fulfill his needs." 7(p34)

#### FAILURE TO ENCOURAGE AUTONOMY

Another problem that can occur in the father-son relationship is the father's failure to encourage or allow his son's autonomy. This can happen directly in at least two ways pointed out by Nicolosi. First, the father may give nurturance to the son but do so in a self-centered and controlling way that defeats the boy's attempts at autonomy. Second, the father may be overprotective and dominating of the son, either pampering him or putting him in an inferior position. 7(p33-34) Some fathers may see their sons as a sort of rival and so may feel a need to dominate them. 7(p53-54) Also, those who performed the Bieber study observed in their individual clinical practices that some fathers of homosexuals responded with hostility any time their sons demonstrated "masculine" behavior. The researchers suggest that sons became anxious about showing masculine behavior and so concealed it with effeminacy. 8(p116)

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## **Pathways into Male Homosexuality**

**By David Matheson**

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### **Same-Sex Ambivalence**

The most basic way to conceptualize the homosexual condition is through the concept of "same-sex ambivalence." This concept, which comes from Elizabeth Moberly, has two aspects. The first is "defensive detachment," which means that the individual withdraws or separates himself from other males (specifically the father) in order to avoid pain or rejection that he has experienced with them. The second aspect is a "reparative drive," or a desire to re-establish the very relationships that were disturbed by his detachment. Moberly refers to this as "an avoidance-approach conflict." 3(p6) Both aspects are described below.

#### **DETACHMENT**

Detachment begins when the boy experiences something in a relationship that is hurtful to him. Essentially, he puts up a wall to protect himself from being hurt again. 13(p110) He separates himself from the person, or people, who caused the pain because he is sure that relating to them again will bring more pain and he doesn't want to take the chance. 4(p107)

#### **Development of Detachment**

Moberly and Joseph Nicolosi see detachment as arising out of the father-son relationship very early in life. They theorize that during the time when the small boy is most receptive to establishing an identification with his father (see chapter 1) he experiences something in the relationship as hurtful or disappointing. He distances himself from his father to avoid being hurt or disappointed again. 14(p105) The parent may not have intended any harm to the child, and the child

may not show outward signs of having been deeply hurt. 3(p4) Nevertheless, the hurt has occurred and is deep enough that the boy becomes unwilling and even resistant to relating or feeling an attachment to the father any longer. Even after the original hurt is gone and forgotten, the resistance toward the father continues. 3(p5-6)

The boy becomes unwilling to trust the father again, which may develop into a deep inability to trust the father. 3(p45) The behavior of the parent after this point is irrelevant, according to Moberly. Even if the father offers love, the child cannot receive it. 3(p4) So the identification that should occur between the boy and his father does not occur. What occurs instead is a *disidentification*," or a reaction against identifying with the father. 3(p12) Nicolosi points out that the damage resulting from this situation is not done by the father but by the son's defensive detachment from his father. 14(p161)

Once this defensive detachment is established in the relationship with the father it then becomes generalized to relationships with other boys and men. 3(p5, 7) The individual closes himself off from intimate relationships with others as a means of self-protection, and he may not even realize he is doing so. 13(p108) He has not identified with his father, and in generalizing the disidentification he rejects the masculinity that his father represents. 14(p105) This obviously prevents the boy from acquiring an understanding of masculinity. 14(p106)

In writing about his own experience, Jeff Konrad said: "I wasn't able to exchange ideas, thoughts, fears, questions, etc., with other boys. I denied myself the opportunity to discover the feelings of my male peers and how they responded to different things in life." 15(p72) He says this also reinforced his sense of being different and alone. Nicolosi adds that this separation from masculinity alienates the individual from his own real self. 14(p105)

## Resultant Issues

The defensive detachment can result in a number of problems in relationships with other men. Nicolosi writes that there may be a tendency to disengage from relationships when problems arise and a subsequent devaluation, or shutting out, of the other person. 14(p106) There may be a fear (and also an excitement) of being truly seen by other men. 14(p272) There may also be a fear of being betrayed or deceived, or there may be fragility in relationships where a slight problem may destroy a tentative trust.

In addition to fear, detachment can also create anger in male relationships. Fear and anger may be expressed as "hostility, competitiveness, distrust, and anxiety about acceptance." 14(p211) Moberly elaborates on the problem of hostility, saying that it "may be expressed in the form of antagonism towards colleagues of the same sex; in a marked tendency towards 'injustice-collecting,' or fault-finding and the accumulation of resentment." 3(p7) Also, both Moberly and Nicolosi mention problems with authority 3(p6), 14(p102) or with parental figures. 3(p7)

Detachment may also lead an individual into creating a fantasy that he is unique or special 14(p215) He may perceive himself as better than other "ordinary" men because he is more sensitive or artistic. This may lend to the difficulty such men experience in developing relationships, thus feeding the detachment. 14(p197-198) Effeminacy and preference for the company of females are additional manifestations of defensive detachment and a failure to identify with masculinity. 3(p11)

Bob Davies and Lori Rentzel list a number of problematic behaviors and attitudes that are associated with defensive detachment. These include the following:

- anger in such forms as explosiveness, silence, and scaring others away
- sarcastic humor that patronizes and puts down others or minimizes the need for relationships
- isolating from other people
- reluctance to receive help from others
- always assuming control of situations one is in
- disclosing selectively while keeping the real problems hidden
- addictiveness and compulsive behaviors, especially toward pornography and anonymous sex
- avoiding physical contact with other people; avoiding personal issues in conversation by talking about impersonal things
- maintaining standards of friendship that are so high that no one can live up to them
- investing emotionally in pets as a substitute for human friendships. 13(p108-109)

#### REPARATIVE DRIVE

Detachment, which may be considered a repression of the need for attachment to other males, creates a natural urge within a person to undo the detachment. 3(p6) The isolation that a detached person creates for himself does not overcome his basic need for intimacy with other men. Rather, it makes the need stronger. 4(p107) Nicolosi suggests that "every male has a healthy need for intimacy with other males." Normally, this need is met in the early relationship with father and then in relationships with peers. 14(p34) When intimacy and identification with other males are blocked by defensive detachment, these needs create what Moberly termed a "reparative drive." 3(p10) Moberly asserts that this reparative drive is the basis of homosexual impulses—homosexual desires are attempts to "make good earlier deficits" caused by the detachment between the boy and other males. 3(p6) This concept will be discussed in great detail below in the section "Sexualization."

### **Boyhood Manifestations**

#### PEER RELATIONAL PROBLEMS

As mentioned above, two of the most widely acknowledged childhood patterns among pre-homosexual boys are non-masculine behavior and problems in

relationships with male peers. 14(p XVI) One review of literature identified poor peer relations in the backgrounds of homosexuals more often than poor relationship with father. 20 Nicolosi suggests this may partially be due to the fact that disruptions in the father-son relationship would have occurred at a very early age and may not be remembered, while problems with peers happen much later. 14(p62)

The section "Emotional Traits" above pointed out that pre-homosexual boys often experience feelings of dependency, weakness, frailty, lack of body coordination due to fear and anxiety, excessive fear of physical injury, and general feelings of being different. These types of factors can create frustration and a sense of rejection in peer relationships that result in the individual feeling left out of peer group activities. 14(p63) Many boys grow up believing that they cannot be part of the male group. They may fear male camaraderie and male environments. 5(Tape 1) A fear of being humiliated in peer activities, such as team sports, may lead boys to pursue solitary activities. 13(p48)

Bieber used the term "defense avoidance behavior" to describe a trait he found in most of the homosexuals in his study. He proposed that "fear of exposure to humiliating jibes of playmates and shame about felt inadequacy and over-attachment to a [close-binding-intimate] mother contributed to the withdrawal from male peer groups." He also suggested that the father's lack of support and contempt toward his son for not being "tough" reinforce the boy's "sense of shame and impotence." 17(p205)

Some figures from the Bieber study provide a comparison between pre-heterosexual and pre-homosexual boys. 17(p175)

In the place of typical boy activities, pre-homosexual boys may involve themselves in music, reading, drawing, computers, and watching television. They may learn to play girls' games, or may establish "safe" friends with other shy boys. 13(p48, 4(p161) Through all of this, the boy may also be longing for some kind of closeness with his male peers. He may feel that the closeness he desires is wrong and makes him even more different from them, increasing his sense of isolation. 5(Tape 1)

Children are not known for their reserved tolerance of one another. They are keenly perceptive of real or imagined differences and tend to be ready and anxious to state their opinions. Young boys can somehow sense insecurity and awkwardness in each other and will attack those weaknesses, either through name-calling or by physical attack. This confirms the shy boy's belief that he is different and unacceptable and further discourages him from trying to integrate with his peers. It also encourages the development of escape mechanisms that the boy can use to avoid the pain of these negative relationships. 17(p316-317), 4(p172), 5(Tape 1)

The mistreatment from other boys increases the pre-homosexual boy's fear and shame and further alienates him from his peers. He misses his initiation into male comrade relationships where masculine identity is conveyed. 14(p189) Bieber emphasizes the importance of what he calls "empathic interactions" that take place



in these groups. 17(p317) Masculine identification seems to be built upon such “empathic interactions”—the sharing back and forth among boys of feelings, ideas, and motivations. Jeff Konrad said in this regard:

“I’m positive that if I allowed myself at a younger age to belong to—and feel a part of—a group of guys, it would have eliminated my gender confusion. I would have received fulfillment of same-sex needs without even consciously realizing it and never would have acquired a homosexual identity.” 15(p212-213)

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From *Coordinates*, by David Matheson (unpublished manuscript)  
Chapter 10—Same-Sex Disaffiliation

## Same-Sex Affiliation

Affiliation means connection or association. It implies close contact, including cooperation and companionship, bonding and love. Affiliation is about being united with or adopted into a relationship or group.

It is natural and normal for people to want to relate to others of their own gender. Boys “hang out” together through much of childhood and adolescence. Grown men often seek each other’s company for recreation and masculine support. These relationships play an essential role in fulfilling the basic human need for affiliation

and companionship.

Three concepts may be helpful in understanding more fully the meaning of affiliation: attachment, approval, and resonance.

### **Attachment**

Attachment is an emotional tie between two people where there is some degree of dependency on each other for emotional satisfaction. It is a binding affection. Attachments can exist between a father and son as well as within male friendships. They are characterized by enjoyment of each other, wanting to be together, and sadness at being separated.

Attachments are considered to be the foundation on which role modeling takes place. Role modeling is the primary process by which gender-concept is learned and masculinity becomes internalized as part of the self-concept.

### **Resonance**

The word resonance is used to describe the intensification of a vibration by a small outside force, such as when a child in a swing is pushed by someone—the motion of the child can be easily maintained or intensified by relatively small pushes.

Resonance also refers to vibrations being set off in one object by the sound vibrations of another object, such as when a guitar string causes the wood of the guitar to vibrate—the sound is intensified and enriched by the sympathetic vibration of the wood.

This word has been borrowed from the world of sound and vibrations to describe a state when the **energy, feelings, and attitudes** within a group of people are set off, maintained, intensified, and enriched by interactions among the group.

When you are watching a sad movie and you begin to cry, you are resonating with the feelings of the characters in the movie. When a congregation is moved to religious fervor by a speaker, they are resonating with his energy and attitudes.

When a group of boys is playing together, they resonate with each other's energy. It is probable that this is a central aspect of gender identity development. The resonance among them may well be how boys take in the "energy" of being male. It is not enough to just be present with them—it is necessary to "resonate" with them. In this way, a boy sees aspects of his self-concept reflected in the boys around him causing self-concept and gender-concept to grow together as a congruent whole.

### **Approval**

Approval is the favorable attitude or opinion of other people. This implies positive acceptance within a group that wants your presence among them. In a sense, their acceptance is a ratification of your value to them. They are affirming your existence and worth.

Validation in male-male relationships comes from feeling affirmed as being like them, being “one of the guys.” This approval contributes significantly to gender-congruity by bringing self-concept together with gender-concept. This validation is completely different from approval from females, which comes from feeling recognized and affirmed as their opposite. Over your life span, both types of validation will be important. But during childhood and adolescence, male validation is pretty much the only validation that matters. And during the change process, it is the affirmation from other males that is most critical.

## **Relational Wounds**

Most people experience some type of pain in their childhood relationships. Some boys experience wounds that cause them to detach and pull away from other males. These are the wounds that can break same-gender affiliation and predispose a boy toward same-sex attraction. These wounds very commonly occur between the ages of 18 months and four years. Abuse later in childhood can also weaken—or further weaken—that affiliation.

We realize that this section is brief and that a great deal more could be written about the wounds received in childhood. This section is not intended to resolve your abuse and neglect. Rather, it is intended to help you better understand how abuse and neglect may have made it difficult for you to affiliate with others of your gender. This section is only a beginning to a more lengthy dialogue on abuse and neglect that should be explored through therapy.

In my experience, most men who develop SSA experienced wounds that broke their affiliation with other boys and men. However, there are some men who develop SSA without experiencing intense relational wounds. Whether you are clear about the pain that broke your same-gender affiliation or think that you may not have experienced such pain, the remainder of this chapter contains some valuable insights for you to consider. Please continue on.

## **Defining Abuse and Neglect**

Whenever a person inflicts physical or emotional harm on another person it is abuse. This is true whether the person inflicted the harm intentionally or unintentionally. And it is true whether the harm is inflicted physically, verbally, emotionally, or sexually. Although much of the abuse that occurs takes place within families, abuse can also come from outside the family. Schoolmates, neighbors, educators, church leaders, employers, and total strangers can inflict abuse.

Neglect occurs when those who are responsible for taking care of our needs fail to do so. Children are dependent on their parents for basic physical needs, emotional nurturing and support, education, safety and learning social skills. Parents, babysitters and other caregivers who fail to provide for these needs are guilty of neglect. Abandonment—which refers to withholding interest and involvement in a child’s life—is one form of caregiver neglect.

## **Severity, Impact, and Lasting Consequences**

The consequences of abuse and neglect are based on not only the severity of the abuse or neglect itself, but also on the way the abuse or neglect is experienced by the child. While extreme abuse will negatively impact almost any person receiving it, the consequences can vary greatly. As you learned in Chapter 2, children are born with differing temperaments, which cause them to respond in unique ways to their environments. This helps us understand why some children are not seriously wounded even by severe abuse and neglect while other children are badly hurt by what some might consider mild abuse.

These different reactions are due mostly to the way the abuse or neglect was perceived by the child himself. You cannot do anything about the way you perceived or reacted to the abuse or neglect you received. It is essential for you to simply accept the way you were affected by your childhood wounds. Avoid making any thinking errors about how you “should” have responded to what happened.

Some people remember their abuse and neglect throughout their lives. But it is possible to forget these wounds over time. And some children create powerful memory blocks to shut out painful childhood experiences. Regardless of whether you have clear memories of the abuse or neglect you received, the effects of these experiences tend to be carried throughout life until they are addressed.

One final thought is important here: serious abuse and neglect are not required to create circumstances that can lead to SSA. Even mild mistreatment can bring about a sufficient level of same-gender disaffiliation.

Below are more specific descriptions about the 5 main forms of abuse: 1) neglect and abandonment, 2) verbal abuse, 3) harassment, 4) physical abuse, and 5) sexual abuse.

### **Neglect and Abandonment**

Neglect and abandonment result from failure of parents or caregivers to provide for basic physical needs, emotional nurturing and support, education, safety, and social skill development.

Some examples of neglect and abandonment include:

- Primary caregivers not providing proper nutrition, housing, clothing and other physical needs.
- Caregivers allowing a child to be exposed to unsafe conditions.
- Loss of time with a primary caregiver because of work, divorce, illness, or death.
- Fathers not showing affection or providing guidance, discipline, and a masculine example for their sons and/or having little nurturing physical contact with them.
- Mothers being distant, cold, and unavailable to their sons.
- A parent's not intervening in another parent's mistreatment of a child.

## **Verbal Abuse**

When one person speaks crudely, angrily or insultingly to another person, it is considered verbal abuse. In some situations, the abusiveness of the words spoken depends on the relationship between the speaker and the hearer. For example, two friends with a close and playful relationship can call each other “gay” or “stupid” and enjoy the teasing. On the other hand, a sensitive younger brother may be devastated if his critical older brother calls him those names.

Sometimes verbal abuse is very blatant, such as when someone angrily shouts at you or threatens to hurt you. But verbal abuse can also be subtle, such as when a person speaks to you in a condescending way or insults you indirectly.

Verbal abuse may come from parents, siblings, other relatives, schoolmates, educators, scouting leaders, and others.

Verbal abuse includes:

- Angry and aggressive shouting.
- Use of foul and vulgar language.
- Threatening harm.
- Insulting, condemning and belittling.

## **Harassment**

Harassment is reported or prolonged mistreatment or persecution. Young people in schools and neighborhoods commonly harass one another. Sometimes, this harassment gets so out of hand or becomes focused so intensely on one individual that emotional harm is done. Often, a boy who is already unsure of himself because of negative experiences he has had in earlier relationships frequently becomes a target for this type of abuse.

Some examples of harassment include:

- Being teased maliciously.
- Having personal belongings stolen or destroyed.
- Being repeatedly threatened or intimidated by actions and gestures.
- Being the object of rumors, gossip, and slander.
- Being spat upon.

## **Physical Abuse**

Any interaction between two people that inflicts severe pain or injury is considered abusive. Physical abuse becomes significant when it creates long-term anger, resentment, mistrust, and problems with self-acceptance. The degree to which physical abuse affects a child can depend on how the child perceives the treatment and the person giving the treatment. For example, some boys may be almost amused by a vigorous spanking from their mother. But these same boys may feel terrified and deeply injured by a mild spanking from their father. The father may have inflicted less pain, but his intimidating personality makes the experience feel worse.

Physical abuse can come from people in your family, people in your neighborhood, scout and club leaders and people at school, such as peers, teachers, coaches and administrators. It can also come from total strangers.

Examples of physical abuse include:

- Parents using harsh and painful physical punishment.
- Schoolmates hitting, beating up, and otherwise inflicting physical pain.
- Being forced to work or exercise to the point of exhaustion or injury.
- Being cut, burned, or hit with an object.

## **Sexual Abuse**

Sexual abuse occurs when one person uses another for his or her own sexual gratification against their will or without their consent. It occurs when an adult engages a minor in sexual activity or exposes them to sexually explicit material or language with or without their consent. It occurs when an older and more powerful child engages a younger or smaller child in sexual activity.

Consent implies the ability and maturity to understand what is going on and the possible consequences of it. Since children do not really understand sexuality, they cannot give consent when an older person involves them in sexual behavior.

Some examples of sexual abuse include:

- Being exposed to sexually explicit talk.
- Being exposed by another person to sexually explicit material found in magazines, television and video, and the internet.
- Being exposed as a child to sexually stimulating behavior by older people whether male or female.
- Being exposed to nudity or to sexual behavior between other people (such as seeing relatives naked or seeing parents or others engage in sex).
- Being touched intimately (on the genitals or other parts of the body).
- Being asked or forced to touch another person's genitals.
- Being asked or forced to have sexual intercourse with another person.
- Having objects inserted into bodily orifices.

## **Sources of Abuse and Neglect**

### **Abuse and Neglect within Families**

Aside from the blatant forms of abuse that are easily recognized, parents, siblings, and other relatives can easily inflict less obvious abuse, sometimes without even being aware they have done so. Abusive family interactions create shame by exposing and insulting the child's natural innocence. Having been convinced that it is wrong to be himself, a child may lock his "real" self in a dungeon and hide the key under defensiveness, self-hatred, and a false exterior. The real self is thereafter not understood, not respected, and not even trusted.

Without knowing it, parents may neglect their children by discouraging their natural drive to become independent. Parents who control, overprotect, over restrict, and manipulate their children destroy their children's opportunities for learning to

choose and accept consequences. These children become dependent on others and fail to learn responsibility and the skill of choice making.

Often, abuse and neglect in families comes under the guise of discipline. But effective and appropriate discipline is quite different from abuse. Appropriate discipline causes children to learn and gain greater self-control and results in a greater fondness and respect between parent and child. Abusive discipline, on the other hand, reduces a child's self-worth and results in resentment and mistrust between parent and child.

## **Father**

Wounds from father can break the father-son attachment, whether those wounds are from distance and neglect, violence, criticism, emotional or verbal abuse, betrayal, or rejection. A poor father-son match can prevent a father-son bond from ever developing in the first place.

Some father-son relationships are not wounding, but still may do tremendous damage to a boy's development. If the father's personality is very opposite that of the boy, a boy may not feel resonance, may fail to attach, and therefore may also fail to ever feel approval or affirmation. These are called "mismatched relationships" and are very common among men with SSA. They create wounds of a less obvious nature. Some scenarios where this could occur include:

- A very weak father with an active, outgoing son.
- An overpowering father with a shy, quiet son.
- A construction worker raising an artistic boy.
- An emigrant father with an Americanized son.

## **Brothers**

Just like wounds from father, wounds from brothers can come from direct abuse or unkindness as well as from mismatch. Very often boys who are in the process of developing SSA view their brothers as extensions of their father. These brothers amplify whatever difficulties the boy is having with his father.

It is also very common for boys who are developing SSA to see their brothers as being more connected to or aligned with their father. Many of the men with SSA that I've known have expressed the sense that "my brother was dad's and I was mom's." For some of these boys it might even feel like their brother is stealing dad's attention or energy, leaving them with nothing.

Not having a brother can be a wound in itself, particularly if a boy is growing up in a very feminized home. A boy's home-life can be feminized by having a lot of sisters, by heavy involvement in the family from grandmothers, aunts, and female cousins, or by being alone in the house with mother because father is absent or often gone.

## **Male Peers**

Problems with peers are not always a prerequisite for same-sex attraction—some



boys develop SSA although they had good male friendships. More typically though, the men I've known have talked about problematic interactions with their peers growing up. Verbal abuse in the form of taunting, teasing, and name-calling is probably the most common form of peer abuse. Physical abuse is also far too common, whether from being tripped or shoved or from actually being beaten up. And far too many boys receive sexual abuse in various forms from other boys.

In addition to the abuse described above, peer wounds can come from not having male peers. Some men have described growing up in a neighborhood where there were no other boys their own age or not being allowed to play with the other boys in the neighborhood.

### **Other Males**

Other boys and men can also contribute to relational wounding in boys. Included here would be authority figures (such as religious leaders, scoutmasters, and coaches), older boys, and male relatives. These males can abuse boys verbally, physically, emotionally, and sexually, creating great harm and pain. These males can also wound boys in less intensive ways by being harsh, cold, or distant. They might be angry, controlling, or manipulative. Or they might simply be repulsive or unappealing to the boy. While less dramatic than full abuse, these personality traits can also damage a boy's interest in connecting with males.

### **Mother and Other Females**

A mother's hatred, disrespect, or criticism of a boy's father, brothers, or friends can prevent or break the bond between a boy and the males around him. Similarly, when a mother compliments her son for being different from these other males she can break his desire or ability to relate with them. If the boy takes his mother's words to heart, his attachments with males can be severed, leaving him feeling disconnected and separated from males. Sisters are sometimes part of such a scenario. Boys who experience this devaluation of the masculine often grow up with a very skewed perspective of other males.

Sometimes when a boy sees his mother being abused, repressed or controlled by his father or another man, he may develop strong negative feelings such as fear, anger and disgust toward the abuser. These negative feelings can become generalized and transferred onto men in general, weakening the boy's interest in connecting with males.

### **Wounds and Choice**

Although everyone has needs for gender affiliation and everyone receives wounds of various types in their relationships, not everyone becomes homosexual. Breaking the father-son bond does not necessarily mean that gender affiliation will be broken. Boys will naturally try to find substitutes for their father, whether through teachers, scouting or religious leaders, male relatives, or peers. There are many men with poor relationships with their fathers who still have a sense of belonging in the male community. Likewise, poor relationships with brothers and male peers do

not always result in broken gender affiliation or homosexuality. If that were true, half the men around you would be gay.

It is not the wounds that cause same-sex attraction and homosexuality. It is the unconscious choices boys make in response to the wounds that lead eventually to same-sex attraction. Let's review some of what we said in Chapter 2 about choice and the development of same-sex attraction.

We said that during the years when a child's core traits are developing, he has little or no awareness of the lasting impact of his choices. He may not even be aware that he is making a choice. Also, his choices are highly biased by the circumstances in which he lives. Typically the choices made by young children are automatic and reactive. They are choices, but the child can hardly be held accountable for them.

We also said that there were thousands of small and large choices that led to the psychological factors that created same-sex attraction. But it is likely that few if any of those choices were made with full awareness or objectivity. Although it is critical for you to begin taking responsibility for the choices you make in your life from this point forward, it is equally important that you forgive yourself for past choices that have led to pain and difficulty in your life. You must not blame yourself for the factors that led to SSA. Rather, try to view yourself with compassion and understanding.

### **Defensive Detachment**

Defensive detachment refers to a particular series of choices that boys make in response to gender disaffiliation and same-gender relational wounds. It implies that a boy not only pulls away (detaches) from the source of the wound but also that he erects a defensive wall against that person. And typically, he feels incapable of doing anything to change the relationship.

Detachment is the opposite of attachment. So it implies that the emotional tie, the binding affection is severed, or perhaps never develops in the first place. There is no resonance or sense of sharing the same energy, attitude, interests, or feelings. Beyond this lack of connection or positive feeling there is also a negative feeling—a wariness, distrust, dislike, disgust, or even hatred. This is the defensive part of the equation and it forms a wall around the boy.

Detachment may involve outward behaviors or internal thought processes or both. It may be a conscious choice or an unconscious reaction. In any case, the result is that the boy is kept "safe" and separate from other males. Although there are several ways boys are able to detach, consider eight of the more prominent ways.

### **Retaliation**

Feeling an urge to punish other males or to "pay them back" for their mistreatment are signs of retaliatory detachment. A boy may feel open hostility toward certain males or types of males, such as "jocks," authority figures, or religious leaders. He may verbally or mentally condemn these males for their faults. There are many ways that boys may detach.

## **Anxiety**

Uneasiness, distress, worry, uncertainty, and dread are all elements of anxiety. Feeling frightened of other boys and men, and of their masculine activities, is part of this form of detachment. Feeling “on guard” around other males and being distrustful and suspicious of their motives are also part of anxious detachment. A boy may freeze up, be rigid in his responses and behavior, and feel nervous or afraid of being seen as noticeably less masculine than others in a group.

## **Avoidance**

Detached boys sometimes disengage from interactions with other males by turning away, cutting off the conversations, or making an excuse to leave. These are examples of avoidant detachment. Turning down invitations to do things with other males or doing things to keep from getting invited are also forms of avoidance. Boys are often especially careful to avoid activities where there will be competition. These behaviors are preventative ways of maintaining separation.

## **Withdrawal**

A boy who is withdrawn is characterized by quiet, passive, uninvolved, and reclusive behavior. Such boys rarely assert themselves and prefer to stay where they feel safe and secure. They may busy themselves with solitary activities or spend time silently observing the activities of others. But they generally prefer not to participate in activities with other males.

## **False Front**

In essence, this form of detachment is characterized by the boy presenting a “façade” or “false self” to others. The pretend appearance is used to cover up the vulnerable “real self.” A boy might accomplish this pretense by developing an extensive social network of shallow relationships, allowing him to appear involved while keeping him clear of any intimacy. Another boy might make himself into the “jokester” or clown, covering up his feelings with humor. Or a boy might become eccentric, flamboyant, and dramatic, behavior which often keeps other males at a distance.

## **Resentment**

The essential element of resentment is holding onto feelings of being unjustly afflicted. Sulking, feeling angry, and being easily hurt by other males are common behaviors among resentfully detached boys. Injustices and offenses are long remembered. These boys may become easily disillusioned and may readily cut off relationships. Resentment can lead to disdain for masculine things and to rejection of certain stereotypical masculine traits, objects, activities, and behaviors.

## **Negative Characterization**

Picking out obvious traits in other males and overemphasizing them as negative

qualities is common behavior for some detached boys. Once a negative quality is identified, the rest of that male's personality is overlooked, and he is dismissed as worthless. For example, a man with a rural accent and limited vocabulary may be dismissed as a "dumb hick" despite the man's kindness and deep wisdom. Or a church leader who advocates strict obedience may be written off as "authoritarian" without the boy appreciating the leader's humility and sensitivity.

### **Compensation**

Boys who feel deficient in traits that are culturally valued may make up for their perceived deficiency by excelling in areas that come more easily to them. The activities, abilities, and interests they pursue may be atypical for boys in their culture and the time and energy spent in these areas may separate these boys from relationships with other males. Boys may also compensate for perceived deficiencies by fantasizing that they are unique, special, or "too good" for other males. They may imagine themselves as possessing great qualities, abilities, and fame.

### **Generalization**

The wall of defensive detachment most typically develops first in the boy's relationship with his father but it can also begin in other relationships, such as with peers or an abuser. In the boy who is developing SSA, the detachment then broadens beyond the original male(s) to include other males. This is referred to as "generalization."

Generalization occurs when a boy unconsciously expects other males to treat him like those who have already hurt and estranged him. Even without interacting with these other males, the boy believes that they are not interested in him, that he doesn't belong with them, or that they don't like him. He expects to be rejected or hurt. His natural response is to protect himself from additional pain. So he detaches from these other males as he has from the significant men and boys in his life.

This does not mean that detached boys have no interaction with other males. But it does mean that they tend to hold other males at a distance using some form of detachment. Their relationships are usually superficial or uncomfortable, although they may have some deeper relationships with other detached males, or males who are unusually nurturing.

Detachment builds on itself. Once a boy has disconnected in a few core relationships, he then can't learn from those relationships the skills necessary for male affiliation. When this is the case, the boy may be unable to affiliate with other males generally, leaving him with no way of forming bonds of affiliation and robbing him of opportunities for attachment, resonance, approval, and affirmation.

The intensity of this detachment and the extent to which it spreads is unique to each man. You might ask, "How severe does it have to get to cause SSA?" The best answer for this is that it must become bad enough to create a painful sense of

longing for male connection. More will be said about his later.

Consider the following examples of how defensive detachment might become generalized.

- A boy with a critical, rejecting, and hurtful father pulls away from his father, feeling anger and disgust toward him. His detachment is intensified by his mother's criticism of his father and also of other men and boys. The boy comes to see all boys in the same light, creating a defensive wall toward all males.
- A boy feels very different from his father and no relationship between them develops. This might be due to major differences between their temperaments or the father's inability to relate with children. The boy is never abused and may think his father is a good man. But because of the lack of interaction between them the boy doesn't learn how to interact with males and struggles in his friendships with other boys.
- A boy with a weak or broken father-son bond experiences teasing or rejection from his male peers. Without the strength of the father-son bond, he is unable to handle the troubles with his peers and so he detaches from them. The sense of gender affiliation is broken.
- A boy who has an adequate relationship with his father is abused by his peers. The abuse causes him to withdraw from other males his age over a long period of time. He does not learn the skills for interacting with other boys and men and carries with him a sense of fear and awkwardness around other males.
- A boy is sexually abused by an adult. He feels violated and angry toward his abuser and perhaps also toward his father for not protecting him from the abuse. Over the course of his life he turns that anger toward many other males and may even become an abuser himself.

In reality, most cases are more complex than this, typically unfolding over the course of years and involving interactions among several or many relationships. But these examples hopefully provide you with a sense of how detachment may become generalized.

### 3. Gender distortion

(Define) Many SSA males engage in distortions and illusions in their female gender concept. They tend to also have an unhealthy self-concept in relation to the feminine. These distortions may have a profound impact on their ability to be sexually attracted to females.

#### 4. Opposite-sex relational wounds

Many homosexual males have experienced lack of attachment, various forms of abuse (including anti-male teasing and harassment), manipulation, domination, and emasculation). This tends to lead to one or more of four relational positions:

- a. Oppositional: rejection, hatred, disgust
- b. Avoidant: indifference, fear, apathy
- c. Dependent: infantilized, needy, guilt bound
- d. Identified: over-familiar, over-resonant, comfortable

#### ***Required Reading:***

##### **Pathways into Male Homosexuality**

**By David Matheson**

[www.genderwholeness.com](http://www.genderwholeness.com)

##### **Mother and Son**

The phenomenon of over-attachment to mother is considered by many writers to be an effect of the more primary concern—detachment from father. Mother becomes “the only remaining channel for attachment.” 7(p8) If this relationship is more rewarding to the boy than that with his father (or whatever male is available), it would not be too surprising that a son would remain attached to his mother and thus fail to identify with the male figure. 7(p32) In such a situation the boy may tend to model himself after his mother’s “mannerisms, expressions, and perspective on life.” 9(p47) This is a safe relationship for the boy, but it is likely to cause him to feel weak, stifled, and confined, leaving him with a deficit not only in masculine identity but also in personal power. 7(p98) So far this description presents mother as a passive factor in the development of homosexuality. However, Bieber’s findings (which we will review in depth below) present mother as a more active participant in the process.

##### **GENERAL DESCRIPTION OF MOTHERS**

Bieber’s study grouped mothers of homosexuals into four main groups. The largest group of mothers (69% of the homosexual group) was described as “close-binding-intimate,” or “CBI.” This type of mother was extraordinarily intimate with her son, who was typically the most significant person in her life, replacing the father as the main object of her love. She behaved seductively toward her son, made him her confidant, and encouraged alienation between father and son. At the same time she was inhibiting, over-controlling, and overprotective—restricting his participation in the usual activities of childhood and adolescence including heterosexual behavior. This type of mother was far less common in the control group, constituting only 32%. 8(p47-60) The effects of these mothers on their sons will be discussed below.

Another group was described as “rejecting-minimizing-hostile but not detached.”

These mothers shared traits of the “close-binding-intimate” mothers (described above) and also had similar effects on their sons as the “CBI” mothers. These mothers were belittling, rejecting, and humiliating toward their sons, but also binding, attached, and seductive. Sons were unable to figure out their mothers’ true feelings for them, developed a sense of inadequacy and low self-worth, and felt unable to gain the respect of other people, especially women. Seven and one-half percent of the homosexual group mothers, and a comparable percentage of control group mothers, were placed in this category. 8(p47, 63-68, 81-82)

A third group was described as “controlling-dominating.” These mothers were egocentric, exploitative, and inconsiderate of their son’s real needs although convinced they had his best interests in mind. They were puritanical and/or frigid and used guilt to control and dominate. The sons became distrustful of these mothers but were unable to defy them because of their profound guilt and so became submissive. This type of mother was more common among the control group (27%) than the homosexual group (8%). 8(p71-74, 83)

The other main group of mothers were considered to be “detached” and either “poorly related” or “hostile.” The “poorly related, detached” mothers were basically rejecting though superficially affectionate. They spent little time with their sons and were not overprotective. The sons apparently did not consciously recognize their mothers’ rejection: none hated their mother, several considered themselves her favorite child, and a number respected her. The “hostile-detached” mothers were openly rejecting. They were not affectionate, spent little time with their sons, and were critical and derogatory. The sons mostly hated and feared these mothers. Among the homosexual group, 10% of the mothers were included in the “detached” group, compared with 9% of the control group mothers. 9(p47, 68-71)

The other groupings of mothers in the study—comprising, in total, less than 5% of the homosexual group—were “Mother surrogates,” “Unclassifiable,” and “Not remarkable.” Interestingly, the “Not remarkable” group included no mothers from the homosexual group, but 19% of the control group. 8(p47)

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## 5. Female impingement on masculine sufficiency

### **Required reading:**

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#### INTERFERENCE WITH NORMAL DEVELOPMENT

Bieber describes ways in which the “close-binding-intimate” and “rejecting-minimizing-hostile, but not-detached” mothers promoted homosexuality in their sons. Together these two groups comprise about 76% of the mothers in the survey. These mothers interfered in four critical areas: 1) heterosexual development, 2) the father-son relationship, 3) peer relations, and 4) development of autonomy.

#### **Heterosexual Development**

Through their seductiveness and excessive intimacy, these mothers sexually stimulated their sons, yet they inhibited their sons’ heterosexual expressions through their restrictiveness or by making male sexuality seem brutish, aggressive, and unacceptable. They also discouraged masculine attitudes, and reduced their sons’ opportunities for acquiring heterosexual interests by interfering with peer relations (discussed below). 8 (p79-80) Some such mothers also punish their sons when they engage in childhood heterosexual play and directly interfere in their activities with the opposite sex during adolescence. 8(p253) Nicolosi adds that some mothers encourage a false “good little boy” role by avoiding acknowledgment of sexuality and aggression—traits that are characteristic of a masculine gender-



role. 7(p243)

### **Father-son Relationship**

These mothers frequently prefer their son over his father. This pits the two males against each other: the father trying to gain or regain the appropriate position with his wife and the son trying to gain exclusive possession of his mother. Such mothers may create an almost romantic relationship with their son, may sleep with him, may involve him in arguments with her husband, and in other ways include the boy in inappropriate situations. 8(p80-81) These mothers are typically possessive of their sons, and by discouraging his heterosexuality she ensures that he will not abandon her for another woman. 8(p315) Davies and Rentzel suggest that these mothers may be looking to their sons to meet their own emotional needs that the father is not meeting, or she may only be trying to compensate for the disinterest or absence of the father. 9(p47)

### **Peer Relations**

Activities and friendships with other boys were discouraged, perhaps because the mother was concerned about the boy's health or fearful that he might become injured. These mothers would not allow relationships with "rough neck" boys, but encouraged their sons to interact with adults. Peers were generally considered to be intruding or of lower class. Also, by choosing one of her children (usually her pre-homosexual son) as the preferred child, she created a competitive situation among the siblings, which would instill in the son a sense of rivalry later carried into his relationships with peers. 8(p50, 81)

### **Autonomy**

These mothers fostered their sons' dependence on them by isolating them from peers, siblings, and their father. They dominated and controlled their sons' decision making, discouraged assertiveness, and babied their sons by their over-concern. 8(p81)

### **FAILURE TO INSTILL BASIC TRUST**

The development of trust is one of the first developmental tasks of childhood. This chapter has discussed a young boy's unwillingness to trust his father, which can lead to a defensive detachment (see "Father and Son" above). It is in the relationship with the first caregiver—usually the mother—that infants acquire, or do not acquire, this basic trust. The degree of trust that will be acquired will depend upon the quality of this relationship. 12(p103) Mothers who are not able or willing to provide a stable relationship with their infants jeopardize the child's ability to trust in future relationships. Boys in this situation would be more vulnerable to disruptions in their relationships with their fathers, which could lead to detachment and perhaps to homosexual development. 9(p45)

### **REFERENCES**

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Additional reading on the family structure, pertaining to sub-sections 1 through 5 above.

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**The Family Structure**

As mentioned above, a certain pattern of family interactions is implicated in the development of men who become homosexual. Such family situations were also shown to exist in the histories of many heterosexual men. 5(p71) The Bieber study, reviewed in some depth above, bears out the similarities between developmental backgrounds of some homosexual and heterosexual men by presenting details from both a homosexual and a control group.

This again begs the question, "Why do some men become homosexual while others do not?" Moberly reminds us that the disturbances that lead to development of homosexuality come out of "specific difficulties in individual relationships," not from a particular type of family environment. 6(p5) As stated above, the child's perception of his relationships and his emotional response to those perceptions is central to his development of identity. 3(p92, 98) (See "Perception and Interpretation" above.) The way a boy perceives and responds to his family situation can depend on many of the factors previously described—such as inborn temperament and personality traits and his sense of basic trust—and these vary greatly across the population creating a vast continuum of vulnerability or invulnerability. Therefore, there should be no surprise when the particular family environment described by Bieber and others fails to produce a homosexual son.

This section will review the factors within family structures that are commonly seen in the backgrounds of homosexual men. First, the marital relationship between father and mother will be considered. Next, the "triangular system" comprised of parents and child will be discussed. Finally, the interactions and attitudes that occur among siblings will be reviewed.

**FATHER AND MOTHER**

Little is written on the marital relationship of the parents of homosexuals though much can be inferred from the general personality descriptions of the fathers and mothers. However, Bieber does state directly that "the majority of [parents of homosexuals] in the study had poor marital relationships." 8(p313) Nicolosi notes that relationships between parents of homosexuals are "frequently atypical or disruptive, often with a struggle for dominance between the parents." 7(p81) Elsewhere he states that some fathers of homosexuals are passive and dependent in their relationship with their wives. 7(p53)

Bieber's description of the "close-binding-intimate" mother includes the detail that her primary object of love is the son whom she pits against her husband in a rivalry for her attention. 8(p47) A mother may turn to her son in this way because her husband does not fulfill her romantic desires. 8(p313) Nicolosi tells us that the attitude of the mother toward her husband is important. If she is openly critical or insulting of him it discourages the son from identifying with him. 7(p84-85)

Obviously, in many instances there is no father in the home. Even so, the way in which the mother represents the father and other men to the son may create a sort of fantasized father image that the son will relate to. If the mother's representation of the father and of men is negative, it may have similar effects on the boy as an actual distressed relationship.

#### FATHER, MOTHER, AND SON

The relationship between a father, mother, and child is frequently referred to in psychological literature as the "triangular system." The relationship between a particular type of triangular system and homosexuality has been established over the past 85 years, beginning with Freud. Nicolosi lists over 20 studies that support this concept. 7(p78-80) The study by Bieber and his colleagues, which we have already reviewed extensively in this chapter, describes this triangular system in detail. This study is used as the basis for our discussion here. Remember that what is presented here is a general pattern and is not intended to fully represent every case. Many variations of this pattern may occur, and the pattern sometimes exists in subtle or incomplete forms.

#### **Classical Triangular System**

A "classical" triangular system leading to homosexuality includes a "close-binding-intimate" mother who dominates and minimizes her husband, the detached father. In Bieber's study such a system occurred in 62% of the homosexual cases, but in only 25% of the control group cases—a statistically significant difference. 8(p142) It is within this triangle that the problems described above between fathers and sons and between mothers and sons are played out. In this situation, an over-sympathetic (or dominating) mother might provide such safety from a frightening father that the boy could totally disengage from the father. 7(p29)

At the same time, the father may be so detached that he does not intervene in the destructive behaviors of the "close-binding-intimate" type mother. If the mother and father argue frequently, the boy may sympathize with his mother and identify with her hurt. He may come to see masculinity as brutal and insensitive and may reject his own masculinity. 7(p83) Furthermore, when mothers place themselves between the father and son through overcontrol and domination, the boy comes to see his father through the feminine perspective of his mother, which distorts and dilutes it. 7(p40)

The problems in the triangular system are reflected in Bieber's study through

statistics showing who the sons wanted to be like in childhood. Among the homosexual group 26% wanted to be like their mother as compared with only 2% of the control group. Only 17% of the homosexual group wanted to be like their father as compared with 34% of the control group. 8(p194)

Bieber found the interactions between the homosexual patients and their parents to be very disturbed and pathological. He states that in these families "neither parent had a relationship with the [homosexual] son one could reasonably construe as 'normal.'" All of these parents showed signs of "severe emotional problems," which contribute to a conflictive marriage in which the son becomes entrapped. 8(p310) Bieber also points out that parents' attitudes toward their children are established by the time the child is four years old. After that time the child will be continually exposed to the same parental attitude, which, if it is negative, can have deep and lasting consequences. 8(p311) Bieber states: "From our statistical analysis, the chances appear to be high that any son exposed to this parental combination will become homosexual or develop severe homosexual problems." 8(p172)

### **Child Self-Blame**

Children commonly idealize their parents. A boy will likely assume that, because his parents are bigger and far more advanced than he, they are right in anything they do. Dallas points out that this can lead to children assuming the blame for any rejection they perceive from their parents. 3(p101-102) This can lead to the child feeling shame, believing he is at fault because others will not give him what he feels he needs. 4(Tape 4) The child may also respond to such situations by crying, complaining, or pleading with his parent. If the parent doesn't respond to his protest, the boy may interpret that to mean that he is unentitled to the caring of others during his times of need. 3(p152)

### **RELATIONSHIPS WITH SIBLINGS**

Although the triangular system is the primary factor in personality development, relationships with siblings can have an impact. To some extent, a good relationship with an older brother can compensate for a poor relationship with father, possibly encouraging heterosexuality in a child who would otherwise have developed homosexuality. 8(p311) On the other hand, an older brother who is aggressive and intimidating can inhibit masculine identification. 7(p84) In sibling relationships where there is rivalry and distress a boy who is already at risk may be nudged that much closer to homosexuality. 8(p311)

Bieber's study provided some insight into the way pre-homosexual boys may view their siblings. One section of the report reviewed answers to three questionnaire items: hatred, fear, and admiration of brothers and sisters. The homosexual group showed far greater hatred/fear of brothers and admiration of sisters than the control group—about twice as much in both instances. Also, the control group showed more moderate overall attitudes toward their siblings while the homosexual group showed greater polarity. In the control group, the percentages of affirmative responses to all three questions fell in a narrow range from 23% (for both

hatred/fear and admiration of sisters) to 35% (for admiration of brothers). Comparatively, the range of affirmative responses in the homosexual group went from a low 6% (hatred/fear of sisters) up to 42% (for admiration of sisters) and then up to 58% (for hatred/fear of brothers). 8(p126) See the table below.

### Hatred, Fear, and Admiration Toward Siblings

Sibling	Group	Hated/Feared	Admired
Brothers	Homosexual	58%	23%
	Control	29%	35%
Sisters	Homosexual	6%	42%
	Control	23%	23%

### Peer Relationships

Gerard van den Aardweg suggests that problems in relationships with peers can be seen in the background of homosexuals more often than a poor relationship with father. 13(p62) The section "Mother and Sons" (above) outlined how some mothers interfered with their sons' peer relations through over-protectiveness, over-concern, encouraging adult relationships, treating the boys' peers as though they were intruding or of lower class, and setting the boys up for rivalrous peer relations. 8(p81) In addition to these behaviors, parental rejection can disturb the boy's peer relations by creating within him an expectation that his peers, like his parents, will reject him. 3(p93)

When children enter school, peers become an important source of nurturing. Boys who have not received sufficient nurturing from parents to prepare them to feel equal to peers, and thus to positively handle peer relationships, may be at a disadvantage. 4(Tape 1), 3(p171) The boy's sense of his masculinity can be quite fragile during this time and he needs the support of his male peers. But it is precisely these relationships that are difficult and problematic. 1(p239-240) It is not uncommon for boys to retreat from these painful relationships to more comfortable relationships with their mothers or other females. They become "kitchen window boys"—watching their peers from the safety of their mother's presence, both attracted to the other boys and also frightened by what the boys are doing. 7(p58)

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## 6. Learning

- a. Associative learning
- b. Classical conditioning. Pairing of sexual pleasure with male stimuli.

## 7. Sexual abuse from the same or opposite-sex.

Contributes to gender incongruity by distorting gender role of the victim, especially if he experienced pleasure.

Contributes to gender disaffiliation by creating anger and fear of the same gender.

When the abuser is opposite-sex, it contributes to gender distortion by creating negative feelings toward the opposite sex.

Contributes to learning/conditioning by directly linking sexual arousal with the same gender.

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#### **Abuse**

"Homosexuals have been hurt, unjustly and unfairly, most at the hands of the people from whom they should have received the most help. This hurt is fueling their anger." 17(Tape 1)

Although this section is written specifically for victims of sexual abuse, much of the information contained here can apply to anyone who has been victimized in any way—physically, verbally, or emotionally—whether by family, peers, acquaintances, or strangers. The feelings of loss, the problems with relationships, the self-recriminations, and the various ways of responding and compensating may be experienced by almost anyone who has endured abusive treatment. At the same time, many symptoms that are attributed in this section to sexual abuse may also be found in persons who have not been victims of abuse. Simply having some of these symptoms does not mean that a person was sexually abused. This section focuses entirely on sexual abuse because of the availability of information and because of its commonness among people dealing with homosexuality. However, it must be remembered that emotional, verbal, and physical abuse may also contribute to the development of homosexuality.

#### **DEFINING THE PROBLEMS**

Sexual abuse may be defined as any instance where a person is coerced or manipulated in any way to perform any sexual action for the gratification of another person. Incest, strictly defined, is sexual intercourse between two persons who are too closely related to be permitted to legally marry. 18(p921) Some authors have chosen to alter the meaning of the term incest, broadening it to include sex between a child and any older person to whom the child would normally look for care and protection, whether or not that person is a blood relative.

In his book *Victims No Longer*, Mike Lew defines incest as "a violation of a position of trust, power, and protection." 19(p16) Davies and Rentzel consider any betrayal of trust that takes a sexual form of any kind to be incest. 20(p126-127) The point of these broadened definitions is that when a person sexualizes, and thus violates, his relationship with a person who is dependent on him in some way, the effects on the victim are essentially the same regardless of the legal relationship between abuser and victim—the trust of the child is betrayed. 19(p16), 20(p50) According to Lew, this destruction of trust is a central issue for victims of incest. 19(p18) Davies and Rentzel add that incest "is the most common and damaging form of sexual abuse." 20(p50)



There are other forms of sexual abuse that would not be included in even the broad definitions of incest. Most relevant for our discussion here would be sexual coercion of younger boys by older boys and men. This might be called molestation, which has been defined as approaching and sexually harassing someone; 21(p455) or it might be called rape, which is defined as having sexual intercourse with someone by force or without their consent. 18(p1494) This section deals mostly with abuse perpetrated by an older and trusted individual.

Sexual abuse can take many forms. It might involve full participation, such as in intercourse, mutual masturbation, or oral sex. It might involve being forced to touch the perpetrator, or being touched by him. Or it might simply involve being forced to look, as when an abuser exposes himself, shows pornography, or performs sexual acts in front of a child. 20(p126-127) Some of these activities may seem minor, but to a child the effect can be very great.

Often, however, boys who are victims do not consider the experience to be abuse. This may be because they felt they were a willing participant even though the event was instigated by an older person. Or it can be because they experienced physical pleasure during the act although they did not want to participate. Occasionally the abuse is too traumatic for the child to deal with so they will either down play its seriousness or they will force it out of their minds and forget it. 20(p50)

In our culture, men are expected to be strong and in control of their situation. They are not supposed to be victims. This creates a special problem for men who have been sexually abused. Lew notes that because of this cultural expectation, sexual abuse "becomes a process of demasculinization." Since men are not supposed to be victims, some men who have been abused refuse to recognize their victimization. Instead they may believe that their sexual experiences were consensual, that they were a willing participant in homosexual behavior. This can lead them to the conclusion that they are gay. Those men who *do* recognize their abuse may arrive at the same conclusion by a different route. Believing that men must not be victims, they may conclude that because they were victimized, they must not be "real" men. They may come to believe that they are some other kind of man—perhaps a gay man. 19(p41)

## EFFECTS OF ABUSE

### Loss

Those who are sexually abused in childhood experience a great deal of loss. Lew provides the following insights into what victims lose. Many victims of abuse experience a loss of childhood memories. Traumatic memories of abuse are repressed to escape the pain they create. But many other memories of childhood may also be repressed to the point where some victims may have few memories of any kind from that period of their lives. Abusive situations tend to be isolating, either because the perpetrator keeps the victim away from other children or because the victim's loss of self-esteem and trust cause him to separate himself from others. This creates a loss of social contact and interaction. Abuse may also

cause the victim to be unable to relax enough to enjoy spontaneous play. His opportunities for play, and subsequently, the learning that children gain from play may thus be lost. This inability to play can continue into adulthood. Most victims of sexual abuse experience a sense of loss of control over their own bodies. For those victims who were abused by the people who should have provided nurturing and care, there is a profound loss of the normal nurturing and love that children need 19(p69-17)

## **Relationship Problems**

Sexual abuse happens in a relationship with another person. Such inappropriate and destructive relationships have a negative impact on other relationships. Survivors of abuse sometimes isolate themselves to avoid the pain associated with relationships. Having been hurt many times in the past, they do not want to open themselves again. It is also common for survivors to involve themselves in relationships that are volatile and very short. Often they will find themselves, years after the original abuse took place, involved in another abusive relationship. Or they may settle for generally poor relationships with people, perhaps feeling that they are worthy of no better. It is not uncommon for a survivor to create a relationship with another survivor. Although such relationships can be healthful and healing, they can also be very unhealthy and destructive. 19(p130-134)

The concept of power in relationships may become very confused for a survivor of abuse. Having been the recipient of a misuse of power by one or more significant adults in his life, he may come to see the world as divided into two groups: victims and perpetrators. He may respond to this by determining never to be a victim again and thus becoming a perpetrator instead. Or he may determine that he will never do to another what was done to him and thus remain a victim. A third possible option is for the person to become a protector of others so that he can give and receive nurturing in a non-abusive way. 19(p43-44)

## **Self-Recriminations**

It is very common for survivors of abuse to blame themselves for what happened and to feel a great deal of shame for it. They are likely to believe that they allowed themselves to be treated in that way. They may say that they should have stopped it. If any part of the abuse was enjoyable to them, they may feel an even greater sense of weakness and failure as a man. 19(p57) Since male bodies are naturally very responsive to sexual stimulation, even an abusive situation is likely to produce some arousal, which may be interpreted as enjoyment. Also, perpetrators will often try to convince the child that the child is enjoying the sex. This may lead a victim to believe that he was the one who wanted it, that it was his fault, and that he is bad. 19(p132-133)

Abuse creates a negative self-image within survivors. This negative self-perception is based on the abuse rather than on any real personal qualities. It is a very difficult perception to change. Even when others are kind or complimentary toward the survivor, he is likely to misread or write off their positive responses to him. He may

question their integrity, devalue their credibility or personal worth, think they are patronizing him, or conclude that they just don't know him yet. 19(p120)

In addition to self-blame and poor self-image, survivors often feel inferior and powerless. This can lead to a feeling that they are "hopelessly flawed" and may keep them from even trying to change their lives. They may come to believe that the only answer for their total flaw is complete perfection, which sets up a dichotomous mind set where perfection and worthlessness, all or nothing, are the only ways of living. 19(p118-119)

### **Responses and Compensation**

Some victims of abuse may feel a need to prove their masculinity and will try various inappropriate means of doing so, such as sexual conquests or self-destructive behavior. Similarly, some may try to conceal their perceived weaknesses by going after great achievements in business or other pursuits. Some simply give up trying to deal with their pain and become repeat victims for other perpetrators. Some struggle through life feeling that strength and power are beyond their ability and fearing the exposure of their dark secret. 19(p41-42)

One response to the painful emotions survivors feel is to numb all of their emotions and to become emotionally dead. Young victims may find certain behaviors that help them to numb themselves. These may develop into addictions by the time they become adults. 19(p109) One response of victims to the anxiety of having been abused by another male is to get involved in homosexual behavior in a misguided attempt to prove to themselves that they do not enjoy it. However, the repeated experience of the behavior actually draws the person in and reinforces the opposite of what they set out to prove. 20(p124)

### **Confused Sexual Feelings**

When a survivor has been molested by his father or some father figure, his natural longing to be close to his father becomes confusing. He may not know if he wants affection or sex from the father. 20(p124) This can be generalized to include other men as well. Davies and Rentzel relate the case of a young man who was molested by his father. Later when a gym teacher showed appropriate interest in him he became confused about what the coach wanted. His first thought was of sex. "If somebody loved you, they had sex with you." 20(p123)

The normal boundaries between impulse and behavior are destroyed by sexual abuse, and victims may believe that feelings always lead to behavior. This may lead to a belief that even their sexual *feelings* are "bad." The survivor may begin to obsessively scrutinize each feeling for sexual content, or he may deaden all his feelings and avoid situations where he might become sexually aroused. 19(p185-186) The opposite of this is compulsive sex. Some survivors engage in very frequent sexual liaisons but at the same time do not want to be touched by their partners, other than on their genitals. Touching for them may be an intimacy requiring interpersonal trust that they do not have. Sex that is purely genital and

anonymous gives them a false sense of being cared about without having to trust. 19(p129)

### **Sexual Abuse Contributes to Homosexual Identity**

Survivors of same-gender sexual abuse may wonder if having been sexually involved with another male means they are homosexual or if it is what made them homosexual. 19(p54-55) Boys who become confused about their sexual identity due to abuse may grow up feeling weak, vulnerable, defenseless, and detached from their masculinity. They may explore their sexuality in the same way they were taught to by their perpetrator—through homosexuality. 20(p124)

A number of studies have been conducted to find the correlation between same-sex abuse and homosexuality. One study reported that young males who were sexually abused by older males are about four times as likely to engage in adult homosexual activity compared to males who were not abused. The researcher speculated that victims may come to believe they are homosexual because of the fact that another male (the abuser) found them sexually attractive. According to the same study, if the victim reported experiencing any pleasure during the abuse he is even more likely to consider himself homosexual. 22(p86)

A similar study found that among males abused by other males the likelihood of becoming homosexually identified was seven times greater than among nonabused men and the likelihood of becoming bisexually identified was six times that of nonabused men. The same study reported that 65% of those who were sexually abused said the abuse affected their sexual identity. 2(p86)

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8. Certain psychological disorders that diminish gender congruity or interrupt gender affiliation.

- a. Obsessive-compulsive traits (the pressure cooker concept)
- b. Obsessive-compulsive personality traits

Rigid thinking and perfectionism can distort gender and self-concepts, contributing to gender incongruity. They can also contribute to gender disaffiliation. Once SSA begins to develop, rigid thinking fixes attention on symptoms, intensifying them like a feedback loop.

- c. Anxiety

Can disrupt sense of power and interfere with learning male-typical behaviors, leading to gender incongruity; can disrupt connections with other males, contributing to gender disaffiliation.

- d. Post-traumatic disturbance
  - e. Temperaments, which are described by Robert Cloninger as biosocial.
9. Certain biological and physical factors that diminish gender congruity or interrupt gender affiliation.
- a. Research on direct biological causes for homosexuality is inconclusive at best and provides few if any answers.

***Required Reading:***

**Pathways into Male Homosexuality**

**By David Matheson**

[www.genderwholeness.com](http://www.genderwholeness.com)

**Chapter 2**

**Predisposing Factors in Homosexual Development**

Evidence suggests that many different factors are involved in the development of homosexuality within any given individual. Among the studies that have been conducted on this subject, there seem to be three main groupings of factors. The first grouping includes developmental factors, such as identity development and family and peer relationships. This was discussed in the preceding chapter. The other two groupings are biology and abuse. These are the topics of this chapter.

Research conducted to date shows some relationships between the factors discussed in this chapter and adult homosexuality. However, it should be remembered that none of the evidence is conclusive and none of it ties homosexuality to any single factor. Human behavior results from complex interactions between the basic biologic drives, interpersonal relations, and psychological factors. 1(p400)

**Biologic Theories**

The research on biological contributors to homosexuality can be divided into four basic areas of inquiry: indirect genetic studies (such as studies of similarities and dissimilarities among twins), hormonal studies, neuroanatomic studies, and direct studies of genes. The significant research in each of these areas is reviewed below.

**TWIN STUDIES**

One of the more significant twin studies to date is that by Bailey and Pillard

published in 1991. These researchers interviewed 110 homosexual males who had twin brothers. Roughly half of these men were from identical twin (called *monozygotic*, or MZ twin) pairs while the other half were from non-identical twin (called *dizygotic*, or DZ twin) pairs. The researchers found that in 52% of the identical (MZ) twin pairs both brothers were homosexual while only 22% of the non-identical (DZ) twin pairs contained two homosexual brothers. The sexual orientation of other (non-twin) biological and adoptive brothers in these men's families was also investigated. The researchers found that 9.2% of the non-twin biologic brothers were homosexual and that 11% of adoptive brothers were homosexual (see table below). 2(p1089)

Relationship of Brothers	Percent Sharing Homosexuality
Identical (MZ) twins	52%
Non-identical (DZ) twins	22%
Non-twins	9.2%
Adoptive	11%

In a review of this and other biologic studies, psychiatrists William Byne and Bruce Parsons of Columbia University point out several important factors. The most obvious observation regarding this study is that only half (52%) of the identical twin brothers—who share identical genetic material as well as prenatal environments—also shared homosexuality. If sexual orientation were fully genetically determined one would expect the rate of identical twin brothers sharing homosexuality to be closer to 100%.

Furthermore, Byne and Parsons point out that non-identical (DZ) twins and non-twin biological brothers share the same amount of genetic material, which is essentially a random sample of the genetic material of their parents. So, if homosexuality were simply genetic, the rates of homosexuality among such brothers would be similar. Yet the study shows a substantial difference (22% for non-identical twins and 9.2% for other brothers). Doctors Byne and Parsons suggest that the greater environmental similarity for non-identical twins verses non-twin brothers (twins experience their environment more similarly than non-twins) must be considered as an explanation for this difference.

Since adoptive brothers share no genetic material, one would expect the rate of homosexuality among such brothers to be far lower than that among biologic brothers. Yet this study shows a rate of 11% for adoptive brothers, which is clearly not lower than the 9.2% rate among the non-twin biologic brothers. 3(p229-230)

Bailey and Pillard printed a comment in their report regarding bias of the sample. Their method of recruiting subjects for the study was by placing ads in gay publications. They suggest it is possible that, because the sampling was not done randomly, certain types of individuals may have been more likely than others to respond, which would create a biased sample and skewed results. 2(p1094) In other words, men with homosexual twins might be more interested in participating in a study about homosexuality among twins than twins with heterosexual brothers.

In conclusion, this study seems to show a correlation between twinship and sexual orientation, but only a partial correlation between genetics and homosexuality. Other studies show similar results.

#### HORMONAL STUDIES

The hypothesis of studies suggesting that prenatal hormonal factors contribute to homosexuality is based on the fact that, in the womb, the brains of mammals begin "female" and must be exposed to androgens in order to become masculinized. 3(p230) Thus it is hypothesized that males were not exposed to sufficient levels of androgens during pregnancy, causing their brains to remain "feminine." 4(p216) Evidence supporting this hypothesis is derived from studies performed on rodents. Researchers were able to produce female sexual behavior (assuming a position receptive to mounting) in male rats that had been deprived of androgens as fetuses; and male sexual behavior (mounting) was produced in female rats exposed to androgens as fetuses 5(p315) Byne and Parsons point out that these studies have limited application to human sexuality. The first limitation they point out is that, in these studies, a rat was labeled "homosexual" due to the display of sexual behavior typical of the opposite-gender (males assuming a receptive position, females mounting) and not due to any manifested attraction to same-sex partners. No evidence is provided by these studies to show that artificially hormonalized rats *prefer* same-gender sex partners. In humans, homosexuality is defined by one's sexual fantasies and the preferred gender of sexual partners as well as by behavior. 3(p231)

The other main limitation pointed out by Byne and Parsons is that sexual behaviors in rodents are very simple and are subject to rigid neuroendocrine control. Humans are far more complex organisms, and it is unlikely that our sexual behavior is fully controlled by endocrine activity. Evidence provided by studies of rodents may be suggestive, but hardly explains the diversity of human sexual behavior. 3(p231)

Researchers Anke Ehrhardt and Heino Meyer-Bahlburg of the New York State Psychiatric Institute reviewed the scientific literature regarding the effects of hormones on gender-related behavior in humans and sub-human species. They reported findings in four areas: gender identity, gender-typical activities, sexual orientation, and mental abilities. Their conclusions are as follows. Gender identity, which they define as one's primary identification with one sex or the other, "depends largely on postnatal environmental influences." Gender-typical activities, which they describe as "all those aspects of behavior in which normal boys and girls differ from one another," "appear to be modified by prenatal sex hormones." Gender-specific mental abilities do not seem to be affected by prenatal hormones. And finally, regarding sexual orientation they state: "we have to assume that prenatal hormone conditions by themselves do not rigidly determine sexual orientation." 6(p1316-1317)

#### NEUROANATOMIC STUDIES

Several studies have been conducted on the hypothalamus, which is a portion of



the brain that regulates such things as body temperature and metabolism. Certain parts, or nuclei, of the hypothalamus are also believed to be involved in regulation of sexual functions. In studies on rodents, researchers have identified several nuclei that are different in size between males and females. The evidence obtained from rat studies sparked interest in searching for gender differences in the human brain. Several studies have subsequently been performed on the human anterior hypothalamus leading to the discovery of several nuclei in this region. But the studies produced inconsistent, and as yet unconfirmed, results regarding gender-related size differences in these nuclei. 3(p234)

One of these studies, performed by Dr. Simon LeVay, reported a size difference in one nucleus (known as INAH3) between homosexual and heterosexual men. 7(p1034) The findings of this study were well publicized as “the first evidence of a biological cause for homosexuality.” 8 Many scientists were skeptical, however, such as Anne Fausto-Sterling, professor of medical science at Brown University, who said simply: “My freshman biology students know enough to sink this study.” 9 Byne and Parsons point out several problems with LeVay’s research. First, LeVay cites studies on a nucleus found in the rat hypothalamus (known as SDN-POA) to support his conjecture that the INAH3 is important in the development of male sexual behavior. Evidence cited by Byne and Parsons shows LeVay’s assumptions regarding the comparison of INAH3 with SDN-POA to be either false or inapplicable.

Second, LeVay’s study had several technical flaws. The most important of these are the small sample size (only 19 homosexual men, 16 other men, and six women were sampled); the fact that all of the homosexual men and six of the other men had died of AIDS, which may affect the size of the nuclei being measured; inadequate sexual histories (the 16 men and the six women were assumed to be heterosexual although their actual sexual orientation was unknown); and inadequate medical histories of the subjects. 3(p234-235)

The most important caution regarding this study comes from LeVay himself: “the results [of this study] do not allow one to decide if the size of INAH3 in an individual is the cause or consequence of that individual’s sexual orientation.” 7(p1036)

Research conducted since LeVay’s study has provided strong evidence that sexual behavior may indeed cause changes in brain structure. Marc Breedlove of U.C. Berkeley carefully controlled the sexual behavior of two groups of rats, allowing one group to copulate while preventing mating behavior in the other group. When the spinal cords of these rats were compared following dissection, a significant difference was found in the size of neurons in the spinal nucleus of the bulbocavernosus (SNB), a part of the rat brain known to be active in males during copulation. Breedlove’s conclusion is that “It is possible that differences in sexual behavior cause, rather than are caused by, differences in brain structure.” 10

## GENE STUDIES

In 1993 Dean Hamer and others published results of a study investigating the

pedigrees and DNA of 114 homosexual men and their families. They found "increased rates of same-sex orientation . . . in the maternal uncles and male cousins of these subjects, but not in their fathers or paternal relatives." 11(p321) This finding suggests that there may be a sex-linked genetic transmission of some factor that increases the likelihood of same-sex orientation. The researchers also selected 40 families with two homosexual brothers and studied their DNA, along with the DNA of their mothers and siblings, where available. They found a small section (or "marker") on the X chromosome that was substantially different in a percentage of the known homosexual individuals. They labeled this marker Xq28. In 33 of the 40 pairs of gay brothers both men had this distinct chromosomal marker. The researchers conclude that, "it appears that Xq28 contains a gene that contributes to homosexual orientation in males." 11(p325)

Because of the complexity of the Xq28 region of the X chromosome and the small number of people tested, the researchers were not able to identify a specific gene. To determine the exact influence of any gene on human behavior requires that the exact DNA sequences be mapped out in order to distinguish the role of inheritance from the influences of environment, experience, and culture. The researchers admit that they do not yet know what percent of all homosexuals have this genetic marker, that little is known of the actual role of this marker in the families studied, and that no information about the presence or absence of this marker in heterosexuals is yet available. 11(p325) Furthermore, the research does not fully explain the seven pairs of gay brothers who did not both inherit the genetic marker.

Anne Fausto-Sterling and Evan Balaban point out several criticisms of this study. First, if this marker is truly linked to homosexuality, then the heterosexual brothers of the homosexuals studied should not have the marker. But Hamer's study provides no data on non-gay brothers. Second, the figures used by the researchers to demonstrate a significant rate of homosexuality among relatives of those studied are controversial. Hamer used 2% as the base rate of homosexuality in the general population. Using this figure, his study showed an unusual rate of homosexuality among test subjects' uncles and male cousins, supporting the idea that homosexuality is heritable. However, the base rate of homosexuality is difficult to determine and even a slightly higher base rate would make Hamer's findings meaningless. Third, Fausto-Sterling and Balaban point out that, "Correlation does not necessarily indicate causation. A gene affecting sexual orientation . . . might do so very indirectly." They suggest, as an example, that having any gene in common might increase the psychological identification between brothers and thereby "influence their similarity in such matters as sexual orientation." 12

## CONCLUSIONS

Despite the extensive criticism of the studies discussed above, they do provide enough evidence to suggest that there may be relationships between biologic factors and homosexuality. There is not enough data as yet to suggest what the specific relationships may be or what the precise causes and effects are. For example, chromosome research and twin studies show only a correlation between genetic factors and homosexuality. Correlation is a way of saying, "Where A is

present, *B* is also often present." A correlation tells us nothing about *why* A and B are often present together, and it does not mean that A caused B or vice versa. But it does provide some clues as to where we might look for more answers.

Byne and Parson concluded that, "There is no evidence at present to substantiate a biologic theory." 3(p228) Their statement echoes what other researchers have said for at least the last 20 years. In 1989, John De Cecco, editor of the *Journal of Homosexuality*, was quoted as saying that, "The idea that people are born into one type of sexual behavior is foolish." 13(p91) Masters, Brown and Kolodny stated in 1984 that, "The genetic theory of homosexuality has been generally discarded today." 14(p91) And in 1974, John Money write, "The child's psychosexual identity is not written, unlearned, in the genetic code, the hormonal system or the nervous system at birth." 15(p91)

At the same time, Byne and Parson also said that, "there is no compelling evidence to support any singular psychosocial explanation." 3(p228) This refers to the types of theories presented in chapter 1. They added, however, that just because the psychosocial theories do not fully explain the development of homosexuality, there is no justification for ignoring them in favor of purely biologic explanations, particularly since the biologic theories do not explain it any better. They feel that the value of psychosocial models is being generally underrated. 3(p228)

One final thought regarding biologic theories must be considered. Human bodies are biological organisms. This obvious fact reminds us that, for the extent of our lives, we are subject to biological givens and processes. Because our brain is part of this biological organism it can be said that all human thought and behavior has a biological basis. Yet the complexity and sophistication of the mind equips it with an awareness of itself and with the capacity to choose. So, in this sense, most human thought and behavior—though based on biology—also represents choice.

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b. Biological factors can have an important indirect impact by affecting other parts of the pathway. Examples include:

- (1) Conditions that cause boys to be singled out as different or to feel different from other boys (typically in negative ways but sometimes also in positive ways). These can include physical deformity or unusual appearance, high or low intelligence, over- or under-weight, penis size or uncircumcision, etc.
- (2) Conditions that interfere with gender-typical activities, especially athletics. These can include poor or late-developing eye-hand coordination, body size and strength, etc.
- (3) Time of puberty (early or late)

### C. Vectors and an Interactive Pathway

The psychological setup for homosexuality is created by the interaction of various factors, which may combine in an infinite number of ways. These factors create a pathway, which will be different for each individual. The risk factors described above represent the situations, issues and conditions that are known to contribute to such an interactive pathway.

Any given individual will have a certain subset of risk factors that contribute to their own pathway. Each primary and essential contributor to the homosexual outcome for a given individual is referred to as a vector. An individual may have a number of vectors, such as estrangement from father, over-connection with mother, obsessive-compulsive disorder, and sexual abuse. It is also possible that an individual may have just a single vector, such as exposure to homosexual pornography during a particular developmental window.

Vectors are of significance in understanding and explaining to the client the causes of his SSA. They are also essential in understanding an individual's current underlying issues since a vector's influence tends to be long-term.

#### D. The Homosexualizing Process — Necessary and Sufficient Conditions

Only two conditions are required for the creation of SSA. These conditions can be created in diverse ways. The conditions are:

1. A situation in which the same sex becomes a focus of intense interest or emotional arousal. This situation is created by an interactive pathway as described above.
  - a. "Intense interest" might include admiration, curiosity, wonder, and fixation. This includes (but is larger than) what Bem described as an autonomic arousal resulting from experiencing another of the same gender as exotic. A purely obsessive-compulsive interest would typically not qualify.
  - b. "Emotional arousal" can include feelings of anxiety, fear, anger, hatred, longing, love, envy, and loss (especially attachment loss).
2. An experience that connects the same-sex interest or emotional arousal with feelings or impulses that are interpreted as sexual.

#### ***Required Reading:***

#### **Pathways into Male Homosexuality**

**By David Matheson**

[www.genderwholeness.com](http://www.genderwholeness.com)

#### **Chapter 4**

### **Development of Symptoms**

Chapters 2 and 3 described biologic and psychosocial factors that many psychologists believe are involved in the development of homosexuality. This chapter investigates how these underlying factors may lead to adult homosexuality.

The chapter begins by considering the concept of an interactional model of homosexual development. In essence, this model suggests that both biologic factors (including genetics and hormonal variables) and psychosocial factors (including relationships with family and peers as well as abuse) may interact in predisposing a boy to develop homosexual longings. The chapter then explores emotional needs and early manifestations of these needs, which result from the underlying biological and psychosocial factors. Finally, the process by which emotional needs created during boyhood become transformed into sexual desires and behaviors is discussed.

### **Interactional Model**

Individuals can arrive at the same place with regard to sexual orientation yet come from many diverse developmental backgrounds. 1(p928) This idea has been expressed by researchers and theorists approaching the topic of homosexuality from many different perspectives. Rochelle Klinger of the Medical College of Virginia said, "I don't think we'll ever find a single cause of homosexuality." 2 Elizabeth Moberly, author of *Homosexuality: A New Christian Ethic* wrote, "many things may cause the attachment disruption underlying homosexuality. There is not a single cause leading to a single effect." 3 (p3)

Joe Dallas, author of *Desires in Conflict*, objects to most theories regarding development of homosexuality because they assume that each person has homosexual attractions for the same reason. 4(p92) Just as there is great lifestyle diversity among homosexual persons, there is also a diversity of factors that contribute to same-sex attraction. 5(Tape 1) Human behavior, it seems, results from complex interactions between the basic biologic drives, interpersonal relations, and psychological factors. 6(p400)

Dr. Allen Bergin suggests that "causality is 1) multiple, 2) reciprocal, 3) cyclical, and 4) agentic, thus resulting in varied pathways and also varied outcomes." 7 The multiplicity of factors mentioned by Bergin has been discussed in chapters 2 and 3. Research presented in those chapters implicates three main sets of factors: relationship problems, biologic factors, and sexual abuse. A fourth factor must be added: the boy's own interpretations and reactions. Bergin's model seems to indicate that each of these factors would influence—and be influenced by—each other (reciprocal) and that these mutual interactions would be repeated many times along the developmental pathway (cyclical). Furthermore, his model suggests that the individual's own actions influence the outcome (agentic).

Byne and Parsons present a similar "interactional model." According to their model, biologic factors (genes and hormones) influence a person's temperament—or bias them toward certain personality traits—but do not determine sexual orientation. 8(p433), 9(p236-237) They refer to the work of Robert Cloninger who suggests that there may be three underlying dimensions of the personality that are genetically determined. These are "*novelty seeking, harm avoidance, and reward dependence*." Novelty seeking is described as a tendency to respond with "intense exhilaration or excitement" to new situations, the possibility of rewards, or

opportunities to avoid discomfort. Harm avoidance is the tendency to respond strongly to, and avoid, things that cause discomfort. Reward dependence is described as a proneness to respond strongly to pleasant things, especially “social approval, sentiment, and succor.” 10(p574-575)

The underlying disposition for these three traits may be genetically determined. But the effect of these traits on the personality and behavior of an individual would be strongly influenced by his relationships and experiences with other people and even on other biologic factors like general health, body size, and strength. Byne and Parsons propose that biological factors would influence temperament. Then through normal psychological processes influenced by the child’s family and social situation, temperament would affect the child’s relationships and also his perception of these relationships. His perception would then contribute to the development of the child’s sexual orientation. 8(p433)

Byne and Parsons suggest a scenario of a boy who is high in harm avoidance and reward dependence but low in novelty seeking. Such a boy might prefer the warm approval of his mother over the less rewarding approval of men and boys. If his father, or some other male, does not take a special interest in him, he might miss out on male role modeling. He would be less likely to participate in sports and rough play (high harm avoidance, low novelty seeking) and so would miss a large part of peer identification. These experiences could lead to the boy feeling unmasculine, isolating himself, becoming a scapegoat for other boys, and feeling rejected by his peers and older males—traits that are common in boys who later develop a homosexual orientation. 9(p237)

The range of possible personality development variations suggested by this scenario is vast. What if the boy described above moves at a young age to a new neighborhood, is befriended by a nurturing scoutmaster, and is accepted by a peer group of accepting boys. He may experience male role modeling, he may learn to at least endure sports for the sake of experiencing friendships, and he may identify strongly with his peers. These factors could foster development of a heterosexual orientation.

At the same time it is possible to imagine a boy with *high* novelty seeking, and *low* harm avoidance and reward dependence who becomes homosexually oriented. If such a child became involved at an early age with other boys who experimented extensively with homosexual play he may find this behavior exhilarating (high novelty seeking). Despite family and social discouragement of homosexuality (low harm avoidance and reward dependence) he may continue to explore the behavior simply because it is exciting and feels good. If other boys find out about his continued homosexual behavior, he may be taunted and rejected even if he otherwise participates in sports and other typical boy activities. The open rejection of his peers could lead to his becoming isolated and feeling unmasculine, which he might compensate for by increasing his homosexual activities.

June Reinisch, director of the Kinsey Institute for Research in Sex, Gender, and Reproduction at Indiana University, stated: “All of us believe that genetic and

hormonal influences are involved in homosexuality . . . but there's also an interaction with the environment." 11 It seems to be a common human trait to look for simple answers, especially in situations that are complex and distressing. However, resorting to simple answers regarding the causes of homosexuality creates frustration, hopelessness, anger, and even greater distress. Byne and Parsons state: "It is imperative that clinicians and behavioral scientists begin to appreciate the complexities of sexual orientation and resist the urge to search for simplistic explanations, either psychosocial or biologic." 9(p236)

## Sexualization

### SEXUAL EXPERIMENTATION

Sexual exploration of various kinds is common among adolescent males. Homosexual exploration also occurs with some frequency, even among boys who will become heterosexual. An analysis of data collected from a national survey conducted in 1970 shows that a minimum of "20.3 percent of adult men in the United States . . . had sexual contact to orgasm with another man at some time in life; 6.7 percent had such contact after age 19; and between 1.6 and 2.0 percent had such contact within the previous year." 23(p338)

This same study states the 3.3% of the adult male population in 1970 had experienced homosexual contacts at least occasionally at some point in their life. 23(p346) This suggests that the rest of those who had experienced homosexual sex (17%) are not what might be termed *actively homosexual*.<sup>1</sup> We might conclude that this 17% represents men who experimented with same-sex behavior but then moved away from it, either into heterosexuality or celibacy. So, considering the male population in general, while only a small segment can be considered "homosexual," a large segment experiments homosexually, mostly in adolescence.

A comparison of homosexual and heterosexual populations suggests that early sexual behavior is more common among homosexuals than heterosexuals. The chart below, adapted from the Bieber study, 17(p191) shows that far more homosexuals than heterosexuals had genital contact for the first time before age 14. The cumulative percentages through age 18 (not shown) also show first genital contact to have occurred more commonly among the homosexual group than the control group by that age. Even through age 24 we can see that more subjects in the homosexual group had experienced sex than in the control group. This chart also shows that, among these groups, heterosexual contact more commonly began at later ages than did homosexual contact. In addition, Bieber mentions elsewhere that the homosexual group was more sexually active from pre-adolescence on 17(p189)

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<sup>1</sup>The difficulty in classifying individuals as "homosexual" or "not homosexual" becomes apparent here. This 3.3% represented men who "occasionally" or "fairly often" engaged in homosexual behavior "at some point in time." 23(p346) The researchers also note that most



of those included in the 3.3% estimate “could not be classified as ‘exclusively homosexual’ throughout their lives” since the majority of these men were married or previously married. 23(p347) Trying to fit these men into simple categories of homosexual, bisexual, or heterosexual seems meaningless.

### First Genital Contact<sup>2</sup> (by group and age) 17(p191)

Age	Homosexual Group		Control Group	
	Homo. Contact	Heter. Contact	Homo. Contact	Heter. Contact
0 thru 14	60%	4%	20%	7%
15 thru 18	25%	10%	0%	29%
19 thru 24	11%	39%	2%	45%
Cumulative	96%	53%	22%	81%

### TRANSITIONAL PHASE

The term “transitional phase” refers to the period of time when the emotional longings of the reparative drive are changed into sexual longings. It could be described as a process of *sexualization* or as going from not having your needs met to having them falsely met through sexual behavior and/or fantasy. Nicolosi calls this “the erotic transitional phase.” 14(p68)

The transitional phase happens in a different way, at a different time, and to a different degree for each person. For those individuals who have not participated in much same-sex exploratory behavior, this transition could take place over an extended period of time and could even span occasions of heterosexual interests. For those who do become heavily involved in sexual behavior early, either through extensive exploration or through sexual abuse, it is possible that the sexualization of their longings could occur before the longing itself is even recognized. It is even possible that sexual abuse could lead to the kinds of hurts that create the longings.

Two distinct sets of needs arise from the problems experienced in the lives of pre-homosexual boys. The first set of needs is emotional and arises from the lack of strong attachments with other males. Within this set are needs for attachment, affection, intimacy, and dependency. Moberly referred to these as same-sex love needs. 3(p17-18) The second set of needs is identificatory and arises from the problems experienced in identity development, which in turn results from the lack of strong attachments during childhood. These two sets of needs become sexualized in different ways and these are discussed below.

### Sexualization of Emotional Needs

Joe Dallas offers the following simple description of the development of homosexual attractions. First, the child has negative perceptions of his relationships to parents and others. Second, the child responds emotionally to his perceptions. Third,

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<sup>2</sup> This chart shows the age at which individuals reported having their first genital contact, both heterosexual and homosexual. It does not show frequency of contact during any age group.

And, fourth, the emotional needs become sexualized. 4(p92) Dallas adds that at some point the boy realizes his desires are more than emotional. He recognizes sexual feelings. Eventually, he hears about homosexuality and assumes it applies to him. 4(p112)

Elizabeth Moberly writes that "it is not surprising that someone who has attained physiological maturity should interpret his or her deepest emotional needs as sexual, but this is to mistake the essential character of these needs." 3(p19) She explains that these are psychological needs that are not filled in childhood and so remain into adulthood where they become confused with physical desires for sexual expression. 3(p20) Although the needs come to be expressed through sex, they "exist independently of sexual expression." 3(p10) Dallas explains that the sexualization of these needs occurs when the *object* of the need (e.g., intimacy with other men) becomes linked with sexual desires. Homosexuality, he says, is "a *function* through which *sexualized emotional needs* are fulfilled." 4(p94)

W. Fairbain linked homosexuality to unsatisfying relationships with parents and commented that the "frustration of his desire to be loved and to have his love accepted is the greatest trauma that a child can experience." This frustration, he writes, drives children to compensate with sexual "substitutive satisfactions." 24(p83) Dallas writes that children commonly idealize their parents. During the normal process of maturing, this idealization gradually gives way to a more realistic view of them. But if some traumatic event or separation causes a boy to be disappointed in his father before he was prepared to let go of the ideal image, he may hold on to the ideal and seek it in other men. 4(p103-104) In this same regard, Moberly writes that "the homosexual love-need is essentially a search for parenting." "The homosexual," she writes, "seeks . . . the fulfillment of these *normal* attachments needs, which have *abnormally* been left unmet in the process of growth." 3(p9)

Joe Dallas suggests that when we reach puberty, if our needs for nurturing from father and peers have not been adequately met, "our bodies won't wait for our emotions to catch up." Instead, the emotional needs will get crossed with our strong sexual desires and same-sex love will become the object of a sexualized need. 4(p110) Similarly, Nicolosi writes that during the transitional phase, the "affectional hunger" for attention and affirmation from father and other males turns into a "sexual striving." 14(p69)

Dallas believes that "we associate warm, positive feelings with sexual response long before we even know what sex is." So when one person wants to experience intimacy with another, it might be expected that the desire could be accompanied by sexual feelings. 4(p110) Meeting emotional needs in improper ways is not an uncommon human behavior. Many men and women use sex as a way of making

themselves feel competent, virile, or special and cared about. 4(p109) Of course, sex is not the only thing improperly used in an attempt to fill emotional needs. Drug and alcohol use, over- and under-eating, gambling, working, and even acquiring possessions can be used in attempts to satisfy deep emotional longings.

### Sexualization of Identificatory Needs

Identity development requires the establishment of an attachment between a boy and the other significant males around him. Through the camaraderie and initiation that occurs in these relationships, the boy is able to take on and internalize the traits of other males resulting in an internal sense of himself as masculine. When this does not occur, the boy is left with a need to connect with other men and find a way into manhood.

Nicolosi speaks of homosexuality as an alienation from males and a subsequent sexualized effort to gain initiation into manhood through another male. 14(p42) Bieber and Moberly suggest that the seeking of "virile partners" by homosexuals is an attempt to identify with the masculinity of the partner. 17(p314), 3(p9) These concepts suggest that homosexuality may—at least in part—be an effort to find a way into masculinity, to demystify and understand it, or to somehow take on the masculine qualities that they sense they have somehow missed. For example, homosexual men who missed out on doing things with their fathers are often attracted to the "mystique of masculine boldness, strength, and power," 14(p39) traits that were not conveyed to them by interaction with their father.

Lacking attachments to other males, pre-homosexual boys are unable to experience genuine masculinity with its strengths *and* foibles, which means that their gender role definition does not develop according to reality, but develops according to childish idealized images. Trying to reach that ideal leaves the boy feeling hopelessly inadequate and dissatisfied with himself. At the same time, the distance of detachment allows him to believe that other men match his ideal. When he sees such men, his interest is piqued. 14(p72-73)

Nicolosi has referred to this entire process using the term "the projected idealized self." 25 This term is a combination of two psychoanalytic concepts. The first concept is the *idealized self*, which is "a perfected and lofty characterization of self in the sense of what one would like to become." 12(p679) The second concept is *projection*, which is "the process by which one's own traits, emotions, dispositions, etc., are ascribed to another" person. 12(p580)

Images of the idealized self develop early in life. Joe Dallas provides insight on how they may be created:

"This image is a combination of people you've actually seen who made an impact on you, figures you've fantasized about, and bodily representations of concepts of masculinity . . . that appeal to you. That is why certain 'types' of people attract us. They remind us of our inner image . . ." 4(p132)

Dallas mentions here "bodily representations of concepts of masculinity." It seems to be a very common behavior among homosexual men to associate certain bodily traits with important traits of masculinity. 4(p133) Confidence, strength, stamina, assertiveness, power, and virility can all be linked to physical traits and behaviors.

During the transitional phase it is common for pre-homosexual boys to become very interested in other boys, especially older boys, who have qualities they admire. This interest may begin as a non-sexual infatuation, but develops into a homosexual attraction. 14(p70) Sexual contact with another, more ideal male provides the homosexual man with a sense of having obtained those ideal traits from himself. 26(p74)

Frank Worthen describes a process whereby the ideal self leads to homosexual desires. It begins when a man compares himself to see if he measures up. He feels that he does not but recognizes others who do. He admires those other men, but the admiration grows into envy and a desire to possess and then to consume the qualities of the other man. At some point, these desires become sexual 27(p4) The sexual bonding experience provides a momentary feeling of possessing those desired traits, of being whole. 14(p73) However, the idealized self is usually made up of specific desirable traits that are emphasized while other ordinary traits may be ignored, devalued, or even held in contempt. The resulting ideal man, far from being whole, may actually be quite unrealistic, almost to the point of being a caricature of masculinity.

The homosexual man may sense the emotional needs described above. But his response to these needs is passive. Rather than establishing nurturing attachments wherein he could gain a connection and understanding of manliness and realize a realistic gender role definition he seeks to meet his needs sexually. A description of homosexuality by Carl Jung is appropriate in this regard. Jung described homosexuality as "a repressed, undifferentiated element of masculinity in the man . . . which instead of being developed . . . from the depths of his own psyche, is sought on a biological plane through 'fusion' with another man." 28(p76)

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From *Coordinates*, by David Matheson (unpublished manuscript)  
Chapter 14—Symptoms and Choices

## The Developmental Setup

A Cornell University psychology professor by the name of Daryl Bem wrote a very important article in 1996 in which he theorized that humans become sexually attracted to individuals whom they perceive as exotic, in other words, different from themselves. The article *Exotic Becomes Erotic: A Developmental Theory of Sexual Orientation* lays out a rather complex though plausible theory of how sexual orientation develops beginning in childhood and adolescence. The outline of this chapter will follow his theory because his theory—though imperfect—makes a lot of sense. I have interwoven relevant concepts from others who have theorized about homosexual development. We focus in this chapter exclusively on male sexual development although Bem's theory applies equally to girls.

Bem begins where we began in this workbook, with biology. He suggests that biological factors such as genes and prenatal hormones (chemicals the baby is exposed to in the womb) influence the development of a boy's temperament. The boy's temperament then influences his choice of activities and playmates. To this I add, as you read in Chapter 2, that a boy's brain and body also significantly bias his choices. I also add that boy's are heavily influenced by environmental factors including family, peers, community, culture, and religion. The result of all of these biological and environmental factors, combined with choice, is the boy's core self.

According to Bem, the next step in the process is that temperaments cause some boys to become "gender conforming," which means they prefer activities and playmates that are typical of boys. Other boys' temperaments lead them to become "gender nonconforming," which means that their interests, activities, and playmates are *not* typical for boys. Eventually, Bem says, the gender nonconforming boys come to see themselves as dissimilar or different from the gender conforming boys. To return again to the concepts you've learned in this workbook, these boys' self-concept (which you explored in Chapter 6) does not match their gender concept (as you learned in Chapter 7). Bem also hypothesizes that the dissimilarity would separate these boys from the activities and company of other boys, causing other boys to seem unfamiliar. In the language of this workbook, he is talking about gender disaffiliation (which we covered in Chapter 8).

## Exotic Becomes Erotic

Bem's theory suggests that humans are hard-wired to become sexually attracted to the types of individuals that they experienced as "exotic" during childhood. The word exotic means foreign, strange, unknown, or mysterious. Gender incongruity and gender disaffiliation would both cause a boy to experience other boys as exotic. And these two conditions could impact and intensify each other, creating a sort of psychological feedback loop.

For example, a boy who sees himself as being very different from the boys around him (gender incongruity) would likely have a difficult time identifying with those boys and fitting in. That could discourage the development of friendships, leaving the boy isolated from his male peers (gender disaffiliation). Conversely, a boy who is raised in a situation where—for whatever reason—he doesn't interact much with other boys (gender disaffiliation) might not be able to develop a clear understanding of other boys. He might come to see them as being very different from himself (gender incongruity).

It is not necessary that a boy experience both incongruity and disaffiliation in order to experience other males as exotic. It is enough to experience *either* incongruity or disaffiliation—as long as it leads to the sense that other males are foreign, strange, unknown, or mysterious.

### **Strong Feelings**

Next, according to Bem's theory, the boy experiences strong feelings in the presence of those other males he finds exotic. Those strong feelings could be anger, fear, or hurt if the boy has been abused by those or other males in the past. The feeling could be fear of the unknown and the unfamiliar. It could be jealousy if the other male is seen as being somehow better or better off. Or the feeling could be the kind of simple curiosity, interest, and excitement that people commonly feel when exposed to something unusual and different.

Feelings consist of two factors: 1) the experience in the body (the physical sensation), and 2) the story in the mind (the interpretation of the sensation). Let me explain this more fully with an example. When you feel angry, your body has certain physical sensations—usually heat in the upper body, pounding heart, and the feeling of tensed muscles. This is the physical sensation. Then, your mind explains these sensations to you with a story ("*I'm really angry!*") based on your past experiences with those same sensations and on what you've been taught to call those sensations. Anger is an emotion that is easily understood. But some feelings can be rather tricky, leaving the mind to sometimes misinterpret them. We will see the potential effects of this in a moment.

### **The Sexual Crossover**

Many theorists have tried to explain what happens next, and there is disagreement between the various schools of thought. So I will present two main views and let you determine what makes most sense to you. The two main theoretical viewpoints are developmental and psychodynamic. To these I add a third view: an experiential perspective. (Don't worry if you don't understand what these terms mean.) Keep in

mind as you read this that everything we are describing happens in a window of time that may not last very long. The situations that caused this may not continue after that time. Problems that created this incongruity and disaffiliation may later be resolved. On the other hand, these situations can last throughout childhood and adolescence.

### **According to Developmental Theory**

Bem's theory is developmental. He cites numerous other theorists and researchers, suggesting that when a boy experiences strong feelings in the presence of an "exotic" male, he may misinterpret those feelings to be sexual attraction. In other words, he feels physical sensations in his body (which could be anything from curiosity to envy to anger) but then his mind tells the wrong story about those sensations, causing him to think he is feeling lust or love. It is sort of a "crossed-wires" theory. Keep in mind that the sexualization of these feelings typically occurs during adolescence when a boy is experiencing strong sexual feelings for the first time. These feelings are new to him, and it is not difficult to imagine such a misinterpretation of feelings happening.

Bem suggests an additional factor here, which is that when we are faced with a strong feeling, our bodies will often naturally produce another opposite feeling to counteract it. Anyone who has ever exercised intensely can relate to the "runner's high" or "endorphin high" you get afterward. Sometimes people who have been depressed a lot will say that in some strange way the depression feels comforting. Sometimes people who are angry report that the anger somehow feels good.

Bem believes this process (which he calls "the opponent process") may be part of what causes boys to develop homosexuality. Being in the presence of someone exotic can create strong feelings. If those feelings are distressful—as would often be the case for gender incongruent and disaffiliated boys—the boy's body will produce a comforting feeling to counteract that distressing feeling. From the boy's perspective, this might feel like attraction or desire, which the mind could easily misinterpret as sexual attraction or desire.

I believe that at least some of the strong distressing feelings these boys experience may be due to a foiled quest for gender wholeness. It may be that gender congruity and gender affiliation, collectively referred to as "gender wholeness," are innate human needs. When these needs are not being met, the person feels distressful emotions.

### **According to Psychodynamic Theory**

As far back as Sigmund Freud, psychodynamic theorists have been writing about the development of same-sex attraction. Although their viewpoint can be quite helpful as a description of what people feel, it tends not to be supported by much hard research. I will survey two different perspectives.

Dr. Elizabeth Moberly wrote that homosexuality is the sexualization of normal attachment needs that were left unmet in childhood. To use the language of this



workbook, gender disaffiliation left the boy detached from his father and his male peers from an early age. So the boy is seeking to create a longed-for attachment. These longings are very intense and his feelings are mistaken for sexual urges resulting in homosexuality. This is once again a crossed-wires theory of sexualization. Similarly, Dr. Joseph Nicolosi wrote that homosexuality is caused by an alienation from other males and a resulting effort to gain initiation into manhood. From this perspective, same-sex attraction results from an attempt to meet same-gender affiliation needs. It is an effort to create a place for themselves in the world of men.

Another theorist by the name of C. A. Tripp suggests that gender incongruent boys are unconsciously attempting to “import” masculine traits that they see themselves as lacking in. The quest for manhood and masculinity later becomes sexualized, presumably through crossed wires. In our language, these men are trying to create gender congruity.

Both of these theories ring true with many men who experience same-sex attraction and both are quite useful. Both focus on same-sex attraction as resulting from unconscious attempts to *repair* damaged relationships or incomplete gender identity. (This is where the term “reparative therapy” comes from.) From this perspective, the sexual feelings are merely inaccurate attempts to heal or fix the underlying problems. These healing attempts don’t work though because they don’t get to the root of the problem. They don’t resolve gender disaffiliation or incongruity.

The weakness of these theories is in their inability to explain the actual process by which emotional needs and longings turn into sexual impulses.

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## **Exotic Becomes Erotic: Interpreting the Biological Correlates of Sexual Orientation**

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*Although biological findings currently dominate the research literature on the determinants of sexual orientation, biological theorizing has not yet spelled out a developmental path by which any of the various biological correlates so far identified might lead to a particular sexual orientation. The Exotic-Becomes-Erotic (EBE) theory of sexual orientation (Bem, 1996) attempts to do just that, by suggesting how biological variables might interact with experiential and socio-cultural factors to influence an individual's sexual orientation. Evidence for the theory is reviewed, and a path analysis of data from a large sample of twins is presented which yields preliminary support for the theory's claim that correlations between genetic variables and sexual orientation are mediated by childhood gender nonconformity.*

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**KEYWORDS:** sexual orientation; homosexuality; heterosexuality; erotic orientation; sexuality; path analysis;

genetic correlates.

## INTRODUCTION

Biological findings currently dominate the research literature on the determinants of sexual orientation. Reports of correlations between various biological variables and homosexuality appear regularly in the professional journals and, just as regularly, receive instant replay in the mass media. As a result, some researchers, many journalists, and sizable segments of the lesbian/gay/bisexual community have rushed to embrace the conclusion that a homosexual orientation is coded in the genes, caused by prenatal hormones, or determined by brain neuroanatomy. Except for the reparative therapists, most of the personality, clinical, and developmental psychologists and psychiatrists who once dominated the discourse on this topic have fallen conspicuously silent. Many have probably become closet converts to biology because they cannot point to a coherent body of evidence that supports a developmental, experience-based account of sexual orientation. The general public is not far behind: In 1983, only 16% of Americans believed that “homosexuality is something that people are born with” (Moore, 1993); by 2000, that figure had more than doubled to 35% (Reuters, 2000).

I find at least two aspects of the current zeitgeist scientifically problematic. The first is the premature rush to interpret correlation as causation. In the absence of any theory of—let alone, evidence for—a developmental pathway from the biological markers to sexual orientation, such an interpretation is still a leap of faith. At best, there seems to be an implicit, primitive gender-inversion theory of homosexuality: If, for example, a biological characteristic that is more prevalent in gay men than in heterosexual men happens also to be more prevalent in women than in men, then, ipso facto, that is somehow deemed to “explain” the homosexual orientation. It was my dissatisfaction with this default “theory” that challenged me to spell out a specific developmental process in which biological variables would interact with experiential and socio-cultural factors to determine an individual’s sexual orientation. My Exotic-Becomes-Erotic (EBE) theory of sexual orientation (Bem, 1996) was the result of that effort.

The second problematic aspect of the current zeitgeist is that it narrowly focuses on the question “What causes homosexuality?” This framing of the inquiry implicitly presumes that heterosexuality is so well understood, so obviously the “natural” evolutionary consequence of reproductive advantage, that only deviations from it require explanation. Freud himself did not so presume: “[Heterosexuality] is also a problem that needs elucidation and is not a self-evident fact based upon an attraction that is ultimately of a chemical nature” (Freud, 1905/1962, pp. 11, 12).

I agree with Freud. In fact, I would go further and assert that even the use of gender as the basis for choosing a sexual partner is a problem that needs elucidation. Accordingly, EBE theory attempts to account for three major observations: First, most men and women in our culture have an exclusive and enduring erotic preference for either males or females; gender is, in fact, the overriding criterion for most people’s erotic choices. Second, most men and women in our culture have an exclusive and enduring erotic preference for persons of the

opposite sex. And third, a substantial minority of men and women have an exclusive and enduring erotic preference for persons of the same sex. In seeking to account for these observations, EBE theory provides a single unitary explanation for both opposite-sex and same-sex desire—and for both men and women. In addition, the theory seeks to account for sex differences in sexual orientation and for departures from the modal patterns, such as bisexual orientations, orientations that are not enduring but fluid and changeable, and sexual orientations that are not even based on the gender of potential partners.

### OVERVIEW OF EBE THEORY

The central proposition of EBE theory is that individuals can become erotically attracted to a class of individuals from whom they felt different during childhood. Figure 1 shows how this phenomenon is embedded in the overall sequence of events that leads to an individual's erotic attractions—the component of sexual orientation addressed by the theory. The sequence begins at the top of the figure with Biological Variables (labeled **A**) and ends at the bottom with Erotic Attraction (labeled **F**).

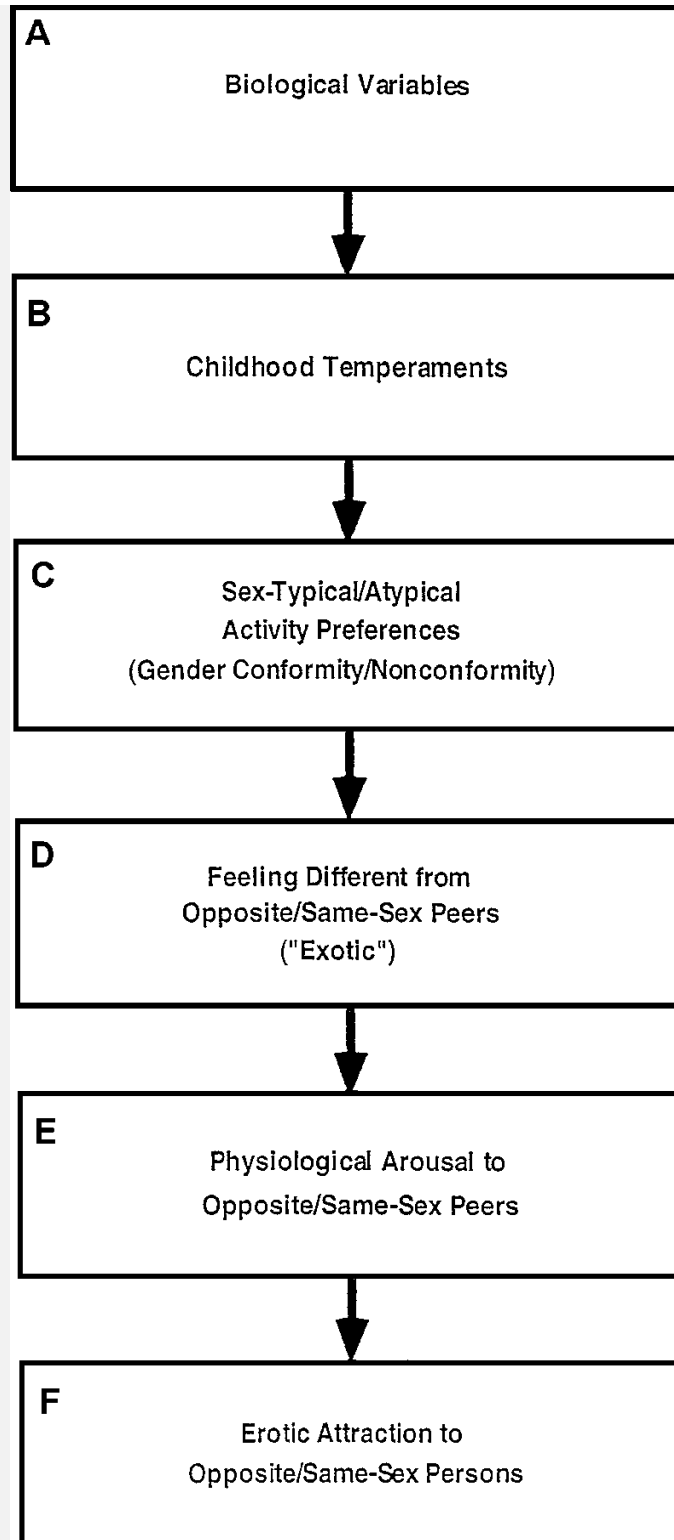
**A → B.** According to the theory, biological variables such as genes or prenatal hormones do not code for sexual orientation per se but for childhood temperaments, such as aggression and activity level.

**B → C.** A child's temperaments predispose him or her to enjoy some activities more than other activities. One child will enjoy rough-and-tumble play and competitive team sports (male-typical activities); another will prefer to socialize quietly or play jacks or hopscotch (female-typical activities). Children will also prefer to play with peers who share their activity preferences; for example, the child who enjoys baseball or football will selectively seek out boys as playmates. Children who prefer sex-typical activities and same-sex playmates are referred to as gender conforming; children who prefer sex-atypical activities and opposite-sex playmates are referred to as gender nonconforming.

**C → D.** Gender-conforming children will feel different from opposite-sex peers, and gender-nonconforming children will feel different from same-sex peers.

**D → E.** These feelings of being different produce heightened physiological arousal. For the male-typical child, it may be felt as antipathy or contempt in the presence of girls ("girls are yucky"); for the female-typical child, it may be felt as timidity or apprehension in the presence of boys. A particularly clear example is the "sissy" boy who is taunted by male peers for his gender nonconformity and, as a result, is likely to experience the strong physiological arousal of fear and anger in their presence. However, the theory claims that every child—conforming or nonconforming—experiences heightened, nonspecific physiological arousal in the presence of peers from whom he or she feels different. For most children, this arousal is neither affectively toned nor consciously experienced.

**E → F.** Regardless of the specific source or affective tone of the childhood arousal, it is subsequently transformed into erotic attraction. Steps **D → E** and **E → F** thus encompass specific psychological mechanisms that transform exotic into erotic (**D → F**).



**Fig. 1.** The temporal sequence of events leading to sexual orientation for most men and women in a gender-polarizing culture

It is important to emphasize that Fig. 1 is not intended to describe an inevitable, universal path to sexual orientation but the modal path followed by most men and women in a gender-polarizing culture like ours, a culture that emphasizes the differences between the sexes by pervasively organizing both the perceptions and realities of communal life around the male–female dichotomy (Bem, 1993).

## **EVIDENCE FOR THE THEORY**

### **Exotic Becomes Erotic (D → F)**

The central proposition that individuals can become erotically attracted to a class of individuals from whom they felt different during childhood is very general and transcends erotic orientations that are based on gender. For example, a light-skinned person could come to eroticize dark-skinned persons through one or more of the processes described by the theory. To produce a differential erotic attraction to one sex or the other, however, requires that the basis for feeling different must itself differentiate between the sexes; that is, to arrive at a sex-based erotic orientation, an individual must feel different for sex-based or gender-related reasons. Simply being lighter-skinned, poorer, more intelligent, or more introverted than one's childhood peers does not produce the kind of feeling different that produces differential homoerotic or heteroerotic attraction.

Data consistent with this analysis comes from an intensive, large-scale interview study conducted in the San Francisco Bay Area by the Kinsey Institute for Sex Research (Bell *et al.*, 1981a). Using retrospective reports from adult respondents, the investigators compared approximately 1,000 gay men and lesbians with 500 heterosexual men and women to test several hypotheses about the development of sexual orientation. The study (hereinafter, the "San Francisco study") yielded virtually no support for current experience-based theories of sexual orientation, including those based on processes of learning or conditioning or on family psychodynamics.

The study did find, however, that 71% of the gay men and 70% of the lesbians in the sample reported that they had felt different from their same-sex peers during childhood, a feeling that was sustained throughout childhood and adolescence for most respondents. When asked in what ways they had felt different, they overwhelmingly cited gender-related reasons. Gay men were most likely to say that they had not liked boys' sports; lesbians were most likely to say that they had been more masculine than other girls were and had been more interested in sports than other girls. In contrast, fewer than 8% of heterosexual men or women said that they had felt different from same-sex childhood peers for gender-related reasons. Those who had felt different from their peers tended to cite such reasons as having been poorer, more intelligent, or more introverted. (All statistical comparisons between gay and heterosexual respondents were significant at  $p < 0.0005$ .)

Several other studies have also reported that gay men and lesbians recall having felt different from same-sex peers on gender-related characteristics during childhood (e.g., Newman and Muzzonigro, 1993; Savin-Williams, 1998; Telljohann and Price, 1993; Troiden, 1979). The major weakness in all these studies, including

the San Francisco study, is that they rely on adults' retrospective reports of childhood feelings. On the other hand, the respondents in some of the studies were relatively close in time to their childhood years; in one study, for example, 88% of gay male youths as young as 14 years reported having felt different from other boys on gender-related characteristics throughout their childhood years (Savin-Williams, 1998). Moreover, the link between childhood gender nonconformity and sexual orientation (described in the next section) has been confirmed in over 50 studies, including prospective ones (Bailey and Zucker, 1995; they also discuss the retrospective problem at length).

### **Gender Conformity and Nonconformity: The Antecedents of Feeling Different (C → D)**

Feeling different from one's childhood peers can have any of several antecedents, some common, some idiosyncratic. The most common antecedent is gender polarization. Virtually all human societies polarize the sexes to some extent, setting up a sex-based division of labor and power, emphasizing or exaggerating sex differences, and, in general, superimposing the male–female dichotomy on virtually every aspect of communal life (Bem, 1993). These gender-polarizing practices ensure that most boys and girls will grow up feeling different from opposite-sex peers and, hence, will come to be erotically attracted to them later in life. This, according to the theory, is why gender becomes the most salient category and, hence, the most common criterion for selecting sexual partners in the first place and why hetero-eroticism is the modal preference across time and culture. Thus, the theory provides a culturally based alternative to the assumption that evolution must necessarily have programmed heterosexuality into the species for reasons of reproductive advantage.

Obviously heterosexual behavior is reproductively advantageous, but it does not follow that it must therefore be sustained through genetic transmission. As long as prevailing environments support or promote a reproductively successful behavior sufficiently often, it will not necessarily get programmed into the genes by evolution. This is true even in species whose sexual choices are far more “hardwired” than our own. For example, it is presumably reproductively advantageous for ducks to mate with other ducks, but as long as most baby ducklings encounter other ducks before they encounter a member of some other species (including ethologists), evolution can simply implant the imprinting process itself into the species rather than the specific content of what, reproductively speaking, needs to be imprinted (Hess and Petrovich, 1977). Analogously, because most cultures ensure that boys and girls will see each other as exotic, it would be sufficient for evolution to implant an exotic-becomes-erotic process into our species rather than heterosexuality per se. In fact, an exotic-becomes-erotic process is actually a built in component of sexual imprinting in some species. For example, Japanese quail reared with their siblings later prefer their slightly different-appearing cousins to their own siblings (Bateson, 1978). This has been interpreted as a mechanism that prevents inbreeding—a biologically promoted incest taboo.

How, then, does a child come to feel different from same-sex peers? As cited

earlier, the most common reasons given by gay men and lesbians in the San Francisco study for having felt different from same-sex peers in childhood were sex-atypical preferences and behaviors in childhood—gender nonconformity. In fact, in the path analyses of the San Francisco study, childhood gender conformity or nonconformity was not only the strongest but the only significant childhood predictor of later sexual orientation for both men and women (Bell *et al.*, 1981a). As Table I shows, the effects are large and significant. For example, compared with heterosexual men, gay men were significantly less likely to have enjoyed boys' activities (e.g., baseball and football) during childhood, more likely to have enjoyed girls' activities (e.g., hopscotch, playing house, and jacks), and less likely to rate themselves as having been masculine. These were the three variables that defined gender nonconformity in the study. Additionally, gay men were more likely than heterosexual men to have had girls as childhood friends. The corresponding comparisons between lesbian and heterosexual women are also large and significant.

**Table I. Percentage of Respondents Reporting Gender-Nonconforming Preferences and Behaviors During Childhood**

Response	Men		Women	
	Gay ( <i>n</i> = 686)	Heterosexual ( <i>n</i> = 337)	Lesbian ( <i>n</i> = 293)	Heterosexual ( <i>n</i> = 140)
Had not enjoyed sex-typical activities	63	10	63	15
Had enjoyed sex-atypical activities	48	11	81	61
Atypically sex-typed (masculinity/femininity)	56	8	80	24
Most childhood friends were opposite sex	42	13	60	40

*Note.* Percentages have been calculated from the data given in Bell *et al.* (1981b, pp. 74, 75, 77). All chi-square comparisons between gay and heterosexual subgroups are significant at  $p < 0.0001$ .

It is also clear from the table that relatively more women than men reported enjoying sex-atypical activities and having opposite-sex friends during childhood. As these data confirm, enjoying male-typical activities is common for a girl in our society, implying that being a tomboy is not sufficient by itself to cause her to feel different from other girls. In fact, we see in the table that the difference between the percentages of lesbians and heterosexual women who report having enjoyed boys' activities during childhood (81% vs. 61%, respectively) is less than half the size of the difference between them in their aversion to girls' activities (63% vs. 15%). Moreover, this latter difference is virtually identical to that between gay men and heterosexual men in their reported childhood aversions to boys' activities (63% vs. 10%).

As noted in the previous section, the San Francisco study does not stand alone. A meta-analysis of 48 studies confirmed that gay men and lesbians are more likely than heterosexual men and women to recall gender-nonconforming behaviors and interests in childhood (Bailey and Zucker, 1995, p. 49). As the authors observed, "these are among the largest effect sizes ever reported in the realm of sex-

dimorphic behaviors." Prospective longitudinal studies come to the same conclusion. In the largest of these, 75% of gender-nonconforming boys became bisexual or homosexual in later years compared with only 4% of gender-conforming boys (Green, 1987). In six other prospective studies, 63% of gender-nonconforming boys later had homosexual orientations (Zucker, 1990). Currently there are no prospective studies of gender-nonconforming girls.

### **How Does Exotic Become Erotic? (D → E → F)**

EBE theory proposes that exotic becomes erotic because feeling different from a class of peers in childhood produces heightened nonspecific physiological arousal (**D** → **E**), which is subsequently transformed into erotic attraction (**E** → **F**). To my knowledge, there is no direct evidence for the first step in this sequence beyond the well-documented observation that novel ("exotic") stimuli produce heightened physiological arousal in many species, including our own (Mook, 1999); filling in this empirical gap in EBE theory must await future research. In contrast, there are at least three mechanisms that can potentially effect the second step, transforming generalized arousal into erotic attraction (Bem, 1996). Only one of these, the extrinsic arousal effect, is discussed here.

In his first-century Roman handbook, *The Art of Love*, Ovid advised any man who was interested in sexual seduction to take the woman in whom he was interested to a gladiatorial tournament, where she would more easily be aroused to passion. However, he did not say why this should be so. A contemporary version of Ovid's claim was introduced by Walster (Berscheid and Walster, 1974; Walster, 1971), who suggested that it constitutes a special case of the 2-factor theory of emotion by Schachter and Singer (1962). This theory states that the physiological arousal of our autonomic nervous system provides the cues that we feel emotional but that the more subtle judgment of *which* emotion we are feeling often depends on our cognitive appraisal of the surrounding circumstances. According to Walster, then, the experience of erotic desire results from the conjunction of physiological arousal and the cognitive causal attribution (or misattribution) that the arousal is elicited by a potential sexual partner.

Although not all investigators agree that it arises from a cognitive attribution process, there is now extensive experimental evidence that an individual who has been physiologically aroused will show heightened sexual responsiveness to an appropriate target person. In one set of studies, male participants were physiologically aroused by running in place, by hearing an audio tape of a comedy routine, or by hearing an audio tape of a grisly killing (White *et al.*, 1981). No matter how they had been aroused, these men reported more erotic interest in a physically attractive woman than did men who had not been aroused. This effect has also been observed physiologically. In two studies, pre-exposure to a disturbing (nonsexual) videotape subsequently produced greater penile tumescence in men and greater vaginal blood volume increases in women when they watched an erotic videotape than did pre-exposure to a non-disturbing videotape (Hoon *et al.*, 1977; Wolchik *et al.*, 1980).

In other words, generalized physiological arousal, regardless of its source or



affective tone, can subsequently be experienced as erotic desire. At that point, it *is* erotic desire. My proposal, then, is that an individual's protracted and sustained experience of feeling different from same- or opposite-sex peers throughout childhood and adolescence produces a correspondingly sustained physiological arousal that gets eroticized when the maturational, cognitive, and situational factors coalesce to provide the critical defining moment.

The precise timing of this moment, however, is influenced by several factors, including actual sexual experience with opposite- and same-sex peers. A recent review suggests that, in general, men and women recall their first sexual attractions, whether same-sex or opposite-sex, as occurring when they were between 10 and 10.5 years of age (McClintock and Herdt, 1996). Nevertheless, social norms and expectations inevitably influence an individual's awareness and interpretation of early arousal. Most individuals in our culture are primed to anticipate, recognize, and interpret opposite-sex arousal as erotic or romantic attraction and to ignore, repress, or differently interpret comparable same-sex arousal. We should also expect to see secular changes and cohort effects. For example, the heightened visibility of gay men and lesbians in our society is now prompting individuals who experience same-sex arousal to recognize it, label it, and act on it at earlier ages than in previous years (Dube', 1997; Fox, 1995; Savin-Williams, 1995, 1998).

### **The Biological Connection ( $A \rightarrow F$ ) versus ( $A \rightarrow B$ )**

As outlined in Fig. 1, EBE theory proposes that to the extent biological factors such as the genotype, prenatal hormones, or brain neuroanatomy influence an individual's later sexual orientation, they do so only indirectly, by intervening earlier in the chain of events to influence a child's preference for sex-typical or sex-atypical activity and peer preferences—his or her gender conformity or nonconformity.

More specifically, the theory specifies that any link between, say, the genotype and gender nonconformity ( $A \rightarrow C$ ) is composed of two parts: a link between the genotype and childhood temperaments ( $A \rightarrow B$ ) and a link between those temperaments and gender nonconformity ( $B \rightarrow C$ ). This implies that the mediating temperaments should possess three characteristics: First, they should be plausibly related to those childhood activities that define gender conformity and nonconformity. Second, because they manifest themselves in sex-typed preferences, they should show sex differences. And third, because they are hypothesized to derive from the genotype, they should have significant heritabilities. (For general discussions and reviews of childhood temperaments, see Goldsmith *et al.*, 1987; Kohnstamm *et al.*, 1989.)

One likely candidate is aggression and its benign cousin, rough-and-tumble play. Gay men score lower than heterosexual men on measures of childhood aggression (Blanchard *et al.*, 1983), and parents of gender-nonconforming boys specifically rate them as having less interest in rough-and-tumble play than do parents of gender-conforming boys (Green, 1976). Second, the sex difference in aggression

during childhood is one of the largest psychological sex differences known (Hyde, 1984). Rough-and-tumble play in particular is more common in boys than in girls (DiPietro, 1981; Fry, 1990; Moller *et al.*, 1992). And third, individual differences in aggression have a large heritable component (Rushton *et al.*, 1986).

Another likely candidate is activity level, considered to be one of the basic childhood temperaments (Buss and Plomin, 1975, 1984). Like aggression, differences in activity level would also seem to characterize the differences between male-typical and female-typical play activities in childhood. Moreover, gender-nonconforming boys and girls are lower and higher on activity level, respectively, than are control children of the same sex (Bates *et al.*, 1973, 1979; Zucker and Green, 1993). Second, the sex difference in activity level is as large as it is for aggression. Even before birth, boys in utero are more active than girls are (Eaton and Enns, 1986). And third, individual differences in activity level have a large heritable component (Plomin, 1986; Rowe, 1997).

### *A Test of the EBE Model*

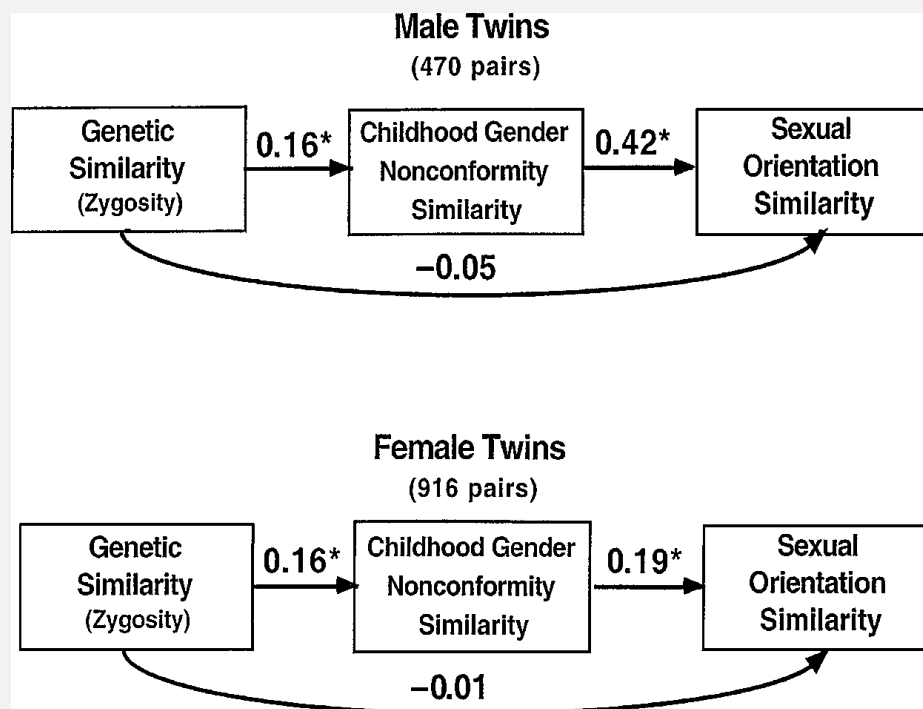
There have now been several studies showing a correlation between an individual's sexual orientation and his or her genotype. In one, a sample of 115 gay men who had male twins, 52% of identical twin brothers were also gay compared with only 22% of fraternal twin brothers and 11% of adopted brothers (Bailey and Pillard, 1991). In a comparable sample of 115 lesbians, 48% of identical twin sisters were also lesbians compared with only 16% of fraternal twin sisters and 6% of adopted sisters (Bailey *et al.*, 1993). A subsequent study of nearly 5,000 twins who had been systematically drawn from a twin registry confirmed the significant heritability of sexual orientation for men but not for women (Bailey and Martin, 1995). Finally, an analysis of families in which there were two gay brothers, suggested a correlation between a homosexual orientation and the inheritance of genetic markers on the X chromosome (Hamer and Copeland, 1994; Hamer *et al.*, 1993).

But these same studies also provided evidence for the link proposed by EBE theory between an individual's genotype and his or her childhood gender nonconformity. For example, in the 1991 study of male twins, the correlation on gender nonconformity between gay identical twins was as high as the reliability of the nonconformity measure would permit, 0.76, ( $p < 0.0001$ ), compared with a non-significant correlation of only 0.43 between gay fraternal twins (Bailey and Pillard, 1991). This implies that even when sexual orientation is held constant, there is a significant correlation between the genotype and gender nonconformity. Similarly, the 1993 family study found that gay brothers who shared the same genetic markers on the X chromosome were more alike on gender nonconformity than were gay brothers who did not (Hamer and Copeland, 1994; Hamer *et al.*, 1993). Finally, childhood gender nonconformity was significantly heritable for both men and women in the large twin registry study—even though sexual orientation itself was not significantly heritable for the women (Bailey and Martin, 1995).

Because this twin registry study is based on a very large sample and includes heterosexual as well as bisexual and homosexual individuals, the data can be used

in a path analysis to test the EBE model against the competing default model that the genotype is more directly linked to sexual orientation or is linked via some alternative but unspecified path. In particular, the EBE model predicts that any correlation between the genotype and sexual orientation is mediated by gender nonconformity and, hence, should vanish when gender nonconformity is entered into the path model. In contrast, the default model predicts that the correlation between the genotype and sexual orientation should remain unaffected when gender nonconformity is entered into the path model.

The path analysis presented here is based on the fact that monozygotic twins will be more similar than dizygotic twins on any trait with nonzero heritability. This is equivalent to saying that zygosity is itself correlated with trait similarity across pairs of twins; the higher the heritability of the trait, the higher the correlation. Accordingly, the unit of analysis here is the twin pair, and each variable is a measure of the pair's similarity on the three variables at issue. (The variables are actually all coded in the direction of dissimilarity.) Genetic similarity (zygosity) is coded as 0 for monozygotic twin pairs and as 1 for dizygotic pairs. The similarity of a pair's childhood gender nonconformity is the absolute value of the difference between their scores on a multi-item scale of childhood gender nonconformity; and, the similarity of their sexual orientations is the absolute value of the difference between their scores on the 7-point Kinsey scale of sexual orientation, which ranges from 0 = *exclusively heterosexual* to 6 = *exclusively homosexual*. A full description of the twin sample and the methodology of the study appears elsewhere in this issue (Dunne *et al.*, 2000).<sup>2</sup>



**Fig. 2.** Path coefficients between genetic similarity (zygosity), childhood gender nonconformity similarity, and sexual orientation similarity for male and female twin pairs. \* $p < 0.001$ .

As shown in Fig. 2, the pattern of path coefficients is consistent with the EBE model for both male and female twin pairs: For both sexes, there is a significant path between the genotype and childhood gender nonconformity and a further significant path between childhood gender nonconformity and sexual orientation, but there is no remaining, direct link between the genotype and sexual orientation.<sup>3</sup>

### *Other Biological Correlates*

In addition to the genotype, prenatal hormones and brain neuroanatomy have also been correlated with sexual orientation in some studies (for summaries, reviews, and critiques see Bailey, 1995; Bem, 1996; Byne and Parsons, 1993; Zucker and Bradley, 1995). But these correlations—even if they turn out to be replicable and not artifactual—do not necessarily controvert the EBE account. Any biological factor that correlates with one or more of the intervening processes proposed by EBE theory could also emerge as a correlate of sexual orientation. For example, any neuroanatomical feature of the brain that correlates with childhood aggression or activity level is likely to emerge as a difference between gay men and heterosexual men, between women and men, and between heterosexual women and lesbians. Even if EBE theory turns out to be wrong, the more general point—that a mediating personality variable could account for observed correlations between biological variables and sexual orientation—still holds.

## **INDIVIDUAL DIFFERENCES**

As noted earlier, Fig. 1 is not intended to describe an inevitable, universal path to sexual orientation but only the modal path followed by most men and women in a gender-polarizing culture like ours. Individual differences, including apparent exceptions to the theory, can arise in a number of ways. First, of course, the theory could simply be wrong or incomplete in fundamental ways. But some of the apparent exceptions to the sequence of events laid out in Fig. 1 are arguably theory-consistent variations.

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<sup>2</sup> Michael Bailey has generously provided the relevant data for these path analyses and, even more generously, given me permission to publish them here even though he and his collaborators have not yet published their own genetic analyses of these data.

<sup>3</sup> To ensure that this pattern of results is not simply an artifact of differing distributions of the two continuous variables (childhood gender nonconformity similarity and sexual orientation similarity), a logistic analysis (Darlington, 1990) was also performed in which these two variables were first transformed into dichotomous variables with identical distributions. Following Dunne *et al.* (1999), a twin pair was considered concordant for sexual orientation if both twins were either exclusively heterosexual (Kinsey scores of 0) or not (Kinsey scores greater than 0). The difference scores on childhood gender nonconformity were then dichotomized so that the number of concordant pairs on this variable equalled the number of pairs who were concordant on sexual orientation. In this way, both variables were given “an equal chance” of being correlated with genetic similarity. This alternative analysis yielded the same correlational patterns and the same significance levels as the analysis depicted in Fig. 2

One such possibility is that some individuals enter the EBE path in the middle of the sequence rather than at the beginning. For example, some children may come to feel different from same-sex peers not because of a temperamentally induced preference for sex-atypical activities but because of more idiosyncratic factors, such as a physical disability, an illness, or an atypical lack of contact with same sex peers. Some of the gay men and lesbians in the San Francisco study reported that although they had been gender conforming in their childhood behaviors, they still felt different from their same-sex peers for gender-related reasons. Moreover, even the sex-typical lesbians in the study were more likely than heterosexual women to report that most of their friends in grade school had been boys. And, consistent with the subsequent steps in the EBE path, this was the strongest predictor of homosexual involvements in adolescence and their homosexual orientation in adulthood.

Cultural factors can also enter to create individual differences that appear to be exceptions to the EBE model. For example, some children might have an activity preference that is gender neutral or even sex typical in the wider culture but gender deviant in their own peer subculture. A contemporary example is the boy who is a clever computer hacker: He would be considered a “regular guy” or even a hero in some male subcultures but a gender-deviant “nerd” in others. Similarly, a child can be permissibly gender nonconforming in some ways—and hence not feel different from same-sex peers—if he or she is gender conforming in other ways that are more gender-defining in his or her subculture. And finally, changes in the wider culture can produce cohort effects; behaviors that are gender nonconforming in one cohort can become more or less so in a later cohort.

For some individuals, the erotic attractions predicted by EBE theory might be supplemented or even superseded by erotic attractions acquired after adolescence. For example, the same-sex eroticism of most of the bisexual men and women in the San Francisco study appeared to be a socially learned, post-adolescent “add-on” to an already established heterosexual orientation. Not surprisingly, these bisexual respondents differed from their exclusively homosexual counterparts on some of the major antecedent variables as well. For example, the path correlation between gender nonconformity and same-sex eroticism was only 0.18 for the bisexual women, but it was 0.62 for the exclusively homosexual women. In fact, 80% of the bisexual women and 75% of the bisexual men in the study reported that as children they had been sex-typically feminine or masculine, respectively. Finally, some women who would otherwise be predicted by the EBE model to have a heterosexual orientation might choose for social or political reasons to center their lives around other women. This could lead them to avoid seeking out men for sexual or romantic relationships, to develop affectional and erotic ties to other women, and to self-identify as lesbians or bisexuals (Kitzinger, 1987), which in turn leads to the topic of sex differences.

## **SEX DIFFERENCES**

One of the more audacious claims made for EBE is that it provides a single unitary explanation for both opposite-sex and same-sex desire—and for both men and women. Not everyone is convinced, however, and I have been challenged to defend

the theory against the charge that it is androcentric: valid for men, perhaps, but not for women (Bem, 1998; Peplau *et al.*, 1998).

To be sure, there is now substantial evidence that men and women differ from one another on several aspects of sexuality, irrespective of their sexual orientations (Peplau *et al.*, 1998). As I tell my students, if you want to understand the sexuality of gay men, think of them as men; if you want to understand the sexuality of lesbians, think of them as women. But most of these differences have to do with the primacy or intensity of erotic desire, the relative emphasis on the physical attributes of potential partners, and the willingness to engage in impersonal sex without romantic involvement. Such differences are not pertinent to EBE theory's account of how erotic orientations develop.

There is, however, one sex difference that *is* pertinent to EBE theory: Women's sexual orientations are more fluid than men's. Many studies, including a national random survey of Americans (Laumann *et al.*, 1994), have found that women are more likely to be bisexual than exclusively homosexual, whereas the reverse is true for men. Non-heterosexual women are also more likely to see their sexual orientations as flexible, even "chosen," whereas men are more likely to view their sexual orientations in essentialist terms, as inborn and unchangeable (Whisman, 1996). For example, men who come out as gay after leaving heterosexual marriages or relationships often describe themselves as having "finally realized" their "true" sexual orientation. Lesbians in similar situation, however, are more likely to reject the implication that their previous heterosexual relationships were inauthentic or at odds with who they really were: "That's who I was then, and this is who I am now."

The greater fluidity of women's sexual orientations is consistent with EBE theory. As noted earlier, Fig. 1 describes the path to sexual orientation *in a gender-polarizing culture*. But in our society, women grow up in a (phenomenologically) less gender-polarized culture than do men. Compared with boys, girls are punished less for being gender nonconforming, and, as the data in Table I reveal, they are more likely than boys to engage in both sex-typical and sex-atypical activities and are more likely to have childhood friends of both sexes. This implies that girls are less likely than boys to feel *differentially* different from opposite-sex and same-sex peers and, hence, are less likely to develop exclusively hetero-erotic or homoerotic orientations.

It is even possible that some of today's non-heterosexual women may be giving a preview of what sexual orientations would look like in a less gender-polarized future. It is possible that we might even begin to see more men and women who, instead of using gender as the overriding criterion for selecting a partner, might base their erotic and romantic choices on a more diverse and idiosyncratic variety of attributes. As I remarked in my original article, "Gentlemen might still prefer blonds, but some of those gentlemen (and some ladies) might prefer blonds of any sex" (Bem, 1996, p. 332).

## EBE THEORY VERSUS WHAT?

Many of my biologically oriented friends and colleagues tell me that they think EBE theory is very clever—and very wrong. They may be right. The existing data are far from decisive, and I am genuinely open to the possibility that biological factors influence sexual orientation more directly than EBE theory would have it. But as much as I prefer being right to being wrong, I will be content if EBE theory does no more than provoke some affirmative competition. To my knowledge, there is no competing theory for a more direct or alternative path between the genotype and sexual orientation. It is not that such a theory has been advanced, tested, and found wanting, but that it has not yet been made.

In their public statements and published articles, my biologically oriented colleagues dutifully point out that correlation is not cause. But, as I have commented elsewhere (Bem, 1996), the reductive temptation of biological causation is so seductive that the caveat cannot possibly compete with the excitement of discovering yet another link between the anatomy of our brains and the anatomy of our lovers' genitalia. Unfortunately, the caveat vanishes completely as word of the latest discovery moves from *Science* to *Newsweek*. Surely the public can be forgiven for believing that we are but one NIH grant away from pinpointing the penis preference gene.

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## E. Homosexuality and Opposite-sex Attraction

Homosexuality can co-exist with opposite-sex attraction (OSA), especially in cases where homosexual behavior is engaged in for reasons other than as an expression of SSA (e.g., indiscriminate sexual behavior, “convenient” homosexuality). More typically however, those with SSA experience diminished OSA (DOSA) or no OSA (NOSA).

Bem’s EBE theory “describes two paths for each individual: a heteroerotic path and a homoerotic path. Conceptually, the two paths are independent, thereby allowing for a panoply of individual differences, including several variants of bisexuality (e.g., being erotically attracted to one sex and romantically attracted to the other).” (p. 332)

Experience suggests that OSA can be diminished or entirely blocked in two different ways:

1. Diversion of sexual interest away from the opposite sex due to intensified same-sex interest or emotional arousal and sexual attraction.
2. Aversion or defensive detachment toward the opposite sex caused by attachment loss, abuse, manipulation, over-involvement, etc. This would likely be a compounding factor on top of the first factor.

When opposite-sex sexual interest is simply diverted, therapy may more easily restore this capacity when same-sex issues are worked through. When an aversion toward the opposite-sex compounds diversion of sexual interest, additional therapeutic work will likely be required to unblock the heterosexual capacity.

## F. Five Types of Homosexuality

Male homosexuality is diverse in terms of both the nature and the object of desires and attractions. Failure to recognize and account for this diversity may lead to improper treatment and poor therapeutic results. The 5 types described below are an initial attempt to classify this diversity.

1. Type 1: Desire for Masculinity. Attractions typically focus on stereotypical male traits, especially related to the body and symbols of power. This is typically indicative of underlying gender incongruity and may be considered (psychodynamically) as an attempt to internalize

projected masculinity or (behaviorally) as an arousal toward an exotic peer.

2. Type 2: Desire for Same-gender Affiliation. Attractions typically focus on experiencing intimacy, connection, affection and love. The desire is for a relationship with another man. This is typically indicative of underlying gender disaffiliation, which may be rooted in attachment loss.
3. Type 3: Age Fixation. These attractions are typically focused on traits of boyhood (pedophilia) or early manhood (ephebophilia). This is likely indicative of significant gender-related trauma or loss at or around the age toward which the attraction is focused.
4. Type 4: Desire for Fathering. The attractions here focus on men who exhibit traits that the individual links to fatherhood. Often the object of attraction is substantially older than the individual. This may be indicative of traumatic gender disaffiliation in the relationship with the father, which may be rooted in attachment loss.
5. Type 5: Not Otherwise Specified. This category includes the less typical presentations, such as learned homosexual response, sexualized anger, sexualized repetition compulsion and situational homosexuality.

NOTE: Individuals commonly present with more than one type. For example, types 1 and 2 frequently coexist although one or the other often predominates. It is possible that additional research and observation may lead to further type divisions.

## **V. SSA Within the Context of a Greater Clinical Picture**

### **A. Concept of Comorbidity**

1. Definition of Comorbidity - The simultaneous appearance of two or more illnesses, such as the co-occurrence of schizophrenia and substance abuse or of alcohol dependence and depression. The association may reflect a causal relationship between one disorder and another or an underlying vulnerability to both disorders (Mental Health Association International.org).
2. Extremely important to carefully assess for comorbid conditions and not focus solely on SSA as the only focus for treatment (see V below).
3. Comorbid conditions can exist from all Axes, including those from DSM and Gender Wholeness Model (see VII below).

### **B. Interplay of SSA and Coexisting/Comorbid Conditions**

1. The covariance of SSA and comorbid conditions is often complex and difficult to analyze at first glance. Quite often, the “chicken/egg” dynamic exists in which it is difficult to determine whether the SSA caused/ resulted in the development of the comorbid condition(s), or the comorbid condition(s) contributed to the development of the SSA.
2. In order to facilitate an accurate understanding of the complexity of the individual (see III above) and to assist in treatment planning and sequencing (see VIII below), it is critical to understand the interplay between the SSA and all comorbid conditions, as well as the dynamic between each of the comorbid conditions themselves.

#### C. Primary Comorbidity vs. Secondary Comorbidity

1. Primary Comorbidity – It has been the experience of the presenters that there are some patients who report a variety of traumatic experiences, dysfunctional family backgrounds, and unique internal dynamics that resulted in psychological/ emotional disorders. These patients, can often retrospectively realize, as a result of treatment, that these underlying conditions and experiences contributed to the development of their SSA. This, therefore, is described as Primary Comorbidity, since it is seen that the comorbid factors contributed to the development of the SSA.
2. Secondary Comorbidity –Other patients present with a clinical picture in which their earliest memories and experiences are of being attracted to boys/men, and as a result, they experienced the development of comorbid conditions such as mood, anxiety, or personality disorders. This is described as Secondary Comorbidity as the comorbid conditions directly resulted from the SSA.
3. It is, at times, difficult to ascertain whether a particular individual manifests Primary or Secondary Comorbidity, because there are elements of both dynamics within the same person. Often the dynamic is so complex that it is not possible to tease out “what came first.”
4. It is vital that the astute clinician understands this Primary/Secondary dynamic, since it will directly affect the treatment approach in terms of planning and sequencing treatment strategies (see VIII below).

#### ***Required Reading:***

##### **Study Indicates Gays and Lesbians Prone To Psychological Symptoms and Substance Abuse**

By Roy Waller

The findings of a study published in the *British Journal of Psychiatry* (December

2003) suggest higher incidences of illegal drug usage, alcoholism, psychological problems, and violence in the gay community than in the general population.

"Gay men and lesbians reported more psychological distress than heterosexual women, despite similar levels of social support and quality of physical health," the researchers reported (p. 556).

The controlled, cross-sectional study was conducted in both England and Wales. No European study in mental health, according to the researchers, has ever before recruited over a thousand gay and lesbian participants.

Surveying a total of 1,161 men (656 self-identified gay, 505 self-identified heterosexual) and 1,018 women (430 self-identified as lesbian, 588 self-identified as straight), the researchers said their main goal was "to compare psychological status, quality of life and use of mental health by lesbians and gay men with heterosexual people."

The researchers found that homosexual males and females both tended to score higher on scales of psychological distress than did their heterosexual counterparts. Further, they were found to be more likely to have used recreational drugs and to have inflicted deliberate harm upon themselves. Gays of both genders were also found to have consulted mental health professionals more frequently than the straight participants.

Additionally, the researchers found that the lesbian participants were the most frequent victims of physical intimidation and violence. Lesbians were also found to be "more likely than heterosexual women to drink excessively."

But bullying at school, the study noted, was reported no more often by gay men than by heterosexual men. Reports that gay men and lesbians are disproportionately vulnerable to school harassment "are often taken at face value," the researchers noted, with researchers failing to draw a comparison to heterosexual students, who--at least in this study--were found to suffer similar high rates of school bullying and harassment.

The actual impetus for this study was, as noted in the paper itself, that "little is known about the mental health of gay men and lesbians living in Europe...almost all data is North American and there are few data for Europe."

Termed the "Sexuality and Well Being Study," the research was conducted by a team headed by Michael King, M.D., Department of Psychiatry and Behavioral Sciences, Royal Free Campus, London; Eammon McKeown, Ph.D, of the Royal Free and University Medical School, London, and James Warner, M.D., Department of Psychiatry, Imperial College, London.

Among the very detailed findings reported, the doctors and their associates present the following statistical data:

- Gay men were almost ten percentage points more apt to suffer mental

disorder (44% to 35%) than heterosexuals, with almost the same relative rate for lesbians compared to straight women (44% to 34%).

- Homosexual men are less likely than heterosexual to be involved in a steady relationship with one partner (48.4% to 38.9%), with the divergence in the statistic for women being considerably smaller (37.5% for lesbians, 35.7% for heterosexual women). Both gay men and women were found to live alone more often than the straight respondents.
- Concerning drug use, 52% of homosexual men and 44% of lesbian women reported such activity within a 30-day period preceding their interview, as contrasted with 45% and 33% of the straight men and women, respectively.
- 38% of gay men and 31% of the lesbians admitted having been physically attacked during the preceding five years, with the rates for heterosexual men and women once again being proportionately lower, despite their much larger representation in the population. Lesbians were the group reporting the highest rates of actual physical harm and/or bullying behavior at the hands of another.
- 54% of the homosexuals and 56% of lesbians had inflicted harm upon themselves, as opposed to 41% of straight men and 50% of straight women.

The research team found that 63 of the gay men and 14 of the lesbians had considered therapy to change their sexual orientation, although only 15 of the men and 2 women said they had actually undergone some reorientation treatment.

In speculating about the reasons for the higher level of psychological problems, the researchers offered the commonly proposed theory that social discrimination could be a source of the problems. But they added that they were not suggesting--as did Bailey (1999) in a prominent prior study--that the higher level of mental disorders could be because homosexuality might constitute a "developmental error."

However, the researchers did note that "gay men and lesbians may have lifestyles that make them vulnerable to psychological disorder. Such lifestyles may include increased use of drugs and alcohol."

The study, which was conducted between September 2000 and July 2002, was the largest ever attempted in Europe.

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Homosexuality and Mental Health Problems

## Homosexuality and Mental Health Problems

By N.E. Whitehead, Ph.D.  
(Author of "My Genes Made Me Do It")

**Summary:** *Recent studies show homosexuals have a substantially greater risk of suffering from a psychiatric problems than do heterosexuals. We see higher rates of suicide, depression, bulimia, antisocial personality disorder, and substance abuse. This paper highlights some new and significant considerations that reflect on the question of those mental illnesses and on their possible sources.*

The American Psychiatric Association removed homosexuality from its diagnostic list of mental disorders in 1973, despite substantial protest (see Socarides, 1995). The A.P.A. was strongly motivated by the desire to reduce the effects of social oppression. However, one effect of the A.P.A.'s action was to add psychiatric authority to gay activists' insistence that homosexuals as a group are as healthy as heterosexuals. This has discouraged publication of research that suggests there may, in fact, be psychiatric problems associated with homosexuality.

In a review of the literature, Gonsiorek (1982) argued there was no data showing mental differences between gays and straights--or if there was any, it could be attributed to social stigma. Similarly, Ross (1988) in a cross-cultural study, found most gays were in the normal psychological range. However some papers did give hints of psychiatric differences between homosexuals and heterosexuals. One study (Riess, 1980) used the MMPI, that venerable and well-validated psychological scale, and found that homosexuals showed definite "personal and emotional oversensitivity."

In 1991 the absolute equality of homosexuality and heterosexuality was strongly defended in a paper called "The Empirical Basis for the Demise of the Mental Illness Model" (Gonsiorek, 1991). But not until 1992 was homosexuality dropped from the psychiatric manual used by other nations--the International Classification of Diseases (King and Bartlett, 1999)--so it appears the rest of the world doubted the APA 1973 decision for nearly two decades.

Is homosexuality as healthy as heterosexuality? To answer that question, what is needed are representative samples of homosexual people which study their mental health, unlike the volunteer samples which have, in the past, selected out any disturbed or gender-atypical subjects (such as in the well-known study by Evelyn Hooker). And fortunately, such representative surveys have lately become available.

### New Studies Suggest Higher Level of Pathology

One important and carefully conducted study found suicide attempts among homosexuals were six times greater than the average (Remafedi et al. 1998).

Then, more recently, in the *Archives of General Psychiatry*-- an established and

well-respected journal--three papers appeared with extensive accompanying commentary (Fergusson et al. 1999, Herrell et al. 1999, Sandfort et al. 2001, and e.g. Bailey 1999). J. Michael Bailey included a commentary on the above research; Bailey, it should be noted, conducted many of the muchpublicized "gay twin studies" which were used by gay advocates as support for the "born that way" theory. Neil Whitehead, Ph.D.

Bailey said, "These studies contain arguably the best published data on the association between homosexuality and psychopathology, and both converge on the same unhappy conclusion: homosexual people are at substantially higher risk for some forms of emotional problems, including suicidality, major depression, and anxiety disorder, conduct disorder, and nicotine dependence...The strength of the new studies is their degree of control."

The first study was on male twins who had served in Vietnam (Herrell et al. 1999). It concluded that on average, male homosexuals were 5.1 times more likely to exhibit suicide-related behavior or thoughts than their heterosexual counterparts. Some of this factor of 5.1 was associated with depression and substance abuse, which might or might not be related to the homosexuality. (When these two problems were factored out, the factor of 5 decreased to 2.5; still somewhat significant.) The authors believed there was an independent factor related to suicidality which was probably closely associated with some features of homosexuality itself.

The second study (Fergusson et al. 1999) followed a large New Zealand group from birth to their early twenties. The "birth cohort" method of subject selection is especially reliable and free from most of the biases which bedevil surveys. This study showed a significantly higher occurrence of depression, anxiety disorder, conduct disorder, substance abuse and thoughts about suicide, amongst those who were homosexually active.

The third paper was a Netherlands study (Sandfort et al. 2001) which again showed a higher level of mental-health problems among homosexuals, but remarkably, subjects with HIV infection was not any more likely than those without HIV infection to suffer from mental health problems. People who are HIV-positive should at least be expected to be anxious or depressed!

The paper thus concluded that HIV infection is not a cause of mental health problems--but that *stigmatization from society* was likely the cause--even in the Netherlands, where alternative lifestyles are more widely accepted than in most other countries. That interpretation of the data is quite unconvincing.

The commentaries on those studies brought up three interesting issues.

1. First, there is now clear evidence that mental health problems are indeed associated with homosexuality. This supports those who opposed the APA actions in 1973. However, the present papers do not answer the question; is homosexuality

*itself* pathological?

2. The papers do show that since *only a minority* of a nonclinical sample of homosexuals has any diagnosable mental problems (at least by present diagnostic criteria), then most homosexuals are not mentally ill.

In New Zealand, for example, lesbians are about twice as likely to have sought help for mental problems as heterosexual women, but only about 35% of them over their lifespan did so, and never more than 50% (Anon 1995, Saphira and Glover, 2000, Welch et al. 2000) This corresponds with similar findings from the U.S.

### **Relationship Breakups Motivate Most Suicide Attempts**

Next, we ask--do the papers show that it is gay lifestyle factors, or society's stigmatization, that are the motivators that lead a person to attempt suicide? Neither conclusion is inevitable. Still, Saghir and Robins (1978) examined reasons for suicide attempts among homosexuals and found that if the reasons for the attempt were connected with homosexuality, about 2/3 were due to breakups of relationships --not outside pressures from society.

Similarly, Bell and Weinberg (1981) also found the major reason for suicide attempts was the breakup of relationships. In second place, they said, was the inability to accept oneself. Since homosexuals have greater numbers of partners and breakups, compared with heterosexuals, and since longterm gay male relationships are rarely monogamous, it is hardly surprising if suicide attempts are proportionally greater. The median number of partners for homosexuals is four times higher than for heterosexuals (Whitehead and Whitehead 1999, calculated from Laumann et al 1994).

A good general rule of thumb is that suicide attempts are about three times higher for homosexuals. Could there be a connection between those two percentages?

Another factor in suicide attempts would be the compulsive or addictive elements in homosexuality (Pincu, 1989 ) which could lead to feelings of depression when the lifestyle is out of control (Seligman 1975). There are some, (estimates vary, but perhaps as many as 50% of young men today), who do not take consistent precautions against HIV (Valleroy et al., 2001) and who have considerable problems with sexual addiction and substance abuse addiction, and this of course would feed into suicide attempts.

### **The Effect of Social Stigma**

Third, does pressure from society lead to mental health problems? Less, I believe, than one might imagine. The authors of the study done in The Netherlands were surprised to find so much mental illness in homosexual people in a country where tolerance of homosexuality is greater than in almost all other countries.

Another good comparison country is New Zealand, which is much more tolerant of



homosexuality than is the United States. Legislation giving the movement special legal rights is powerful, consistently enforced throughout the country, and virtually never challenged. Despite this broad level of social tolerance, suicide attempts were common in a New Zealand study and occurred at about the same rate as in the U.S.

In his cross-cultural comparison of mental health in the Netherlands, Denmark and the U.S., Ross (1988) could find no significant differences between countries - i.e. the greater social hostility in the United States did not result in a higher level of psychiatric problems.

There are three other issues not covered in the *Archives* journal articles which are worthy of consideration. The first two involve DSM category diagnoses.

### **Promiscuity and Antisocial Personality**

The promiscuous person--either heterosexual or homosexual --may in fact be more likely to be antisocial. It is worth noting here the comment of Rotello (1997), who is himself openly gay: "...the outlaw aspect of gay sexual culture, its transgressiveness, is seen by many men as one of its greatest attributes."

Ellis et al. (1995) examined patients at a clinic which focused on genital and urological problems such as STD's; he found 38% of the homosexual men seeking such services had antisocial personality disorder, as well as 28% of heterosexual men. Both levels were enormously higher than the 2% rate of antisocial personality disorder for the general population (which in turn, compares to the 50% rate for prison inmates) (Matthews 1997).

Perhaps the finding of a higher level of conduct disorder in the New Zealand study foreshadowed this finding of antisocial personality . Therapists, of course, are not very likely to see a large number of individuals who are antisocial because they are probably less likely to seek help.

Secondly, it was previously noted that 43% of a bulimic sample of men were homosexual or bisexual (Carlat et al. 1997), a rate about 15 times higher than the rate in the population in general--meaning homosexual men are probably disproportionately liable to this mental condition. This may be due to the very strong preoccupation with appearance and physique frequently found among male homosexuals.

### **Ideology of Sexual Liberation**

A strong case can be made that the male homosexual lifestyle itself, in its most extreme form, is mentally disturbed. Remember that Rotello, a gay advocate, notes that "the outlaw aspect of gay sexual culture, its transgressiveness, is seen by many men as one of its greatest attributes." Same-sex eroticism becomes for many, therefore, the central value of existence, and nothing else--not even life and health itself--is allowed to interfere with pursuit of this lifestyle. Homosexual promiscuity fuels the AIDS crisis in the West, but even that tragedy it is not allowed

to interfere with sexual freedom.

And, according to Rotello, the idea of taking responsibility to avoid infecting others with the HIV virus is completely foreign to many groups trying to counter AIDS. The idea of protecting *oneself* is promoted, but protecting others is not mentioned in most official condom promotions (France in the '80s was an interesting exception). Bluntly, then, core gay behavior is both potentially fatal to others, and often suicidal.

Surely it should be considered "mentally disturbed" to risk losing one's life for sexual liberation. This is surely among the most extreme risks practiced by any significant fraction of society. I have not found a higher risk of death accepted by any similar-sized population.

In conclusion, then, if we ask the question "Is mental illness inherent in the homosexual condition?" the answer would have to be "Further research--uncompromised by politics --should be carried out to honestly evaluate this issue."

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### **High prevalence of mental disorders and comorbidity in the Geneva Gay Men's Health Study.**

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**BACKGROUND:** Several large surveys have suggested high prevalence of psychiatric disorders among gay men and other men who have sex with men. **METHODS:** In 2002, a comprehensive health survey was conducted among 571 gay men in Geneva, Switzerland, using probability-based time-space sampling. The Composite International Diagnostic Interview Short-Form (CIDI-SF) was used to assess 12-month prevalence of major depression, specific phobia, social phobia, alcohol dependence, and drug dependence. **RESULTS:** Nearly half (43.7%, 95% CI=39.0-48.4) of the sample fulfilled the criteria for at least one of the five DSM-IV disorders: 19.2% had major depression, 21.9% had specific and/or social phobia, and 16.7% had an alcohol and/or drug dependence disorder in the past 12 months. Over one quarter of the cases were comorbid with another kind of disorder, and 35.7% of cases consulted a health care professional in the past 12 months for mental health. Like cases, screen-positives for mood and/or anxiety disorders (24.7%) also reported significantly greater disability and lower quality of life. **CONCLUSIONS:** Nearly two-thirds of this community sample of gay men was affected by psychiatric morbidity with new evidence for comorbidity, subthreshold disorders, and low levels of awareness of psychiatric disorders and their treatment. This population needs to be a priority in psychiatric epidemiology and mental public health.

## **Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States.**

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Recent estimates of mental health morbidity among adults reporting same-gender sexual partners suggest that lesbians, gay men, and bisexual individuals may experience excess risk for some mental disorders as compared with heterosexual individuals. However, sexual orientation has not been measured directly. Using data from a nationally representative survey of 2,917 midlife adults, the authors examined possible sexual orientation-related differences in morbidity, distress, and mental health services use. Results indicate that gay-bisexual men evidenced higher prevalence of depression, panic attacks, and psychological distress than heterosexual men. Lesbian-bisexual women showed greater prevalence of generalized anxiety disorder than heterosexual women. Services use was more frequent among those of minority sexual orientation. Findings support the existence of sexual orientation differences in patterns of morbidity and treatment use.

### **D. Comorbid Conditions that Commonly Coexist with SSA**

#### **1. Anxiety Disorders**

- a. OCD (Obsessive-Compulsive Disorder) - an anxiety disorder. OCD is characterized by uncontrollable intrusive thoughts and action that can only be alleviated by patterns of rigid and ceremonial behavior. Symptoms frequently cause considerable distress and interference with daily social or work activities. There may be a major preoccupation with the smallest of details in daily life. Obsessive ideas frequently involve contamination, dirt, diseases, germs, real or imagined trauma, or some type of frightening, unpleasant theme. People recognize their obsessive ideas do not make sense but are unable to stop them. These obsessive thoughts frequently lead to compulsive behaviors as the person try to prevent or change some dreaded event. They frequently repeat activities over and over again. (e.g., washing hands, cleaning things up, checking locks)

##### **(1) Obsession**

Thoughts or impulses that are distressful, persistent and recurrent. These thoughts or impulses must not just be worries of real-life problems. The person must be aware that these thoughts or impulses are only a product of his / her own mind

and they must be actively trying to suppress, ignore, or neutralize them with other actions.

## (2) Compulsion

Must show repetitive behavior physical or mental that cannot be controlled. (e.g., washing hands, checking locks, praying over and over again, counting or saying words repeatedly) These actions must be aimed at trying to prevent or reduce some distressful situation. Recognize that the obsession or compulsion is unreasonable.

At least one hour daily must be taken up doing distressful obsessive/ compulsive activities or there must be some type of marked impairment in important areas of functioning. (E.g., work, social life)

It is often the case that the person, for the most part, does not recognize that the obsession or compulsion is unreasonable.

## b. Generalized Anxiety Disorder (GAD)

Characterized by free-floating anxiety that seems to be a constant feature of daily existence. GAD can range from mild nervousness to a continuous feeling of dread. There may be somatic symptoms, muscle tension, muscle aches, or shaky feelings. Given the stresses of modern life, it is normal to experience occasional anxiety. However, people with Generalized Anxiety Disorder, or GAD, suffer from persistent worry and tension that is much worse than the anxiety most people experience from time to time. The high level or chronic state of anxiety associated with GAD can make ordinary activities difficult or even impossible.

The main symptom of GAD is an exaggerated or unfounded state of worry and anxiety, often about such matters as health, money, family, or work. Although people with GAD may realize that their anxiety is excessive or unwarranted, they are unable to simply "snap out of it"—for them, the mere thought of getting through the day can provoke anxiety.

The persistent worry characteristic of GAD is hard to control, and interferes with daily life. Many GAD sufferers seem unable to relax, and may startle easily. In addition, GAD is often accompanied by physical symptoms, such as fatigue, headaches, and muscle tension. GAD does not appear suddenly; it develops over time. To be diagnosed with GAD, you must have had anxiety more days than not for at least 6 months.

## c. Posttraumatic Stress Disorder (PTSD)

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that develops after a severe traumatic event or experience. Several distressing symptoms are common in the person with PTSD, including Psychic numbing, emotion anesthesia, increased arousal, or unwanted re-experiencing of the trauma. These symptoms can affect any sex or age group. Anxiety, irritability, and depression are also common in people who have PTSD. People with PTSD have a diminished ability to experience emotion, including tenderness or intimacy. There may be problems falling or staying asleep. A person with PTSD will avoid any reminders of the trauma but re-experiencing the event in dreams, nightmares, or painful memories are common. Some people will turn to drugs or alcohol to escape the pain of PTSD. While others may become suicidal or self-defeating.

(1) The event or experience must be re-experienced in at least one of the following:

- i) Distressing recollections of the event or experience that is both intrusive and reoccurring.
- ii) Dreams that are reoccurring and distressful.
- iii) Reliving the event or experience in the form of flashbacks, hallucinations, or illusions.
- iv) If exposed to any aspect of the event or experience a intense psychological distress followed.
- v) Reacting in a physiological manner to any aspect of the event or experience.

(2) Avoiding anything associated with the trauma and a numbing of responsiveness. Indicated by at least three of the following:

- i) Avoiding any thoughts or feelings about the trauma, including not wishing to engage in any conversation about the event or experience.
- ii) Avoidance of places, persons, or things that set off feelings about the trauma.
- iii) Cannot recall important facts about the event or experience.
- iv) A marked disinterest in significant activities.
- v) Feelings of being detached or alienated from others.
- vi) Changes in range of affect.(e.g., loss of loving feelings )
- vii) Feelings of no real future.

(3) Persistent indicators of increased arousal, at least two of the following:

- i) Problems with falling or staying asleep.

- ii) Irritability or outbursts of anger, sometimes unexpected and for no apparent reason.
- iii) Having problems concentrating.
- iv) Hypervigilant.
- v) Response to being startled is overstated.

Must be impairment in important areas of functioning. (e.g., work, social life).

#### d. Social Anxiety Disorder

Social Anxiety Disorder is a persistent fear without apparent justification of social or performance situations. A person may feel that their behavior will be scrutinized by others, leading to embarrassment and an anxiety response in the form of a situationally bound or a situationally predisposed panic attack.

Persistent and marked fear of showing the symptoms of anxiety, humiliating, or embarrassing one's self in a social or performance situation(s). There may be more than one social or performance situation that renders fear. Children will show anxiety in peer settings and not just then interacting with adults.

Exposure to the social or performance situation(s) that is feared can lead to embarrassment and an anxiety response in the form of a situationally bound or a situationally predisposed panic attack. In children the anxiety may be expressed in the form of crying, tantrums, freezing up, or clinging.

Recognize this fear is excessive or unreasonable, children may not recognize this.

The feared social or performance situation(s) may be avoided or endured with intense distress and interferes significantly with a person's normal daily routine. (e.g., school, work, social activities, relationships).

## 2. Mood Disorders

### a. Dysthymic Disorder

A mood disorder over a two year period, characterized by more days than not of feeling down or sad. These feelings are less intense than major depression but still disrupt everyday life.

(1) Feelings of hopelessness.



- (2) Impairment in cognitive functioning.(e.g., hard time concentrating, Hard time in making decisions).
- (3) Loss of appetite or overeating.
- (4) Low levels of energy or fatigue.
- (5) Low self-esteem.
- (6) Problems with sleep.(e.g., insomnia, hypersomnia).

b. Bipolar Disorder – Type I

Bipolar I Disorder is a mood disorder characterized by one or more manic episodes. Extremely disruptive and intense experiences of heightened mood alternate between periods of depression. Most often seen as a genetically-based biochemical illness, it is phasic in nature, characterized by clear manic, depressive, and euthymic phases. When in a manic phase, individuals are more at risk for acting-out behaviors and behaving without regard to consequences.

c. Bipolar Disorder – Type II

Bipolar II Disorder is a mood disorder with a clinical course that is characterized by periods of hypomania (less intense than full-blown mania), interspersed with depressive episodes. Many psychodiagnostic researchers conceptualize this diagnostic entity as less of an Axis I Disorder, and more of an Axis II personality disorder, very distinct from classic manic depression (Bipolar I). It is often conceptualized as a Bipolar Personality, characterized by extreme emotional intensity and instability of mood that is less phasic and more rapid shifts of affect. Differentiation from Borderline Personality Disorder (See below) is often challenging, but is clarified by the lack of the more severe psychopathology often seen in BPD.

d. Major Depression

A person who suffers from a major depressive episode must either have a depressed mood or a loss of interest or pleasure in daily activities consistently for at least a 2 week period. This mood must represent a change from the person's normal mood; social, occupational, educational or other important functioning must also be negatively impaired by the change in mood. A major depressive episode is also characterized by the presence of a majority of these symptoms:

- (1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). (In children and adolescents, this may be characterized as an irritable mood.)
- (2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
- (3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
- (4) Insomnia or hypersomnia nearly every day.
- (5) Psychomotor agitation or retardation nearly every day.
- (6) Fatigue or loss of energy nearly every day.
- (7) Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
- (8) Diminished ability to think or concentrate, or indecisiveness, nearly every day.
- (9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

### 3. Personality Disorders

#### a. Narcissistic

Narcissistic personality is characterized by behavior or a fantasy of grandiosity, a lack of empathy and a need to be admired by others. Narcissistic personality has a pathological unrealistic or inflated sense of self-importance, has an inability to see the viewpoints of others, and is hypersensitive to the opinions of others.

- (1) Grandiose sense of self-importance.
- (2) Fantasies of and preoccupied with beauty, brilliance, ideal love, power, or unlimited success.
- (3) A belief of being special and unique and can only be understood or a need to associate with people of high status.
- (4) A need for excessive admiration.

- (5) An unreasonable expectation of being treated with favor or excepting an automatic compliance to her / his wishes.
- (6) Will use others to achieve her / his goals.
- (7) Lacks empathy.
- (8) Believes others are envious of her / him or is envious of others.
- (9) Contemptuous or haughty attitudes / behaviors.

b. Obsessive-Compulsive

Characterized by perfectionism and inflexibility. A person with a Obsessive-Compulsive Personality becomes preoccupied with uncontrollable patterns of thought and action. Symptoms may cause extreme distress and interfere with a person's occupational and social functioning.

Marked inflexibility and preoccupation with orderliness, perfectionism, and mental / interpersonal control, as indicated by at least four of the following:

- (1) Marked preoccupation with details, lists, order, organization, rules, or schedules.
- (2) Marked perfectionism that interferes with the completion of the task.
- (3) Excessive devotion to work.
- (4) Excessive devotion and inflexible when it comes to ethics, morals, or values.
- (5) Cannot throw out worn-out, useless, or worthless objects with no sentimental value.
- (6) Insist others work or do task exactly as they would.
- (7) View money as something to hoarded.
- (8) Stubborn and rigid.

c. Borderline

Borderline Personality Disorder is characterized by a lack of one's own identity, with rapid changes in mood, intense unstable

interpersonal relationships, marked impulsively, instability in affect, and instability in self image, as indicated by at least five of the following:

- (1) Going to about any lengths to avoid real or imagined abandonment.  
Intense unstable interpersonal relationships characterized by changing between idealization and devaluation the relationship.
- (2) Lack of one's own identity. A Marked instability of self image or the sense of self.
- (3) Impulsively in two or more areas that are self damaging. These may included abuse, sex, spending, eating, driving reckless, or etc.
- (4) Recurrent gestures, self mutilation, suicidal behavior, or threats.  
Instability in affect.
- (5) Marked feelings of emptiness.
- (6) Frequent displays of anger due to a difficulty in control.
- (7) Dissociative or paranoid.

d. Histrionic

Primarily characterized by exaggerated displays of emotional reactions, approaching theatricality, in everyday behavior. Emotions are expressed with extreme and often inappropriate exaggeration. Persons with this disorder are prone to sudden and rapidly shifting emotion expressions.  
Pattern of excessive emotionality and attention seeking, as indicated by at least five of the following:

- (1) Uncomfortable if not the center of attention.
- (2) Interaction with others in a inappropriate provocative or seductive manner.
- (3) Shallow and rapid changing of emotion.
- (4) Uses appearance to draw attention.
- (5) Speech that lacks in detail and excessively impressionistic.
- (6) Theatrical, self dramatization, or out of proportion expression of emotion.

(7) Easily influenced, suggestible.

(8) Feels even a sociable relationship is intimate.

e. Dependent

Primarily characterized with a extreme need of other people, to a point where the person is unable to make any decisions or take an independent stand on their own. There is a fear of separation, cling, and submissive behavior. They have a marked lack of decisiveness, self-confidence, and self-denigration.

Excessive need to be taken care of, as indicated by at least five of the following:

- (1) Has a hard time in making everyday decisions without getting reassurance and advice from others.
- (2) Has other assume the responsibility for the major areas of their life.
- (3) Cannot show disagreement with others for fear of being rejected.
- (4) Difficulty in doing things on their own.
- (5) Will do almost anything to get the support of others.
- (6) When alone, a feeling of being uncomforted or helpless.
- (7) When one caring or support relationship ends they are compelled to seek another.
- (8) A preoccupation and unrealistic fear of being left alone to care for themselves.

f. Avoidant

Characterized by marked social inhibition, feelings of inadequacy, and extremely sensitive to criticism. Individuals wish to but are fearful of any involvement with others. They are terrified by the thought of being embarrassed in front of others. They avoid situations that give them social discomfort, this in many cases leads to social withdrawal.

- (1) Avoid activities that involves interpersonal contact.

- (2) Avoids get involved due to a fear of not being liked by others.
- (3) Restraint in intimate relationships due to a fear of shame or ridicule.
- (4) Marked preoccupation of being rejected or criticized by others.
- (5) Stay away from new interpersonal situations due to feelings of inadequacies.
- (6) Views oneself as inferior, socially inept, or personally unappealing.
- (7) Takes few if any personal risks in the engagement of new activities, for a fear of being embarrassed.

#### 4. Sexual Disorders

##### a. Gender Identity Disorder

A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:

- (1) Repeatedly stated desire to be, or insistence that he or she is, the other sex.
- (2) In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing.
- (3) Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex.
- (4) Intense desire to participate in the stereotypical games and pastimes of the other sex.
- (5) Strong preference for playmates of the other sex. In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In children, the disturbance is manifested by any of the following: in boys, assertion

that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

b. Paraphilias

- (1) Exhibitionism.
- (2) Fetishism.
- (3) Frotteurism.
- (4) Pedophilia.
- (5) Sexual Masochism.
- (6) Sexual Sadism.
- (7) Transvestic.
- (8) Voyeurism.

c. Sexual Addiction

The term "sexual addiction" is used to describe the behavior of a person who has an unusually intense sex drive or an obsession with sex. Sex and the thought of sex tend to dominate the sex addict's thinking, making it difficult to work or engage in healthy personal relationships.

Sex addicts engage in distorted thinking, often rationalizing and justifying their behavior and blaming others for problems. They generally deny they have a problem and make excuses for their actions.

Sexual addiction also is associated with risk-taking. A person with a sex addiction engages in various forms of sexual activity, despite the potential for negative and/or dangerous consequences. In addition to damaging the addict's relationships and interfering with

his or her work and social life, a sexual addiction also puts the person at risk for emotional and physical injury.

Behaviors associated with sexual addiction include:

- (1) Compulsive masturbation (self-stimulation).
- (2) Multiple affairs (extra-marital affairs).
- (3) Multiple or anonymous sexual partners and/or one-night stands.
- (4) Consistent use of pornography.
- (5) Unsafe sex.
- (6) Phone or computer sex (cybersex).
- (7) Prostitution or use of prostitutes.
- (8) Exhibitionism.
- (9) Obsessive dating through personal ads.

Generally, a person with a sex addiction gains little satisfaction from the sexual activity and forms no emotional bond with his or her sex partners. In addition, the problem of sex addiction often leads to feelings of guilt and shame. A sex addict also feels a lack of control over the behavior, despite negative consequences (financial, health, social, and emotional).

## 5. Other Associated Disorders

### a. Substance Abuse

Alcoholism and drug abuse are often issues with individuals who deal with unwanted SSA. The stress of the conflict between their values and sexuality, along with that which occurs with the leading of double lives, can lead to the need to emotionally escape through the abuse of substances.

### b. Body Dysmorphic Disorder (BDD)

A preoccupation with an imagined physical defect in appearance or a vastly exaggerated concern about a minimal defect. The preoccupation must cause significant impairment in the individual's life. The individual thinks about his or her defect for at least an hour per day.



The individual's obsessive concern most often is concerned with facial features, hair or odor. The disorder often begins in adolescence, becomes chronic and leads to a great deal of internal suffering.

The person may fear ridicule in social situations, and may consult many dermatologists or plastic surgeons and undergo painful or risky procedures to try to change the perceived defect. The medical procedures rarely produce relief. Indeed they often lead to a worsening of symptoms.

c. Attention Deficit Hyperactivity Syndrome (ADHD)

A biologically based disorder that involves frontal lobe dysfunction that results in a syndrome of various symptoms involving executive functioning, such as hyperactivity, impulsivity, inattention, and difficulty focusing. Symptoms of inattentiveness and hyperactivity are discussed as follows:

(1) Inattentive Symptoms

- i) Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
- ii) Often has difficulty sustaining attention in tasks or play activities.
- iii) Often does not seem to listen when spoken to directly.
- iv) Often does not follow through on instructions and fails to finish school work, chores, or duties in the work place (this failure is not due deliberately refusing to do it or not understanding instructions).
- v) Often has difficulty organizing tasks or activities.
- vi) Often avoids or is reluctant to engage in tasks that require sustained mental effort.
- vii) Often loses things necessary for tasks or activities.
- viii) Is often easily distracted by extraneous stimuli.
- ix) Is often forgetful in daily activities.

(2) Hyperactive/Impulsive Symptoms

- i) Often fidgets with hands or squirms in seat.
- ii) Often leaves seat in classroom or in other situations in which remaining seated is expected.
- iii) Often runs about or climbs excessively in which it is inappropriate (in adolescents and adults, may be limited to subjective feelings of restlessness).
- iv) Often has difficulty playing or engaging in leisure activities quietly.
- v) Is often "on the go" or often acts as if "driven by a motor."

- vi) Often talks excessively.
- vii) Often blurts out answers before questions have been completed.
- viii) Often has difficulty awaiting turn.
- ix) Often interrupts or intrudes on others (e.g. butts into conversations or games).

To avoid diagnosing individuals who show only isolated difficulties, at least 6 inattentive symptoms and/or 6 hyperactive/impulsive symptoms must be present to possibly qualify for an ADHD/ADD diagnosis. In addition, these symptoms must have been present for at least 6 months to a degree that is considered inappropriate for the individual's age.

## **VI. Data Collection/Evaluation**

### **A. Non-empirical Clinical Assessment**

Clinical assessment vs. Empirical evaluation – Clinical assessment can either involve a systematic psychodiagnostic interview or a more general clinical impression based on presentation and symptom profile.

### **B. Formal Psychodiagnostic Assessment**

Empirical, comprehensive evaluation utilizing a combination of:

1. Formal clinical interview
2. Collateral data, if possible
3. Objective psychometric tests
4. Projective tests
5. Intelligence/Academic testing, if necessary

### **C. Collateral Data/Feedback**

Obtaining information, when possible and appropriate, from family members, significant others, previous clinicians that can be included in overall assessment.

### **D. Impact of Psychometric Feedback on Client**

1. Clarity of diagnoses/general psychological dynamics
2. Deeper understanding of how the SSA developed
3. Greater awareness of strengths/weaknesses

4. Greater insight in terms of treatment goals
5. Clearer understanding of treatment plan

## **VII. Case Conceptualization**

A multi-axial diagnostic system is used.

A. DSM Axis I (Clinical issues)

1. General clinical issues
2. Problem sexual behavior

B. DSM Axis II (Personality disorders)

C. DSM Axis III (Medical conditions)

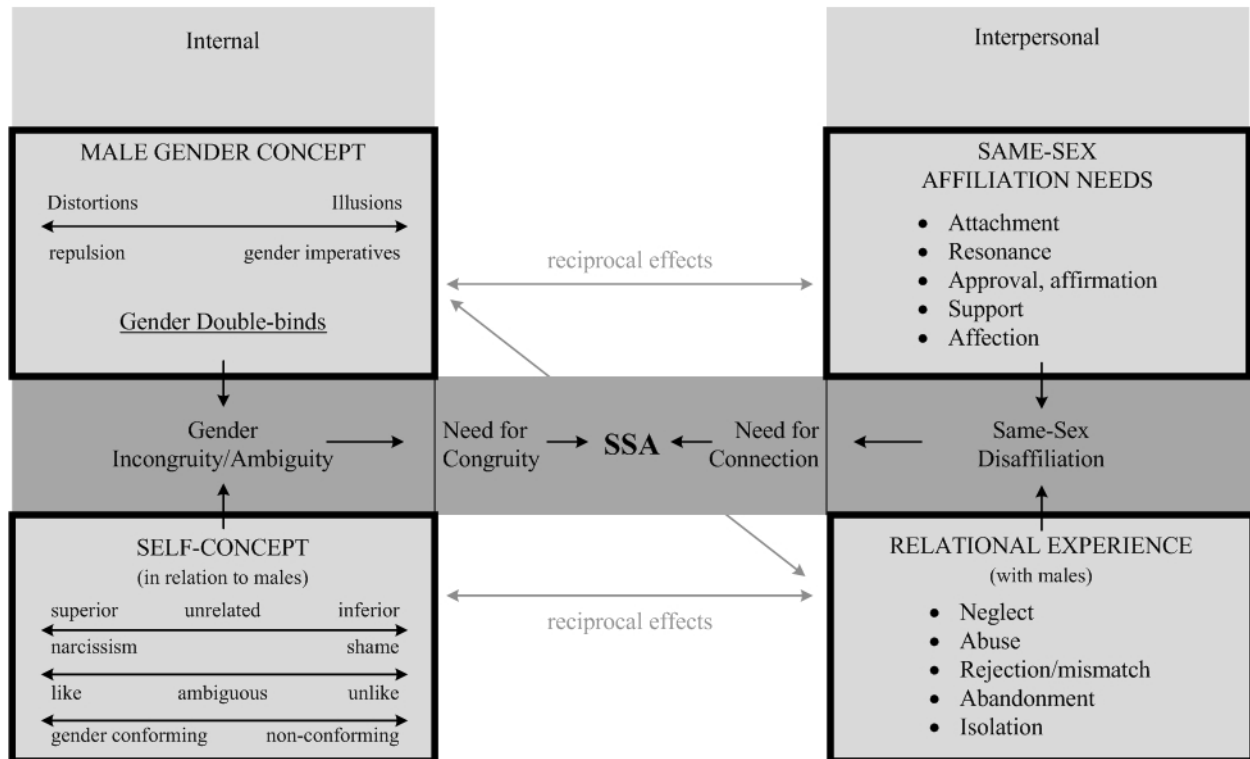
D. DSM Axis IV (Social and environmental)

- E. Axis M describes the impact of a male's relationship to masculinity and to other males. Two core hypotheses constitute this axis. The first hypothesis is "gender incongruity," which is a subjective sense of being at odds with one's gender concept. The second hypothesis is "same-gender disaffiliation," which is caused by defensive detachment and results in a lack of fulfillment of same-gender affiliation needs.

Please see the graphic on the following page.

# GENDER DISRUPTION MODEL

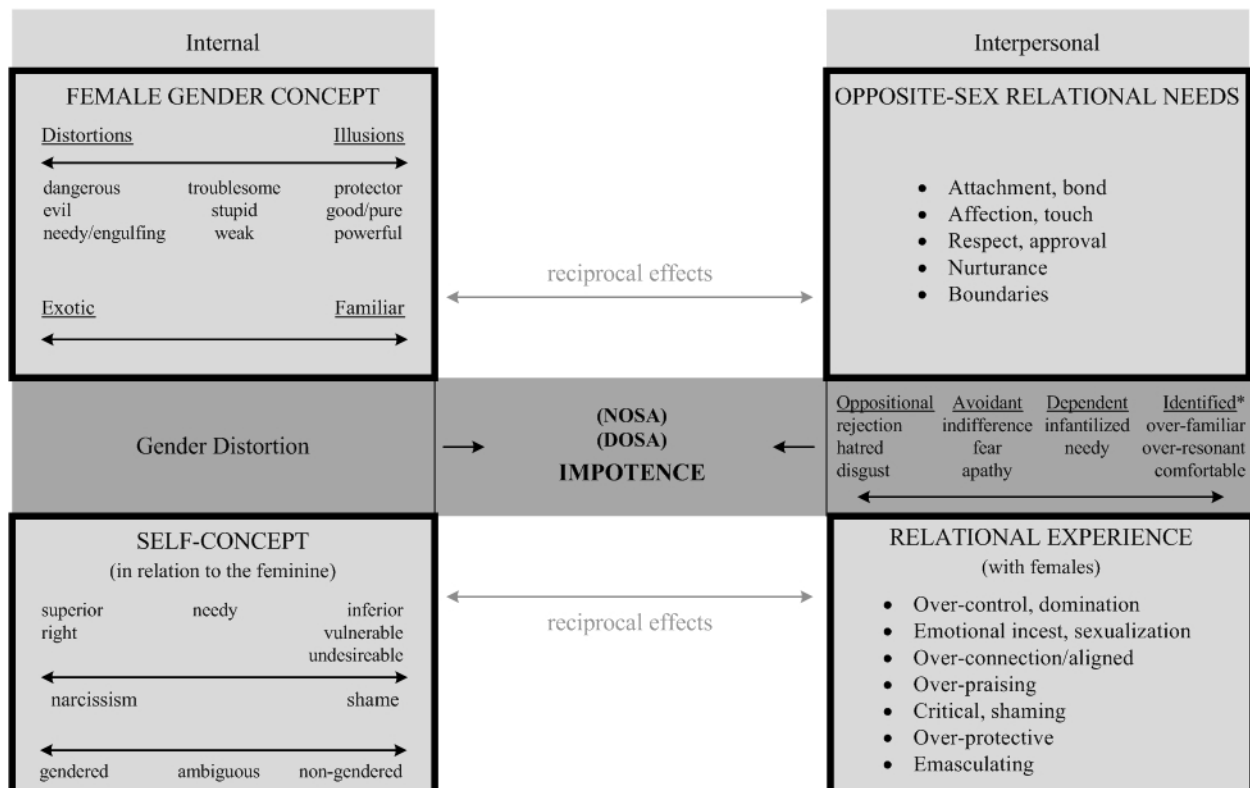
**M Axis (relationship to masculine)**



- F. Axis F describes the impact of females on a male's loss of opposite-sex attraction (OSA) and development of SSA. Of significance here are the ways in which a man relates both interpersonally and intrapsychically with females and femininity. Four key factors may be implicated here: safety, capability, genderedness and desirability.

## GENDER DISRUPTION MODEL

**F Axis (relationship to feminine)**



\* Identified with females as peers or like-group.

## G. Interactions between Axis M and F

Issues with males and females represented on the two axes interact with one another in a reciprocal and cyclical way.

### **Required Reading:**

From *Coordinates*, by David Matheson (unpublished manuscript)  
Chapter 13—Gender Disruption

### **Interactions**

In the illustration on the previous page you will notice gray lines among the circles.

These lines depict the interactions that occur among the four quadrants of the gender disruption model. For example, you will notice a gray line running between the self-concept bubble and the actual relationship experiences bubble, reminding us that these two quadrants can interact with each other. Specifically, those quadrants interact when abuse, neglect, or a mismatch with my father or peers impacts my self-esteem or other aspects of the way I see myself. Below are some additional examples of interactions among the quadrants.

### **Self-Concept and Actual Relationship Experiences**

As mentioned above, abuse and neglect from father or peers damages self-esteem and contributes to a negative self-concept. Also, mismatches in those relationships can lead to a lack of resonance and approval and leave the boy feeling that he doesn't fit in—another injury to his self-concept. Contrastingly, if the boy is approved of by other males, it can impact his self-concept in a very positive way.

### **Self-Concept and Same-Gender Affiliation Needs**

When a boy sees himself as not masculine enough, his needs for connection and approval from masculine boys and men may be intensified. Also, when a boy or man sees himself as having needs that are “too strong,” he may choose to believe that there is something wrong with him—that he is needy or gay—damaging his self-concept.

### **Gender Concept and Same-Gender Affiliation Needs**

Very typically, men want their same-gender affiliation needs to be met by a man who matches their gender imperatives.

### **Gender Concept and Actual Relationship Experiences**

A boy's actual experiences with other males greatly impact the development of his gender concept. For example, being bullied can cause a boy to see males as dangerous and cruel. The detachment and isolation that result from abuse can leave a boy with little actual information about what males are actually like. This opens the door for the formation of both distortions (inaccurately negative perspectives) and illusions (inaccurately positive beliefs). Distortions form when the boy generalizes to all males the pain he experiences from a few males. Illusions form when the boy creates positive male fantasies to sooth his pain.

Once a negative view of other males has become part of a boy's gender concept, a reverse effect may begin to occur. Because he has come to believe that males are dangerous, hurtful, or in some other way bad, the boy anticipates abuse or rejection and begins to avoid other males, creating isolation.

- H. Axis L describes the impact of social learning, associative learning, and classical conditioning on the development of SSA and homosexual

behavior. This includes the role of sexual abuse, same-gender sex play and early exposure to pornography.

- I. Axis B describes the impact of biological issues that may contribute to SSA, such as temperament, body type, illness, age of puberty and rate of physical development.

## **VIII. Treatment Planning/Sequencing**

### **A. Gender Wholeness Theory**

Gender wholeness theory (GWT) essentially suggests that treating each element that contributes to gender disruption, in an appropriate sequence, will bring about the best possible therapeutic results. This must, of necessity, include treating co-morbid issues.

The clinical application of GWT would entail the following:

1. Use of the five standard axes plus the four supplemental gender disruption axes for assessing and diagnosing the client. Awareness of the type of SSA and the vectors is part of this process.
2. Establishment of a flexible sequenced treatment plan that addresses all of the issues noted on the nine axes.

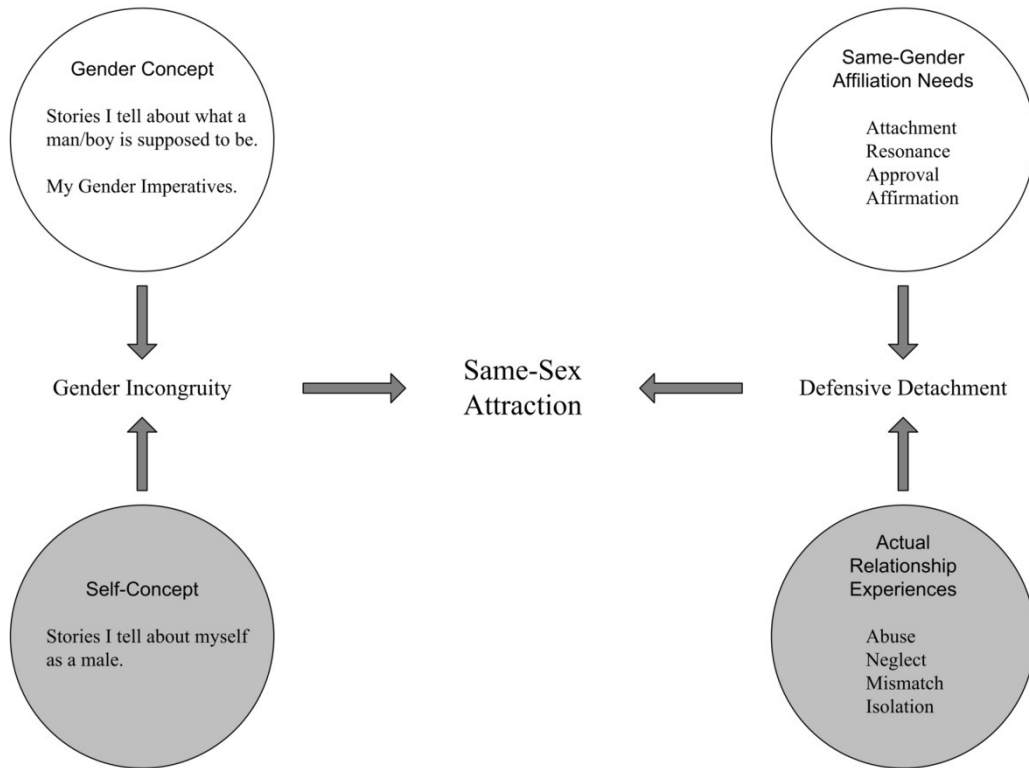
Determining the appropriate sequence for treatment is of paramount importance since even proper treatment approaches, given in the wrong order, can lead to poor results.

### ***Required Reading:***

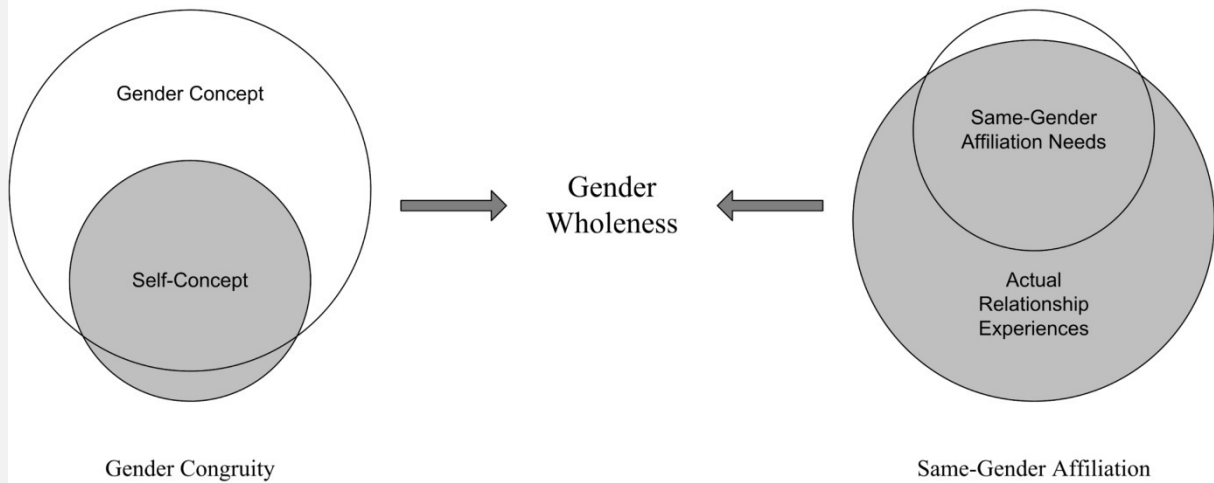
From *Coordinates*, by David Matheson (unpublished manuscript)  
Chapter 15—Gender Wholeness

Gender wholeness is easy to understand conceptually. Most simply put, it is the quest for similarity and familiarity with your own gender. It has two parts. First, your self-concept adequately matches your gender concept. In other words, you have a secure sense of being a man and being masculine, which you don't question in any significant way. You see similarity between yourself and other males. Second, gender wholeness means that your same-gender affiliation needs are fulfilled by your actual relationship experiences. In other words, you feel securely connected to other men in the world around you, have a sense of attachment and resonance with these men, and feel adequately approved of and affirmed by them. You experience a deep familiarity with other males. All of this can be summarized very briefly with the statement, "I am a man among men." The diagrams on the next page illustrate this.

### Gender Disruption Model



### Gender Wholeness Model





Gender wholeness tends to diminish homosexual feelings and impulses. Attractions toward other males tend to become de-sexualized. For some men, gender wholeness eventually leads to the development of opposite-sex attraction. There is no way to tell how long this will take or even if it will work for every man, but in my experience gender wholeness gives a man the best opportunity for change. And of course, the deeper and more intense the sense of gender wholeness, the greater the change is likely to be. These changes tend to become more constant and consistent over time as gender wholeness deepens.

### **Gender Congruity**

The diagrams on the preceding page contrast gender disruption with gender wholeness. Looking at the two circles on the left side labeled “Gender Congruity,” notice how the “gender concept” circle is so much larger than the “self-concept” circle. Very often as men progress toward gender wholeness the illusions and distortions they once believed about masculinity begin to fall away. This comes from having greater exposure to, and therefore, greater understanding of other men. The loss of these false stories about masculinity allows their gender concept to broaden. They come to appreciate men for a far wider range of masculine traits than the more narrow gender imperatives that once characterized their view of men and masculine roles. As they explore, develop, and come to accept their own masculinity, their self-concept changes. They begin to see themselves as masculine and as possessing traits within their own gender concept.

No man possesses all masculine traits. Rather, each man has a different set of masculine traits and gifts that manifest maleness in a unique way. This is why the “self-concept” circle is smaller than the “gender concept” circle. You don’t have to be “everyman” to experience gender wholeness because gender wholeness is not about perfection—it is about deeply and fully accepting yourself as good enough. By developing unconditional love for yourself as a man you can experience gender wholeness even if some of your traits still don’t fit within your gender concept. This is illustrated by the small sliver of the grey “self-concept” circle that remains outside the “gender concept circle.”

### **Same-Gender Affiliation**

Now look at the overlapping circles on the right side of the gender wholeness diagram labeled “Same-Gender Affiliation.” Gender wholeness cannot be experienced when needs for same-gender affiliation are left unmet. As men expand their base of male connections—and then take emotional risks in those friendships—they create greater opportunities for themselves to meet their needs for affiliation with other males.

Equally important to creating same-gender affiliation is resolving the hurt experienced in painful past relationships. This work completes grieving processes, leads to forgiveness, and allows men to move on into new ways of seeing and experiencing themselves and others. Also, many of the distorted stories men

believe about other men were created by these past painful relationships. Grieving and moving past these relationships helps dissolve those distortions. The work of grieving also leads to an expansion of relational abilities such as the ability to forgive, to love unconditionally, and to experience both anger and love in the same relationship.

You'll notice that the "actual relationship experiences" circle is larger than the "affiliation needs" circle. This represents the expansion of emotional abilities just spoken of as well as the expansion of male friendships both in quantity and quality. It is also an illustration of the reality that not all of your male associations will meet your needs. You may have to try multiple friendships before finding those that are deeply fulfilling. The part of the "affiliation needs" circle that is outside the other circle is a reminder that not all of your affiliation needs will be met perfectly all the time. As I said above, gender wholeness is not about perfection. It is about having your same-gender affiliation needs met adequately. Some degree of loneliness or lack of resonance or approval will still have to be tolerated.

#### B. Understanding What Enables Change from SSA

Diminishing SSA seems to require overall relative mental health and emotional wellbeing. Symptoms of distress seem to cause/exacerbate SSA. Clearing up issues that cause distress comes first.

However, clients presenting with unwanted SSA sometimes have limited patience with working on issues that don't seem to advance their primary goal—freedom from SSA. You have to make the case with them that other things must be dealt with in order to affect their sexuality issues.

#### C. Relationships Among Symptoms and Underlying Issues

It is essential to understand the causal relationships among the symptoms and the underlying issues. For example, is anxiety primary, secondary or reciprocally related to the SSA? Anxiety can be a primary factor in the patient's life (e.g. when the history of anxiety begins in pre-teen years). Anxiety can be secondary to the SSA (e.g., when the client has anxiety about having SSA). And anxiety can have a reciprocal relationship to the SSA (i.e., having contributed to its original development, then being exacerbated by the SSA and finally contributing to its continuation). This same principle can be true of depression/dysthymia.

The relationship among the issues does not necessarily indicate the same treatment sequencing.

#### D. Treatment Priorities

The following general priorities are suggested (in this order):

1. Issues that endanger life (suicidality, severe substance abuse, dangerous sexual behavior)
2. Issues that create life instability (severe marital disputes, severe sexual addiction, PTSD and dissociation)
3. Issues that create internal distress (intense shame, severe OCD, clinical depression, post-traumatic disturbance, compulsive sexual behavior)
4. Issues not noted above that block possibility of experiencing gender congruity or same-sex affiliation (OCD, OCPD, social phobia, attachment loss)
5. Axis M issues (gender incongruity, same-sex disaffiliation)
6. Issues that diminish OSA (Axis F)
7. Axis I issues that are secondary to SSA (shame, guilt, anxiety, spiritual conflict)

#### E. Flexibility and Open-endedness

Individual treatment planning must be flexible and tailored to the person since individual differences are the rule, not the exception. It should be seen as open-ended rather than as something to be completed in the first few sessions. As the therapy unfolds the therapist will need to modify the treatment plan as:

1. Unexpected details emerge (he finally tells the truth or remembers past abuse)
2. The clinical picture becomes more clear (e.g., understanding of relationships among issues develops)
3. Interventions have an other-than-expected result
4. Life circumstances change causing shifts in priorities
5. The individual's goals change

### **IX. Goals/Ongoing Assessment of Progress/Change**

#### A. The Importance of Goals

1. Clarity in terms of what is being targeted for change.
2. Helps to focus treatment, and to establish clear priorities.
3. Helps in terms of treatment planning (see VIII above).
4. Allows for measuring progress (see C below).

#### B. Reinforcing Changeability

1. Reinforces the concept that change is indeed possible.
2. Helps to decrease dysthymia/dysphoric mood.
3. Increases motivation/hope.
4. Allows for a different sense of self as change unfolds.

#### C. Ongoing Assessment of Change

1. Importance of assessing change on a periodic, ongoing basis.
2. Assessment is not only pre-post, although this is important as well.
3. Helps patient to focus on progress on an ongoing basis.

#### D. Assessment Measures

1. Likert Scale
2. BDI
3. MMPI
4. Others

### ***Required Reading:***

Source required

## **Psychological Testing**

### **Background**

PSYCHOLOGICAL tests aren't magic, so let's get that clear right at the beginning. They assess and evaluate information that you give to the examiner, which is why the formal name of psychological testing is psychological assessment. You give this information either in the form of answers to interview questions or as answers on paper—or on a computer—to specific questions. Ultimately, a test's accuracy depends on how carefully and seriously you answer the questions you're asked.

Please note that you won't find copies of any of the standard professional tests online because the tests are copyrighted by the test publishers. Also, for professional reasons, the security of the tests must be maintained, so all mental health professionals are under ethical obligations (enforced by licensing boards) to maintain proper test security.

### **Types of Psychological Tests**

Psychological tests fall into several categories:

**Achievement and aptitude tests** are usually seen in educational or employment settings, and they attempt to measure either how much you know about a certain topic (i.e., your achieved knowledge), such as mathematics or spelling, or how much of a capacity you have (i.e., your aptitude) to master material in a particular area, such as mechanical relationships.

**Intelligence tests** attempt to measure your intelligence—that is, your basic ability to understand the world around you, assimilate its functioning, and apply this knowledge to enhance the quality of your life. Or, as Alfred Whitehead said about intelligence, "it enables the individual to profit by error without being slaughtered by it." [1] Intelligence, therefore, is a measure of a potential, not a measure of what

you've learned (as in an achievement test), and so it is supposed to be independent of culture. The challenge is to design a test that can actually be culture-free; most intelligence tests fail in this area to some extent for one reason or another.

The concept of IQ derives from about 1916 when a Stanford University psychologist, Lewis Terman, translated and revised the intelligence scale created by Alfred Binet and Theodore Simon. Hence the name of the new instrument, the Stanford-Binet Intelligence Scale. In this instrument, Terman used the ratio of mental age to chronological age. This ratio—or quotient—concept led to the use of the term IQ (Intelligence Quotient). For example, a six year old child with a mental age of 6 would have an IQ of 100 (the “average” IQ score); a six year old child with a mental age of 9 would have an IQ of 150.

This mental age-chronological age concept works well for children, but what do you do about adults? What's the difference between a mental age of 25, say, and a mental age of 45? Needless to say, the problems here are so complicated that today psychologists have generally given up the idea of IQ and speak simply about intelligence. Today, intelligence is measured according to individual deviation from standardized norms, with 100 being the average.

**Neuropsychological tests** attempt to measure deficits in cognitive functioning (i.e., your ability to think, speak, reason, etc.) that may result from some sort of brain damage, such as a stroke or a brain injury.

**Occupational tests** attempt to match your interests with the interests of persons in known careers. The logic here is that if the things that interest you in life match up with, say, the things that interest most school teachers, then you might make a good school teacher yourself.

**Personality tests** attempt to measure your basic personality style and are most used in research or forensic settings to help with clinical diagnoses. Two of the most well-known personality tests are

- The Minnesota Multiphasic Personality Inventory (MMPI), or the revised MMPI-2, composed of several hundred “yes and no” questions, and
- The Rorschach (the “inkblot test”), composed of several cards of inkblots—you simply give a description of the images and feelings you experience in looking at the blots.

**Specific clinical tests** attempt to measure specific clinical matters, such as your current level of anxiety or depression.

Psychological tests are usually administered and interpreted by a psychologist because studies in psychopathology, along with academic courses and supervision in psychological testing, are an integral part of the doctoral degree in clinical psychology. A counselor who has had the appropriate academic courses and supervision may administer occupational tests or achievement and aptitude tests,

but most counselors have not received the training to administer personality tests. Academic courses and supervision in psychological testing are usually not a part of a psychiatrist medical training, so most psychiatrists can ethically administer only some specific clinical tests that are straight-forward check-lists of symptoms.

Of course, ethics is one thing, and the desire to make money is another thing. Therefore you will often find individuals offering to do all kinds of psychological testing—especially on the Internet—even when they lack the professional training to administer and interpret such tests. So, as in all things, buyer beware.

### **Justifications for Using Tests**

Psychological tests were created for three main reasons, all of which are interconnected:

*It's easier to get information from tests than by clinical interview.* Most people won't talk about this, but, believe it or not, many psychologists are rather inept at dealing with people, and so it's a great relief to them to be able to administer a test rather than conduct a competent interview. Thankfully, such psychologists tend to specialize in testing (or research, or teaching) rather than psychotherapy. Think about this if ever you find yourself sitting in front of a steely-eyed psychologist while being given a battery of psychological tests.

*The information from tests is more scientifically consistent than the information from a clinical interview.* If a psychologist is simply trying to arrive at a diagnosis to help determine the course of psychotherapy, an interview is just fine. But when decisions have to be made about legal matters, disability issues, and so on, then the standardized information from tests allows one person to be directly compared with others, and it makes things more fair.

*It's harder to get away with lying on a test than in a clinical interview.* Many tests have multiple "alarms" that go off when a test taker tries to lie. And some tests, such as the Rorschach (the "inkblot test") don't even give a clue as to what preferred, or healthy, responses might be, so it's pretty much impossible to make yourself "look good" by fabricating deceptive answers to a test like this.

### **Validity and Reliability**

The overall problem with psychological tests concerns their ability to measure what they are supposed to measure.

The accuracy, or usefulness, of a test is known as its validity. For example, suppose you wanted to develop a test to determine which of several job applicants would work well in a bank. Would an arithmetic test be a valid test of job success? Well, not if the job required other skills, such as manual dexterity or social skills.

- Construct Validity refers to the ability of a test to measure the psychological construct, such as depression, that it was designed to measure. One way this can be assessed is through the test's convergent or divergent validity, which

refers to whether a test can give results similar to other tests of the same construct and different from tests of different constructs.

- Content Validity refers to the ability of a test to sample adequately the broad range of elements that compose a particular construct.
- Criterion-related Validity refers to the ability of a test to predict someone's performance on something. For example, before actually using a test to predict whether someone will be successful at a particular job, you would first want to determine whether persons already doing well at that job (the criterion measure) also tend to score high on your proposed test. If so, then you know that the test scores are related to the criterion.

The ability of a test to give consistent results is known as its reliability. For example, a mathematics test that asks you to solve problems of progressive difficulty might be very reliable because if you couldn't do calculus yesterday you probably won't be able to do it tomorrow or the next day. But a personality test that asks ambiguous questions which you answer just according to how you feel in the moment may say one thing about you today and another thing about you next month.

- Internal Consistency Reliability refers to how well all the test items relate to each other.
- Test-retest Reliability refers to how well results from one administration of the test relate to results from another administration of the same test at a later time.

Note that without reliability, there can be no validity. A thermometer, for example, may be a valid way to measure temperature, but if the electronic thermometer you are using has bad batteries and it gives erratic (that is, unreliable) results, then its reading is invalid until the batteries are changed.

Note also that no psychological test is ever completely valid or reliable because the human psyche is just too complicated to know anything about it with full confidence. That's why there can be such uncertainty about a case even after extensive testing.

### **Science and Pseudoscience**

In its original sense, science (from the Latin *scire*, to know) simply meant the state or fact of knowing, as compared to intuition or belief. The current technical sense of the word, however, refers to knowledge obtained from systematic observation, study, and experimentation.

Now, as I said above, psychological tests aren't magic; most of them have been developed through sound scientific principles. In fact, anyone who wants to become a psychologist must learn all the scientific principles of test construction; even if a psychologist has no desire to create a new test, he or she must be competent to

evaluate the scientific value of any specific test before using it clinically.

Unfortunately, there are many psychological tests in wide use that are accepted as being scientific just because they are called “tests.” For example, the Myers-Briggs Type Indicator and the *Enneagram*, often used in educational and corporate personnel settings to assess personality “types,” are based in pseudoscience and psychobabble and have about as much worth in clinical settings as astrology. Any competent psychologist can use intuition to get as much information as these “tests” provide.

And then there is the classic Rorschach test that uses inkblots to assess a person’s inner psychological experience. Several methods for administering and scoring the Rorschach have been developed, and although some of them are surrounded with a considerable amount of published research, it would be surprising if any two independent psychologists could administer the Rorschach to the same person and achieve identical findings.

Similarly, tests such as the *Thematic Apperception Test* (TAT), which asks a person to tell stories about various pictures of social interactions, and the *Draw-A-Person* and *House-Tree-Person*, which ask a person to draw pictures, are not usually objectively scored and give results of questionable validity.

In the end, then, psychological testing can, in some ways, be both valid and reliable; yet, in other ways, it often does not achieve much more than an impressionistic evaluation of a person. And often the science and the pseudoscience are quietly mixed together in one “scientific” report.

## **Cautions**

Psychological test scores can be very useful under the proper circumstances—and when the limitations of psychological testing are properly understood and respected.

Note, however, that the score you get on any psychological test is nothing more than “the score you have gotten on that test.” Let’s say you took an IQ test and got a score of 126. Well, your IQ test score may be 126, as measured by that test, at that time, under those circumstances. But what is your *real* IQ? Well, no one knows. And that’s a fact. So what does an IQ test really measure? Well, again, no one knows. And that’s another fact.

Note also that every well-known and widely used psychological test in the US was developed and standardized in English. This might not seem very important, but just consider what happens when someone needs to be tested who doesn’t speak English fluently. If the test is translated into another language—either in print or through a translator—all kinds of problems can occur. English words with multiple meanings cannot be adequately translated. English idioms cannot be expressed in another language without changing the entire sentence structure along with the underlying logic of the sentence—and when that happens *standardization*, and the guarantee of fairness it promises, is lost.



So, even though translated versions of tests might be used, and even though you might be given a score that appears to be official and scientific, that score is nothing more than “the score you have gotten on that test.” This might not mean much to you, and it might seem like philosophical quibbling. *But what if your life depended on that score?*

## **X. Interdisciplinary Team**

### **A. The Concept of a Team**

1. Definition: “A team is a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they are mutually accountable.” (Katzenbach and Smith, 1993)
2. In contrast to solo clinicians – much more able to deal with complexity of cases and to bring in different types of expertise and skills.

### **B. The Importance of an Interdisciplinary Team**

1. Definition of interdisciplinary: “Of, relating to, or involving two or more academic disciplines that are usually considered distinct” (Webster).
2. Interdependent – Each member of the team has a unique combination and team members are dependent on each other to draw from their unique contribution to accomplish a common goal.
3. Critically important for holistic approach, since no one clinician can have expertise and focus on all aspects of treatment.

### **C. Treatment Coordination**

Since clinicians on interdisciplinary teams are interdependent, they need to make sure that they are coordinating treatment, and communicating on an ongoing basis.

### **D. Role Clarity**

Also important for all team members to know what their individual roles are, and how relate to and are distinct from the roles of other team members. Important to know when roles are connected, and when there is a need for boundaries.

***Required Reading:***

**Interdisciplinary treatment**  
**Encyclopedia of Psychology**

Paula Ford-Martin

Holistic healthcare, the concept that the body is not just a collection of separate and distinct parts but rather an assemblage of interrelated components that form a unified whole, is at the root of interdisciplinary treatment. The holistic viewpoint is that mental health is related to and interdependent on physical well-being, and vice-versa. An interdisciplinary treatment team has the ability to pool their knowledge and expertise towards the recovery of the whole individual, not just his or her disease.

The members and make-up of the interdisciplinary team are tailored to the patient and his or her physical, emotional, and functional needs. Team members may include, but are not limited to, physicians (from a variety of medical specialties), nurse practitioners, surgeons, psychologists, psychiatrists, social workers, school counselors, nutritionists, physical therapists, vocational counselors, occupational therapists, and creative therapists (i.e., art therapists, music therapists).

Interdisciplinary treatment was first introduced to mental healthcare in the United States in the late 1940s by Dr. William Menninger and colleagues. Menninger, who was then chief of Army neuropsychiatry and president and co-founder of the renowned Menninger Clinic, would become the 75th President of the American Psychological Association (APA) in 1949, providing him the opportunity to promote the benefits of treatment teams to a wide audience of healthcare professionals.

Today, mental healthcare professionals are becoming involved in a wider spectrum of what have been traditionally considered physical ailments. Psychologists have become an essential part of the treatment team in oncology (cancer medicine), geriatric medicine, cardiology (heart and circulatory medicine), pediatric medicine, and other specialties. Likewise, cross-disciplinary teams have become more common in mental healthcare. Individuals suffering from a disease such as schizophrenia, for example, may be treated by a team consisting of a psychiatrist, a psychologist, a neurologist, a vocational counselor, a family therapist, an art therapist, and a social worker.

Some patients may require ancillary services and after-care support such as vocational rehabilitation (job training or retraining), independent living skills training, social skills training, and housing assistance. For these individuals, specialists outside of traditional medical disciplines may be integrated into the interdisciplinary team.

Interdisciplinary teams are becoming more commonplace in clinical settings that

involve healthcare research, also. A program for teen pregnancy prevention started at the University of Minnesota in 1997 is staffed with a team of psychologists, sociologists, physicians, nutritionists, nurses, biostatisticians, epidemiologists, and others who can provide effective strategies, and translate their results into meaningful research data that can improve quality of care.

Hospice care, a treatment setting for terminally ill patients, is another example of interdisciplinary treatment at work. Hospice patients, who are often coping with chronic pain and with emotional and spiritual issues related to the end of life, require care that focuses on both physical symptom relief and emotional well-being. Their interdisciplinary care may consist of one or more physicians, a psychologist, a family therapist, and other healthcare professionals. In addition, bereavement care for the patient's family is often worked into the overall interdisciplinary treatment plan.

One of the challenges of an interdisciplinary treatment approach is harmonizing the varying methods and philosophies of different professionals into a cohesive care plan that works toward a unified treatment goal. One approach is for the interdisciplinary team to perform the intake interview (or initial assessment) of the patient in a group setting to ensure unity in their treatment approach, and then follow up with regularly scheduled meetings to create the treatment plan and adjust it as necessary as they follow the patient's progress.

However, the logistics of such a plan are often difficult, given the patient care load of many healthcare providers. What is more common is the appointment of a case manager, who is responsible for coordinating delivery of treatment and following the patient's progress, to organize and inform the treatment team. The manager provides the patient with a "point person" to approach with any problems or concerns. They also have responsibility for scheduling therapies and treatments in the correct sequence for maximum benefit to the patient, and for coordinating aftercare services such as housing assistance and networking the patient with support groups. Case managers are often licensed social workers, but can also be laypeople.

- Satcher, David. Mental Health: A Report of the Surgeon General. Washington, D.C.: Government Printing Office, 1999. [available online at [www.surgeongeneral.gov](http://www.surgeongeneral.gov)] Further Information
- American Psychological Association (APA)., 750 First Street, NE, Washington, D.C. USA 20002-4242; Toll-free: 202-336-5500; Phone: 800-374-2721; E-mail: [public.affairs@apa.org](mailto:public.affairs@apa.org) Website: <http://www.apa.org>

## **XI. Resourcing/Outsourcing**

### **A. Definitions**

1. Resourcing – Finding resources: the work of finding and providing the material, financial, or human resources required for a task. Finding resources outside one's sphere of involvement (e.g. team) to facilitate the attainment of a particular goal within the context of the team.
2. Outsourcing – The practice of having goods or services provided by a person or persons outside the business or organization. Choosing an entity outside of your organization to provide a service on a regular basis (drug testing, psychodiagnostic testing, psychiatric services/medication management, etc.).

B. Deciding to Outsource vs. Resource

Factors to consider:

1. Ability to utilize resource within the structure of the team.
2. Ability to manage and supervise function.

C. Importance of Communication and Collaboration

1. Critical to have ongoing contact with other professionals regardless if they are resources within team or outside of team.
2. Important to get/give feedback on ongoing basis.
3. Vital to ensure that agreed upon goals are still in place.

D. Issues of Safety and Value Congruence when Turning to Resources

1. Extremely important to make sure *a priori* that resources assisting team either share values and goals of reparative therapy or, at the very least, have a healthy respect for what is trying to be accomplished and an explicit commitment to be neutral or supportive of the individual's desire to change.
2. Ongoing monitoring of feedback/input of collateral resources is important to ensure fidelity of the therapy process.