Supplemental Website Material

for

The Heart of Female Same-Sex Attraction:

A Comprehensive Counseling Resource

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The material included on this site is meant to supplement ideas or assertions made in footnoted material or the main text of *The Heart of Female Same-Sex Attraction.* The following documentation is not meant to be comprehensive; only select topics are included as a means to fill out topics that could not be adequately covered within the main text. The sections under **Supplemental Research** are updated and maintained on a periodic basis.

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Supplemental Research

Scientific Evidence on Causal Influences of Female Homosexuality

Overview

In 1974, Dr. Alan Cooper, Hon. Senior Lecturer in Psychiatry at St. Mary's Hospital Medical School, published an article offering a balanced approach to the etiology of homosexuality. He suggests that homosexuality arises out of both biological and environmental components but concludes, on a sad note, stating "in spite of a great deal of work and many ingenious theories the causes of homosexuality remain undetermined. *It may well be that the complexity of society will defeat all investigative efforts and keep it this way* [italics added]" (1974, p. 21). True to Dr. Cooper's concerns, the vast majority of the scientific research on the causes of homosexuality in the last 30 years has not been balanced, but primarily focused on "finding" a *biological* basis. Focused research and dialogue with respect to the environmental or developmental influences of homosexuality has become essentially politically incorrect.[1]

[1] Edward Stein (1999), philosopher, educator, and author, suggests that the popularity of biological studies over psychological studies is not necessarily warranted by the ensuing scientific evidence but is in fact, much more likely attributed to the positive shift of public opinion towards homosexuality in general. "A person who is favorably inclined towards lesbians and gay men may be more willing to accept biological theories than psychological ones…" (page 230). However, he stresses that many of the theories arising out of the biological research "require *psychological and experiential theories* [italics added] to provide a full account of the development of human sexual orientation" (p. 231).

Genetic Influences

Yet, most of the leading researchers who have investigated the genetic component of homosexuality, primarily through twin studies, agree that homosexuality ultimately arises out of both *nature* and *nurture.* For example, in his 1997 twins study, Dr. Scott Hershberger concludes that while there is a significant genetic effect on female homosexuality, "environmental effects were also important for sexual orientation, in fact, *more important* [italics added] in the aggregate than genetic effects" (1997, p. 221). According to Dr. Jeffrey Satinover, a Fellow in Psychiatry and Child Psychiatry at Yale University and lecturer in Psychology and Religion at Harvard, "If 'homosexuality is [solely] genetic' as activists and their media supporters repeatedly claim, the *concordance rate* between identical twins – that is, the incidence of the two twins either both being homosexual or both being heterosexual – will be 100 percent. There would *never* be a *discordant* pair" (1996, p. 83). Based on five of the most recent studies involving female twins, the concordance rates for homosexuality have ranged from 20 to 75%, the higher of which having never been replicated.[2] In their most recent study on the genetic influences on sexual orientation, Bailey, Dunne and Martin (2000), after first suggesting that sexual orientation development is not the same between the sexes and that "male and female sexual orientation should be analyzed separately," concede they "did not provide statistically significant support for the importance of genetic factors" (p. 533-534).

In reviewing the extant research, Bearman & Bruckner (2002) note, "As samples become more representative, concordance on sexual behavior, attraction, and orientation, as expected, declines" (p. 1184). Based on their own findings involving a twin and sibling sample, they

[2] See Table A1 at end of website material.

conclude, "If same-sex romantic attraction has a genetic component, it is massively overwhelmed by other factors" (p. 1198).[3] In 2002, Friedman & Downey boldly claimed that the "assertion that homosexuality is [solely] genetic is so reductionistic that it must be dismissed out of hand as a general principle of psychology" (p. 38). Francis S. Collins, M.D. and Ph.D., clarifies that whatever genetic influence might exist, it is not "hardwired by DNA, and that whatever genes are involved represent predispositions, not predeterminations" (2006, p. 260).

Nevertheless the media carelessly touts every new biological study as the final "proof" that homosexuality is *solely* genetic or hormonally predetermined. Margo Rivera, a gay affirmative psychologist specializing in trauma with non-heterosexual clients, despairs of this trend pointing out that

> Every new study tends to be hailed as if the results offer a simple answer to a simple question, but so far there are no data that point to genes, life experience, or brain morphology as the sole and simple source for the many variations in the ways in which sexual desire, longing for affiliation, and gender identity manifest themselves in different people. (2002, p. 45)

Even if there were a high degree of genetic influence, Dr. Bruce Lipton, stresses that we as living organisms "are far from being genetically determined." We may "*actively select, or in some instances, even rewrite gene programs"* as we "*experience and interpret environmental stimuli*" (Lipton, 1998, p. 6). An article in *LIFE* magazine tackled this controversial subject some

[3] Bearman & Bruckner (2002) did find that decreased gender socialization in childhood and preadolescence might have a substantial impact on *male* homosexuality.

years back. I found the author articulate and brave. He notes that genes don't cause direct behavior but are essentially "nudges" and if "genes are not commands but nudges, we can nudge back. *We are the only animals on earth that can overrule our genes* [italics added]. And we do so constantly - whenever an alcoholic chooses not to drink or an obese person diets" (Colt, 1998, p. 44). Colt continues by quoting Stanley Greenspan, "'we can't change the genes, but we can change the way genes express themselves. We can change behavior'" (p. 46).

For a listing and overview of the studies and research exploring the various genetic influences on female homosexuality, please refer to:

Table A1: *Genetic Influences* at the end of the website material

Hormonal Influences

In 1995, Dr. Amy Banks, Clinical Instructor in Psychiatry at the Harvard Medical School and Dr. Nanette Gartrell, Associate Clinical Professor of Psychiatry at the University of California, after reviewing the studies evaluating hormonal influences, stated "*At this time the literature does not support a causal connection between hormones and homosexuality* [italics added]" (Banks & Gartrell, 1995, p. 263). Meyer-Bahlburg et al. (1995) similarly conclude in a research article on "Prenatal Estrogens and the Development of Homosexual Orientation":

> we do not think that a given biological factor by itself can plausibly be expected to fully determine a complex behavior such as homosexual orientation. …As discussed elsewhere…, our working hypothesis is one of multiple developmental pathways that may lead to a homosexual or heterosexual orientation, involving the

> dynamic interplay of *both biological and social variables that interact with each other throughout a person's life course* [italics added]. (p. 20)

In a review of the current research, Jones and Kwee (2005) conclude that the "findings of biological causation of homosexual orientation, though popular, are not strong or unequivocal, and there may be evidence of environmental causal variables (though this research is not strong or unequivocal either) (p. 314)." Even the American Psychological Association admits in their *Fact Sheet on Gay, Lesbian and Bisexual Issues* that "No one knows what causes heterosexuality, homosexuality, or bisexuality."[4]

For a listing and overview of the studies and research exploring the various hormonal and neurodevelopmental influences on female homosexuality, please refer to:

Table A2: *Prenatal & Adult Hormonal and Neurodevelopmental Influences* at the end of the website material.

Psychosocial and Environmental Influences

Poet, novelist and former lesbian Jan Clausen, criticizes "biological determinism that seeks to explain sexual orientation as a function of some physical attribute: a tiny cell group in the brain, or a gene on the X chromosome" (1999, p. xix). Having journeyed through a lesbian marriage into a relationship with a man, as told in her book *Apples and Oranges*, she complains that researchers rarely bother with the basic question of *why* a woman might be attracted to another woman - or a man for that matter. "They do not inquire, for instance, whether what we

[4] See http://www.psych.org/public_info/gaylesbianbisexualissues22701.pdf, date retrieved November 24, 2004.

call sexual attraction is in fact a single, easily defined experience, the same for everyone in all times and places" (p. xix).

She and other lesbian-identified women believe sexual orientation involves cultural, psychological and emotional components. In fact researchers Friedman & Downey (1993) admit that women, in particular homosexual women, are commonly "led" to their romantic partners "by a need for empathy, intimacy, connectedness, and caring" (p. 1190). Claussen concludes by stating

> Despite widespread popular appeal and an enthusiastic acceptance among a large subset of gay men, biologically determinist theories have not, by and large, appealed greatly to women who feel under pressure to explain their own erotic inclinations. While some who felt their queerness early do invoke hard wiring or genetic influence, large numbers of lesbian-identified women prefer to speak in terms of emotional makeup, political or moral commitment, or long-range practice versus mere experimentation. (p. xxvii)

The scientific debate around biological causes of female SSA seems bogus even to lesbian-identified women.

To a large extent, the research record on the *possible* affectively based, psychosocial or environmental and cultural influences of female homosexuality, have arisen out of survey studies, comparing homosexual and non-homosexual women on a variety of variables such as childhood sexual abuse, recalled gender nonconformity or quality of relationship with parents. For example, there are a variety of studies that have examined the birth order of women with

SSA. Bell, Weinberg & Hammersmith (1981) find no recognizable pattern, however, other studies suggest that women with SSA are more often *only* children or first born (Gundlach & Reiss, 1967, 1973; Hogan, Fox & Kirchner, 1977; Rothblum, Balsam & Mickey, 2004; Saghir & Robins, 1973; Swanson et al., 1972). Gundlach & Reiss (1967) additionally note that in larger families, women with SSA more often number amongst the youngest children, suggesting that their mother's age was often greater. According to a more recent Danish cohort study by Frisch & Hviid (2006), there is a higher incidence of homosexual marriages (legal in Denmark) amongst only and youngest children. Correlations, such as these, are often not consistent. Even in the cases where there is consistency, they cannot be translated into a direct causal explanation for female homosexuality.

Studies have not, for the most part, specifically defined or evaluated the more complex and consequently psychological *mechanisms* or *developmental processes* related to these and other variables and their associated influence on sexual orientation and identity development. Nor does the horizon seem to be substantially expanding in terms of developing new research questions or identifying other potential salient developmental or psychosocial influences.

For a listing of the correlational and comparative studies the theories exploring the various psychosocial influences of female homosexuality, please refer to:

Table A3: *Psychosocial and Environmental Influences* at the end of the website material

A Call for Ethical Research

Dr. Colin Ross, a specialist in dissociative disorders and trauma, has encountered a dilemma in attempting to explain why there is a consistently higher percentage of gay, lesbian

and transgendered individuals in inpatient trauma treatment programs than non-homosexual or non-transgendered individuals. If sexual orientation is always endogenous (inborn) and not influenced by such things as trauma, then the percentage of gay and lesbian men and women experiencing trauma should be the same as heterosexual men and women. Ross believes that for the sake of deepening our understanding of the possible relationship between homosexuality and trauma, we must further our research and study. He therefore encourages mental health professionals to stay true to the ethics of science versus compromising it with a political agenda:

> Scientifically, the challenge is to transform clinical hunches and ideas into testable hypotheses. It is the data derived from tests of hypotheses that are relevant, not one's ideological position on an issue or problem. Ideology may be a source of scientific hypotheses, but these must be tested, otherwise there is disagreement and political warfare, but no science. (Ross, 2002, p. 144)

To be sure, there is much needed in this important area of scientific inquiry. Dr. Robert Spitzer, one of the primary psychiatrists involved in the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), also challenges the mental health community in this regard:

> Science progresses by asking interesting questions, not by avoiding questions whose answers might not be helpful in achieving a political agenda. Gay rights are a completely separate issue, and defensible for ethical reasons. At the end of the day, the full inclusion of gays in society does not, I submit, require a

> commitment to the false notion that sexual orientation is invariably fixed for all people. (Spitzer, 2001, n.p.)

In summary, the scientific research to date should not dissuade any woman from seeking help or a therapist from offering help for unwanted same-sex feelings, behaviors, relational patterns, or associated struggles.

Supplemental Research

Fluidity of Female Sexuality

Many researchers have noted the strong emotional or psychological component and therefore greater tendency of fluidity within female sexuality in general.[5] For example, based on her clinical work with college-aged lesbian women, Ann Fleck Henderson (1979) concludes that "Sexual orientation, as this group of lesbians describes it, is not an organic or biological fact that one discovers" but "has much to do with the context in which one lives," occurring in the "interaction of person and culture" (p. 178). Later, she suggests, "female sexual orientation is less fixed than male sexual orientation and liable to later shifts" (1984, p. 218).

During Dr. Joan Sophie's study of the stages a woman typically moves through as she begins to identify herself as a lesbian, three women formerly identified or living as lesbians began dating and intimately relating with men. She notes "we are mistaken if we interpret the notion of stability [of sexual orientation] to mean that individuals who have become lesbian cannot subsequently change" (Sophie, 1986, p. 49). She suggests that the concepts of stability or unchangeability may only have meaning for those women who *do not* desire to change.

In 1990, Margaret Nichols, an openly gay counselor states

> Clearly, lesbianism is not merely a matter of an overwhelming, single-focus sexual attraction. These facts about bisexuality [such as Bell & Weinberg's (1978)

[5] See Diamond (1998 & 2000); Dixon (1985); Henderson (1984); Nichols (1988); and Sophie (1986). Michael, Gagnon, Laumann & Kolata (1994), in their national survey on *Sex in America*, note, that as a whole, women are more apt to identify themselves as "bisexual" or capable of having a romantic relationship with both sexes, than men.

> report that only half of lesbian women claim they have exclusive homosexual attraction] make the nonbiologic factors operative in lesbianism even more relevant and give insight into the claim of some gay women that they 'chose' their sexual orientation. (p. 355)

Ann Menasche (1998), in her book entitled *Leaving the Life: Lesbians, Ex-Lesbians and the Heterosexual Imperative*, explores the common trend for many lesbians (sometimes formerly bisexual, sometimes purely lesbian) to leave a lesbian life and pursue heterosexual relating. While she asserts that many of these women may have left due to the heterosexual imperative (cultural pressure), she admits that many not only changed their behaviors but also their emotional affections. Dr. Lisa Diamond followed 80 non-heterosexual young women (lesbian, bisexual and unlabeled) over a two-year period. She found that half of the women "reported multiple changes in sexual identity, and nearly one fourth of lesbians pursued sexual contact with men" (2000, p. 246).

In 2004, Dr. Ellen Schecter of the Fielding Graduate Institute, presented a dissertation with the interesting title "Women-Loving-Women Loving Men: Sexual Fluidity and Sexual Identity in Midlife Lesbians." She interviewed "11 women who had identified as lesbians for more than 10 years, but who after age 30 were now in intimate relationships with men lasting at least a year" (Greer, 2004, p. 28). In reviewing Schecter's study, Greer (2004) suggests sexual identity can change and evolve as a woman grows and assimilates the meaning of her experiences and relationships.

Hope Edelman interviewed many gay and straight women for her heart-felt book entitled *Motherless Daughters*. She speaks of many lesbian women who claim to have *chosen* women as

partners after realizing 1) their relationships with men "failed to provide the nurturing and comfort they sought" or 2) they "channeled their sexual impulses toward women because they feared having such impulses toward men while living alone with their fathers" (1994, p. 169).

One gay affirmative therapist points out that "Theorists and researchers from Freud onward have demonstrated that the boundaries between sexualities are quite fluid and that many more people than those who label themselves bisexual manage to experience multiple forms of sexual expression with partners of both sexes despite cultural dictates and institutional arrangements" (Rivera, 2002, p. 41). Setting aside the moral implications of such realities, sexual attractions and behaviors are often flexible or fluid, or in other words, evolving or changing for many people across time. This seems especially true for women.

Jan Clausen, a former lesbian but now married to a man, speaks of this fluidity as "an instance of human self-making." She admits "there's a logic to my erotic choices that relates very closely to what's happening in other areas of my life" (1999, p. xxi). She believes women have more of a choice with respect to not only the individual but the gender of the person with whom they will sexually relate. Indeed, in general, women tend to emphasize the emotional or *affectual* component of sexuality, focusing on the quality and nature of the relational connection as the basis for sexual involvement. Clausen (1999), who believes it is perfectly fine to be either straight or gay, acknowledges that since "a person's sexual partners would seem no more relevant a gauge of his or her basic nature than would a host of other habits, preferences, and tastes," (p. xxv) people who move within the fluidity of sexuality and *change* their sexual attractions should not be bullied as "border-crossers. What's got to stop is the rigging of history to make the either/or look permanent and universal" (p. xxviii).

It is indeed unfortunate, that while the secular community agrees sexuality is fluid and therefore subject to change, it only allows for "change" in one direction. I do not believe that most gay affirmative mental health professionals and educators are supporting the "many possible options" or "multiple forms of sexual expression" a woman may have across her life span, *especially when that expression involves a predominantly lesbian woman seeking a liaison with a man*. To attempt to express heterosexual love is considered suspect, and at worst, deemed unhealthy and dangerous. Yet the heterosexual woman leaving her husband to seek out a lesbian relationship, on the other hand, would be fully affirmed and supported. This is a fatal inconsistency in the theoretical base of the sexually liberal therapeutic community. This bias is not only being tolerated but is used as a part of the "indoctrination" of new mental health professionals. I find it untenable in light of the readily acknowledged emotional components and fluid nature of female sexuality.

In discussing their work with lesbian women who were formerly married to men, Bridges and Croteau (1994) note we as counselors need to help our clients "to realize that sexual orientation may, but does not necessarily, fall into one of two neat categories that remain stable over time. …*The counselor should help the client see that there are many possible options for defining and understanding one's sexuality. The client can thus feel free to discover and shape an identity that fits her at that point in time* [italics added]" (p. 137). This is a quintessential representation of a therapist's acknowledgement of the fluidity of female sexuality *and* respect of a client's right for self-determination.

Having established the fluid nature of female sexuality, a distinction must still be made. The concept of sexual *fluidity,* defined as the *spontaneous* evolution or transformation of one's sexual attractions, preferences, behaviors or identity, is not identical to the concept of

changeability involving *intentional* effort directed towards altering or changing one's sexual attractions, preferences, behaviors or identity. The fact that sexual preference does spontaneously change for some women, does *not* directly translate into proof that *any* woman with SSA can easily change or alter her same-sex attractions. It does however confirm that *sexual feelings and behaviors are not absolutely immutable or unchangeable*, and "If considerable swings in sexual orientation can happen without therapeutic intervention, it makes sense they would be even more considerable if they are therapeutically encouraged in a motivated person" (Whitehead & Whitehead, 1999, p. 188).

The degree to which a woman with SSA can or will experience change in her same-sex attractions or orientation will be uniquely determined based on the nature of biological influences on her psychosexual differentiation, other innate traits, environmental history, degree of exclusivity of her same-sex feelings (versus also experiencing bisexuality), nature of her same-sex behaviors and patterns of emotional dependency, level of identification with homosexuality, current circumstances, and motivation to do so.

Supplemental Research

Psychopathology and Homosexuality

While the debate continues with respect to the causes, treatability, and nature of homosexuality in terms of healthy versus unhealthy behavioral, developmental, or psychological norms, numerous studies have been conducted since the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973, comparing psychopathology amongst homosexuals and heterosexuals. The most comprehensive and recent include Fergusson, Horwood, Beautrais (1999); Fergusson, Horwood, Ridder & Beautrais (2005); Herrell et al. (1999) (men only); Hughes, Haas, Razzano, Cassidy & Mathews (2000); Sandfort, deGraaf, Bijl & Schnabel (2001); Warner et al. (2004); and Welch, Collings & Howden-Chapman (1999). In summarizing two large studies, Fergusson et al (1999) and Herrell et al. (1999), J. Michael Bailey, a leading researcher on the causality of homosexuality, concludes

> 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 a substantially higher risk for some forms of emotional problems, including suicidality, major depression, and anxiety disorder. (Bailey, 1999, p. 883)

Additionally, research has found an increased risk within homosexual women for drug and alcohol dependency (Bradford, Ryan & Rothblum, 1994),[6] a greater prevalence of utilizing mental health/substance abuse services (Cochran & Mays, 2000; Hughes et al., 2000; Welch et al., 1999), an increased comorbidity for multiple disorders (up to two to four times greater) including depression, anxiety, panic disorder, and substance abuse or dependence,[7] and increased risk for self harm[8] when compared to heterosexual female populations. This does not mean that every women with SSA struggles with these mental health factors, however, these problems may be more common in those women who seek professional counseling.

Depression is often very pervasive in many of my client's lives. It often feels like a perpetual state of mourning or intrinsic undertone that has been woven into their baseline personality. Studies show that women, in general, are two times more likely than men to suffer from depression.[9] Dana Crowley Jack, in *Silencing the Self*, explains that because a woman's "orientation to relationships is the central component of female identity and emotional activity," (1991, p. 3) disruptions within her relationships make her extremely vulnerable to low self-

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[6] Childhood sexual abuse has been found to be closely associated with adult alcohol abuse in both homosexual and heterosexual women (Hughes, Johnson & Wilsnack, 2001), potentiating greater complications in alcohol recovery in general in lesbian women (Hall, 1996). Considering the research that supports higher rates of sexual abuse amongst homosexual women (see The Prevalence and Nature of Sexual Abuse in Lesbian Women), one might then also expect higher rates of alcohol related difficulties amongst homosexual women.

[7] See Cochran, Sullivan & Mays (2003); Fergusson et al. (1999); Fergusson et al. (2005); Koh & Ross (2006); Razzano, Matthews, & Hughes (2002); Sandfort et al. (2001); Warner et al. (2004); Welch et al. (1999)

[8] See Fergusson et al. (1999); Fergusson et al. (2005); Hughes et al. (2000); Matthews, Hughes, Johnson, Razzano & Cassidy (2002); Skegg, Nada-Raja, Dickson, Paul & Williams (2003); Warner et al. (2004); Welch et al. (1999).

[9] American Psychological Association (2005). *Research agenda for psychosocial and behavioral factors in womens health: Chronic Diseases*. Retrieved September 20, 2005 from http://www.apa.org/pi/wpo/chronic.html

esteem and depression. Perhaps because of their bitter struggle with relational issues, many of my clients experience a chronic unrelenting depression. Added risk factors for depression include chronic difficulties in both familial and peer relationships, trauma, abuse, and loss, not uncommon for many women with SSA.[10]

Some say that the high incidence of emotional difficulties amongst homosexual men and women is simply related to the social oppression of homosexuals. Dr. Neil Whitehead, coauthor of *My Genes Made Me Do It,* an excellent book unpacking the scientific debate surrounding homosexuality, points out in an Internet article that this explanation does not hold up in light of the most recent research.[11] The Sandfort et al. (2001) and Fergusson et al. (2005) studies were done on populations within the Netherlands and New Zealand, respectively. Both of these countries are known for their open acceptance and gay-affirming tolerance of homosexuals, even to the extent of granting special legal rights. Whitehead notes that the incidence of mental health difficulties is no different between these countries and the United States, the latter of which is considered to be much more overtly intolerant of homosexual men and women.

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[10] Of interest, early childhood depression has also been found to result from an "environment where the child learned that, in order to be loved, she or he had to repress authentic feelings and present an outwardly conforming false, self" (Jack, 1991, p. 93), an extremely common phenomena in many of my client's lives. Increased levels of depression and somatization with underlying anxiety have also been reported amongst adolescent girls who perceive the presence of bias or limitations placed upon them or their mothers because of their gender (Silverstein, Perlick, Clauson & McKoy, 1993), especially if attitudes of male superiority are held by their fathers (Silverstein & Lynch, 1998). Many women with SSA have been extremely sensitive to the gender discrimination so prevalent still in our society, churches, and homes.

[11] See http://www.narth.com/docs/whitehead.html, retrieved 12/9/2004.

So although the research *does* support the assertion that higher rates of psychopathology are associated with homosexuality, it does *not* conclude that the psychopathology is directly caused by social oppression and heterosexist attitudes, although the effects of societal and religious attitudes should not be minimized. Nor does it support the notion that homosexuality in and of it self is pathological, the direct cause of psychopathology or that psychopathology is the direct cause of homosexuality. All of these views, if applied dogmatically, miss the complexity of the developmental, interactive, or adaptive nature of homosexuality *and* psychopathology. What *is* important to acknowledge, is that regardless of a client's level of acceptance or conflict with respect to their homosexual feelings, behavior, or identity, there may be legitimate psychological needs and concerns that deserve a therapist's attention and care.

One unfortunate result of the APA decision to view homosexuality from a non-disease model, is the "logical error that if diagnosis of homosexuality as a disease entity is faulty and destructive, then diagnostic concepts applied to homosexual individuals, and perhaps diagnosis itself, is faulty and destructive" (Gonsiorek, 1982, p. 9). Dr. John Gonsiorek, a gay affirmative clinician and researcher admitted that these "anti-diagnostic views are not only less than helpful, but their *sole* application may constitute incompetence or malpractice" (p. 10).

Supplemental Research

Homosexual Women and Weight

In a National Lesbian Healthy Care Survey, Bradford, Ryan, & Rothblum (1994) found overeating amongst lesbians to be far more common than undereating. Over two thirds of their sample admitted that they overate. In a study on sexual orientation and eating disorders, Siever (1994) reports that on an average, the lesbian women were significantly heavier than the heterosexual women.[12] Brown (1987) notes that "Lesbians appear to be over-represented among fat activists, that is, people who define fatness as a normative variation" (p. 295), however, Schneider, O'Leary, & Jenkins (1995) found no differences in terms of obesity.

In a more recent National Lesbian Health Survey from New Zealand, Saphira & Glover (2000) found that 45% of the 791 (minus 31 who did not give their weight) women surveyed were overweight or obese. Many of these researchers also note that homosexual women are probably not as influenced by the cultural standards of "thinness" as are heterosexual women. I would suggest that for many women with SSA, because of their underlying depression and possible core emptiness, "food" has possibly become one of their only reliable friends and source of comfort and fullness.

[12] See also Brand, Rothblum, & Solomon (1992) and Rothblum & Factor (2001).

Supplemental Research

The Prevalence and Nature of Sexual Abuse in Lesbian Women

Several studies have shown that the prevalence rates of childhood sexual abuse (CSA)[13] are higher amongst lesbian populations than non-lesbian women in the general population.[14] Prevalence rates for the general population of adult females range from 15-32%,[15] while prevalence rates for lesbian women range from 30-56%.[16] For example, Matthews, Hughes, Johnson, Razzano & Cassidy (2002) found 16% of 279 heterosexual women versus *30% of 550 homosexual women* versus reporting childhood sex abuse. Balsam, Rothblum & Beauchaine (2005) found 30% of 348 heterosexual versus *44% of 332 homosexual women*, Hughes, Haas, Razzano, Cassidy & Matthews (2000) found 24% of 279 heterosexual versus *41% of 550 homosexual women*, and Hughes, Johnson & Wilsnack (2001) found 27% of 57 heterosexual versus *42% of 63 homosexual women*, reporting CSA. Roberts & Sorensen (1999) found that *39% of 1633 lesbian women* drawn from a national community based sample reported a history of CSA. In the New Zealand Lesbian Mental Health Survey, Welch, Collings & Howden-

[13] Within the bulk of this research, various definitions of CSA were used as well as various age spans in terms of defining "childhood."

[14] See Balsam, Rothblum & Beauchaine (2005); Hughes, Haas, Razzano, Cassidy & Matthews (2000); Hughes, Johnson & Wilsnack (2001); Lechner, Vogel, Garcia-Shelton, Leichter & Steibel (1993); Matthews, Hughes, Johnson, Razzano & Cassidy (2002); Tjaden, Thoenness & Allison (1999).

[15] See Fergusson, Lynskey, Horwood (1996); Lechner et al. (1993); Anderson, Martin, Mullen, Romans & Herbison (1993); Vogeltanz et al. (1999).

[16] See Balsam et al. (2005); Hall (1996); Hughes, Haas, Razzano, Cassidy & Matthews (2000); Hughes, Johnson & Wilsnack (2001); Matthews et al. (2002); Roberts & Sorensen (1999); Welch, Collings & Howden-Chapman (2000).

Chapman (1999) found *56% of 561 lesbian women* had experienced sexual abuse prior to 16 years of age while another 56% had unwanted sexual experiences after age 16.

Cameron & Cameron (1995) report that incest was more common amongst bisexual and homosexual women when compared to heterosexual women. Peters & Cantrell (1991) report that lesbian women report more forced sexual experiences than non-lesbian women and Tjaden, Thoennes & Allison (1999) found that "same-sex cohabitating women were nearly twice as likely as opposite-sex cohabitating women to report being forcibly raped as a minor" (p. 419). According to the National Lesbian Health Care Survey, 19% of 1,779 lesbian women have been involved in incestuous relationships growing up and 41% report rape or sexual attacks or abuse at some point in their life (Bradford, Ryan & Rothblum, 1994). Balsam et al. (2005) and Tomeo, Templer, Anderson & Kotler (2001) report that more homosexual than heterosexual women have been abused by a female.[17]

When determining the potential long-term impact of CSA, variables such as age at onset, sex of victim and perpetrator, relationship to the perpetrator, duration, number of acts, severity of acts, nature of force, level of invasiveness, and underlying family functioning must be considered (Beitchman, Zucker, Hood, DaCosta, Akman & Cassavia, 1992).[18] In general, abuse by a male

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[17] In a book on mother-daughter incest, Beverly Ogilvie states, "it is not uncommon for a mother-daughter incest survivor to choose lesbian partners in later life" (2004, p. 65). In referencing Tower (1988), Ogilvie suggests that the daughter, rather than avoiding women as she might with a male abuser, seeks out a "nonexploitive mother figure to love her for herself and not for her sexual acquiescence" (p. 65).

[18] As a seeming contradiction to the observation that many women with SSA experienced a *delay* in their sexual development, researchers have found that women with SSA, in general, are sexually active *heterosexually* at an earlier age (often pre-puberty) than non-SSA women (Bell et al., 1981; Peters & Cantrell, 1991; Saghir & Robins, 1973; Van Wyk & Geist, 1984). However, the studies do not qualify the nature of this activity nor the girls'

can create an aversive reaction in females towards males in general, male body parts, and sexuality, especially opposite sex intimacy. Van Wyk & Geist (1984) found that girls, who had been forced, coerced or betrayed by a man or older boy to participate in sexual touch or activity were "more likely to choose to engage in sexual activity with other females as an adult" (p. 537). Lechner, Vogel, Garcia-Shelton, Leichter & Steibel (1993) and Wise, Zierler, Krieger & Harlow (2001) also report that women with CSA are more likely to have adult homosexual experiences than women without CSA.

It has also been found that sexually abused girls often experience confusion or dysphoria around their gender and sexuality in general. Cosentino, Meyer-Bahlburg, Alpert & Gaines (1993), observe that girls with CSA (most of whom were incested), unlike their nonabused counterparts, "manifest relatively intense feelings of conflict and ambivalence regarding their gender identity and role as girls," display more masculine behavior, and identity with their male aggressor (p. 946). Schwartz & Southern (1999) note that girls who face abuse or trauma may attribute (or misattribute) the ensuing sense of badness or defectiveness to her "gender or genital sexuality" (p. 167). As a result, "disorders may emerge … [such as] gender dysphoria or sexual desire disorder" (p. 167). Female adolescents with sexual abuse histories also tend to deny their womanliness, viewing menstruation and other womanly signifiers as anathemas (Brooks, 1985, p. 408). For young girls already struggling with gender identity or role confusion, sexual abuse can add another layer of cloudiness and repulsion to her fledgling sexuality and sense of self.

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reactions or feelings as a result. It is possible that this sexual activity was part of a sexually abusive experience or otherwise negative experience.

Supplemental Research

Violence in Lesbian Relationships

Ellyn Kaschak, in her edited book *Intimate Betrayal: Domestic Violence in Lesbian Relationships,* opens by stating

> It has been difficult for many members of the lesbian community and feminists, whether lesbian or not, to accept that there are among us women who batter and abuse other women. Yet, unfortunately, they exist in large enough numbers to require the systematic attention of researchers and therapists alike. (2001, p. 2)

In general, lesbian and bisexual women report more experiences of victimization than their heterosexual counterparts in their adult relationships (Balsam, Rothblum & Beauchaine, 2005; Tjaden, Thoennes & Allison, 1999).[19] It is possible that over 50 percent of lesbian women have been victims of physical abuse or used violence within their same-sex relationships.[20] Verbal, emotional and psychological violence are the most common form.[21] So severe is the abuse and overt control in some relationships, that many women literally have to *escape* from the

[19] Many therapists suggest that the inherent hostility and aggression inherent to many lesbian relationships arise out of the stressors and social pressures unique to gay and lesbian people.

[20] See Brand & Kidd (1986); Coleman (1990); Lie & Gentlewarrior (1991); Lie, Schilit, Bush, Montagne, & Reyes (1991); Renzetti (1992).

[21] Lie et al. (1991); Lockhart, White, Causby & Isaac (1994); Renzetti (1988).

relationship.[22] One study shows that 77% of 100 lesbian women who had been victim to violence within their same-sex relationships, admit, "that the first abusive incident occurred less than 6 months after the start of the relationship" (Renzetti, 1988, pp. 387-388.)

Researchers have found a direct correlation between the degree of fusion or dependency within a lesbian relationship with its propensity for violence. The more emotionally dependent a woman is upon another, the more apt she will be to use aggression or violence, usually in an attempt to inhibit her partner's efforts toward separation or independency.[23] Similarly, a correlation has also been found between a lesbian woman's need for control and *independence* with increased physical violence (Miller, Greene, Causby, White & Lockhart, 2001, p. 120). I would imagine then that the relationships between these two types of women, a "dependent" with an "independent" woman, would create the greatest level of volatility.

It has also been found that once abusive behaviors are introduced into a female same-sex relationship, they typically escalate in severity over time (Renzetti, 1988, 1992). Sadly, the confusion and chaos of an abusive relationship can reinforce a woman's core negative beliefs about her lack of value and ability to have good relationships, and further fuel her shame, self-doubt, anger, and insecurity, or low self-esteem, for example.

Now imagine if two faith-based women become tangled in a same-sex relationship that is increasing in intensity and violence. In the beginning, they felt guilty about developing a same-sex relationship in the first place, but also felt they were going to somehow shrivel and die without welcoming the deep connection they experienced together. They may have, over time,

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[22] Researchers have also found that women who have been abused within their family of origin or witnessed family violence were more likely to be a victim or a batterer in her intimate same-sex relationships. See Lie et al. (1991) and Lockhart et al. (1994).

[23] Renzetti (1988). See also Lockhart et al. (1994); Miller, Greene, Causby, White & Lockhart (2001).

excluded some of their other friends, and thereby weakened each of their outside support systems. But now, much to their surprise and disappointment, they are in over their heads in conflict, hostility, emotional violence, and overwhelming feelings of desperation, fear, and shame. To whom can they reach for help? If one decides to take the risk and share about her situation, will she find someone who can help her by compassionately listening and responding to her situation by offering support, resources, and a safe place? Or will she simply be judged and told she is in this fix because she's "gay."

> I feel terrible about it, but, it's like I'm angry all the time. Then she does something that puts me over the edge, and I'm gone. I explode all over her, sometimes with my words, sometimes with my fists. Then we both feel worse. (*twenty-three year old, Latina, lesbian, alienated from her fundamentalist Christian family of origin)* (Tigert, 2001, p. 74)

Supplemental Research

Longevity of Lesbian Relationships

The pattern of initial enthusiasm and profound sense of love and intimacy between two women, all too often eventually spirals into disillusionment and insurmountable difficulty. Historically, therapists have regularly observed this relational pattern within lesbian pairs (McCandlish, 1982). Nichols (1990) notes that for as much as females may have a natural tendency to value connection and relationship (and in lesbian relationships this means there are *two* females), this tendency does not seem to translate into the "ability to make a relationship last" (p. 358).

Laumann, Gagnon, Michael, & Michaels (1994), challenging the assumption that since homosexual women tend to form such extremely strong bonds with one another their relationships must remain stable and enduring, found that the women, similar to homosexual men, have "higher average numbers of partners" (p. 314). Other researchers have confirmed that lesbian relationships, in general, have less durability than heterosexual relationships and promote, within each woman, a persistent feeling of impermanence.[24]

[24] See Blumstein & Schwartz (1983); Rothblum, Balsam & Mickey (2004); Rothblum & Factor (2001); Schneider (1986).

Supplemental Research

Research Findings on Women with SSA Using the Measures of Psychosocial Development

In 1993, Dr. Sheryl Brickner, in an unpublished doctoral dissertation, assessed the developmental differences between heterosexual and homosexual women using the Measures of Psychosocial Development (MPD), an assessment tool designed to evaluate a person's resolution of Erik Erikson's eight stages of psychosocial development.[25] The total resolution of each stage is assessed by measuring the level of positive resolution and level of negative resolution in each stage. For example, for Erikson's first stage of development, a woman's level of Trust is assessed separate from her level of Mistrust. The two scores are then combined to provide a total score for the overall level of resolution of the stage. And finally, the positive resolution scores for all stages are totaled, as are the negative resolution scores, resulting in a Total Positive Resolution and Total Negative Resolution.

While Brickner admits that the scope of her research does not establish the cause of the differences, "Of the 19 scales analyzed, six of the scales indicated a significant difference in the scores between the two groups of women" (1993, p. 3). Brickner found that, as a group, the 54 heterosexual women scored significantly higher on the positive resolution scales of *Trust, Intimacy*, and *Generativity* (the latter being defined as the meaningful contribution to the next generation vs. self absorption and stagnation). As a group, the 54 lesbian women scored significantly higher on the negative resolution of *Identity Confusion, Stagnation* (opposite of Generativity), and *Total Negative Resolution*. According to her findings, in general, lesbian

[25] The *Measures of Psychosocial Development* (MPD), ©1988, is published by Psychological Assessment Resources, Inc. and available by calling 1-800-331-TEST.

women, compared to non-lesbian women, experience greater *Identity Confusion* and *Stagnation* and report more struggles with *Trust, Intimacy*, and *Generativity*.[26]

Over the past few years, I began to administer the MPD to all of my clients during the opening stage of therapy.[27] They have given me permission to report on the generalized findings of their assessments as a group. Based on their assessment profiles, many of my clients suffer conflicts at every developmental stage yet, as a whole, exhibit some patterns that may be similar to Brickner's findings. Of the 45 women with SSA that I have tested, 26 or 58% report either *Mistrust*, *Identity Confusion* or *Stagnation* as their most conflicted negative resolution scale (these scales are high) or *Trust, Identity* and *Generativity* as their most conflicted positive resolution scale (these scales are low), often scoring at least two standard deviations above or below the assessment's normative mean *and* often simultaneously exhibiting extremely elevated or depressed scores on more than one of these scales, respectively. It is important to note however, that all of these women have sought out psychotherapy, making them a unique subset of lesbian women in general. Perhaps it is these very conflicts that prompted them to seek professional help.

I have also noticed another pattern emerging in my client's test profiles. *Relative to their other scores*, these women often score extremely high (peaking) in the positive resolution of *Initiative* or *Industry* or both. In fact, for 21 of the 45 women (46%), *Industry* or *Initiative* was their overall *highest* positive resolution scale. It might be possible to conclude that these women simply exhibit healthy assertiveness, aggressiveness, and sense of confidence and achievement in

[26] Striegel-Moore, Tucker, & Hsu (1990) also observed a significant increase in interpersonal distrust amongst lesbian women in contrast with heterosexual controls.

[27] I do not randomly assess my clients; all are required to undergo a battery of assessments upon commencement of therapy.

their work and accomplishments. However, the fact that these scores are often spiked far above all other positive resolutions, might also suggest that the realms of *Initiative* and *Industry* have been used in a compensatory fashion, especially in light of their elevated scores in *Mistrust* and *Identity Confusion*.[28] In other words, it is easier for them to focus on and succeed in the external realms of professionalism and achievement than in the internal realms of self-acceptance, self-understanding and a core trust that can support variegated intimacies.

Following is an illustration of these outstanding patterns and possible explanation of difficulty in each of the stages.

Note to Editor: Need a circle around Mistrust, Initiative and Instrusty together, identity confusion, isolation and stagnation.

[28] Several historic studies have shown that homosexual women embody traits more commonly associated with men, such as motivational patterns of work satisfaction (Freedman, 1968), goal-directededness (Siegelman, 1972), responsibility, and self-confidence (Ohlson & Wilson, 1974; Thompson, McCandless & Strickland, 1971), and independence and self-sufficiency (Hopkins, 1969), more often than heterosexual women. It is possible these measurements parallel the significantly elevated traits of *Initiative* and *Industry*. However, sampling bias within these studies may account for these results since most of the homosexual respondents were volunteers and recruited from homophile organizations.

Oberstone & Sukoneck (1976) found that the homosexual women, in comparison to heterosexual women, scored significantly higher on the Mf (Masculinity/femininity) and Ma (Hypomania) scales in the Minnesota Multiphasix Personality Inventory (MMPI). This was interpreted as meaning that the homosexual women were more "masculine," such as more independent, self-determining or aggressive, and were characterized by higher levels of activity and spurts of productivity, and an enterprising personality, all traits inherent in an *Initiating* and *Industrious* personality. Adelman (1977), surveying a group of professionally employed women, found that the homosexual women also scored significantly higher on the Mf scale, interpreting that homosexual women depart more from stereotypic feminine behavior than the heterosexual women.

Developmental Stage to be Resolved			**Age**	**Possible Conflict and Modes of Survival**
(positive)		(negative)		
Trust	vs.	Mistrust	0 – 18 months	Defensive Detachment & Disidentification based on Mistrust and Disrespect
Autonomy	vs.	Shame	18 – 36 months	Gender Identity Confusion
Initiative	vs.	Guilt	3 – 6 years	Development of False Self
Industry	vs.	Inferiority	6 – 11 years	based on toughness and performance
Identity	vs.	Identity Confusion	Adolescence	Hidden True Self
Intimacy	vs.	Isolation	Young Adult	Relational Ambivalence
Generativity	vs.	Stagnation	Middle Adult	Existential Aloneness
Ego-Integrity	vs.	Despair	Old age	Inner Emptiness

If we followed the assessment's suggested methods of interpretation, we might conclude that as a whole, these women often feel insecure and unsafe in their world, unsure of others, and doubt that anything good will last. They have used performance, competence (intelligence and intellectual strengths), productivity, and assertiveness in a compensatory fashion, probably to gain a sense of control and purpose. If this is true, in reality they have not overcome their deep feelings of insecurity and inferiority, but have repressed them. Internally, they still lack a sense

of inherent value and clear identity, as indicated in their high scores of *Identity Confusion*. They struggle with intimacy and are restricted in meaningfully contributing to the next generation. Emotionally and psychologically, they may remain in a depressed state of self-absorption. The word "self-absorption" is not to be understood derogatorily, but developmentally. These women are essentially lost in their most primal and narcissistic stage of development.

Supplemental Research

Characterological Patterns and Women with SSA

Putting aside differences in terminology and theoretical explanations, there appears to be some measure of agreement within the mental health field as to the core features of a personality disorder. These include a "failure to develop a stable, cohesive, separate, and individuated self" (Klein, 1989, p. 31) and chronic interpersonal difficulties, defined as "repetitive maladaptive patterns of thoughts, feelings, and actions that occur in relationship to significant others" (Livesley, 2001, p. 10). In general, risk factors for personality disorders include attachment insecurities, inherent temperament of child, family adversity, ineffectual parenting practices, and abuse. As highlighted in *The Heart of Female Same-Sex Attraction*, these core difficulties involving self, relationships, and attachment patterns are not atypical in the lives of many women with SSA. It should not be a surprise then that some of them might be dealing with a personality disorder.

Dr. Gregory Lester, a dynamic speaker, author, and psychologist specializing in personality disorders, asserts that personality disorders do not exclusively arise out of trauma or abuse, but are a result of a person's *adaptation* to their own biological predisposition (temperament) and "disruptive early experience(s)" (1999, p. 15). This adaptation, or collection of survival strategies, perceptions, and coping mechanisms, essentially becomes rigid and inflexible, often denying the person any further individual or interpersonal growth and development. They are forced to face and cope with all of life's circumstances with a very limited set of tools.

Over the past several years, I began to administer the Millon™ Clinical Multiaxial Inventory–III (MCMI)[29] to all of my clients at or near the beginning of treatment.[30] They have given me permission to report on the generalized findings of their assessments as a group. Based on the assessment's *Interpretative Report* for each client, combined with my clinical observations, it is possible that 23 out of 39 women (59%) meet the full criteria for *at least* one personality disorder. Of the 39 women, 20 or 51% meet the full criteria for an Axis I syndrome involving either a generalized anxiety disorder, mood disorder or both.[31]

The clients who produce the MCMI profiles with the highest comorbidity in terms of multiple Axis I and Axis II diagnoses, typically show a personality configuration of Depressive, Dependent, Masochistic (self-defeating), *and* Borderline Personality Disorders *with* a mood and anxiety disorder and Alcohol Dependence. This means that many of these women may be simultaneously struggling with pleasure-deficient, interpersonally-imbalanced, intrapsychically-conflicted, and structurally-defective personalities, in accordance with Millon's four personality groupings (Millon & Davis, 1996). Other severe profiles may also involve Avoidant and Schizoid Disorders or Traits.

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[29] The MCMI is an instrument designed to help clinicians accurately assess personality disorders and clinical syndromes. Normative data and transformation scores for the MCMI-III are based *entirely* on clinical samples and are applicable only to persons showing psychological symptoms or are engaged with professional psychotherapy or psychodianostic evaluation (Millon, 1997). The *Millon™ Clinical Multiaxial Inventory–III* (MCMI-III™), ©1994, DICANDRIEN, INC., is published and distributed by NCS Pearson, Inc. and available through NCS Assessments, 800-627-7271, http://assessments.ncpearson.com.

[30] Since I began using the MCMI within my practice, I have required *all* of my clients to take it and a battery of other psychological assessments. I do not randomly assess my clients.

[31] Many professionals are of the opinion that the MCMI overpathologizes clinical personality patterns and syndromes. This possibility must be considered as I discuss the patterns I observe within my clientele.

As one might imagine, profiles with such heightened comorbidity[32] usually indicate the highest levels of psychological distress and represent women who are not necessarily concerned about "changing" their sexual feelings or orientation. Although they remain dissonant with their same-sex feelings, they are more concerned with stabilization and support for overarching difficulties in daily functioning and overall direction for their life. These personality configurations are most often seen in the women who fit Profiles 1 and 2 described in Chapter 8 of *The Heart of Female Same-Sex Attraction*.

Women with Profile 3 and 4 also exhibit a pattern of sorts. Their personality configuration is usually limited to only one possibly pervasive personality *trait* or slight personality *feature*.[33] The most common personality traits are Histrionic, Narcissistic, or Obsessive Compulsive. The most common Axis I diagnosis is Anxiety Disorder but is seen far less frequently than in the more severe profiles. These women are usually able and willing to tackle the underlying dynamics involved in their same-sex attractions and emotional dependencies if they are not too entrenched in the dismissive style of attachment.

While these statistics and observations cannot be projected onto the general population of women with SSA without substantiating research, they may still be partially indicative of a small subgroup of women with SSA: those who are faith-based, in conflict with their same-sex feelings and behaviors, *and* seeking out professional counseling. For their sakes, a brief discussion about Axis I and Axis II involvement seemed appropriate. Many excellent resources exist that can assist in understanding the treatment nuances and modalities for Axis I or Axis II disorders. My

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[32] See *Psychopathology and Homosexuality* for prevalence of mental health issues amongst homosexual women.

[33] The MCMI measures Axis II involvement along a continuum of severity in terms of inflexibility. One can assess as having *features*, considered the least severe, *traits*, or the most severe, a *disorder* of any given pathological personality pattern.

intent here is to merely increase awareness that several Axis I and various characterological issues may emerge in a practitioner's work with women with SSA, making these resources absolutely essential.

History of Treatment of Female Homosexuality

Introduction

In the preface of her book on female homosexuality, Dr. Elaine Siegel, a supervising and training analyst at the New York Center for Psychoanalytical Training, tells the story of how she simultaneously treated 12 homosexual women within her private counseling practice. All of her clients viewed homosexuality as liberating and not one of them, at the outset of therapy, had a conscious desire to change. Since Dr. Siegel did not interpret homosexuality as an illness, she "did not set out to 'cure' them or to dissuade them from their lifestyle" (1988, p. xi). She merely prepared herself to listen as she would to any client and made herself emotionally available.

She reports that as her clients resolved and distanced themselves from inner conflicts, their anxiety decreased, and life, in general, became more joyful and productive. Further, "With the *attainment of firmer inner structures* [italics added]," their "interpersonal relationships also solidified and became more permanent" (p. xi). In other words, as these women began to root themselves within their unique stories, their true authentic and feminine self, and assume ownership of their personal needs, feelings, and desires, they established the foundation upon which healthy and long lasting relationships could be sustained. Through solidifying a *self*, they created the avenue through which to solidify *intimacy*. Needless to say, her clients, as a whole, reached extremely satisfactory conclusions to their years of psychoanalytic treatment.

But something else unexpectedly happened. During the course of treatment, more than half of her clients began to experience *other-sex* attractions and romantic desires, ultimately becoming, as Siegel puts it, "fully heterosexual" (p. xii). She admits that this profound change within her clients was partially due to her willingness to remain open to their deeper issues and "often heavy developmental needs" (p. xii) rather than simply affirming their homosexuality as

normative. It was also due to her client's willingness to address their developmental needs and to continue to grow as individuals and women, allowing internal and external change, including the transformation of their sexual preferences and identity.

Since the advent of psychotherapy, women *in conflict* with same-sex attractions and behaviors have sought out professional help. Many women who were *not in conflict* with same-sex attractions have experienced profound change. Counseling practitioners and new counseling students have not heard much about these women. Yet for decades, women and their therapists have reported appreciable reductions in their same-sex struggles. They have a story to tell.

The Historic Literature and the Possibility of Change

As early as the 1920s, there are documented case studies of psychoanalytic practitioners treating men and women with unwanted homosexual feelings.[34] While published literature on this topic was sparse during these early years, more reports began to appear in the 1950s. For example, in 1954, Dr. Frank Caprio claims, "Many patients of mine, who were formerly lesbians, have communicated long after treatment was terminated, informing me that they are happily married and are convinced that they will never return to a homosexual way of life" (1954, p. 299). He continues by noting, "It is claimed that a willingness to be cured is halfway to health. This particularly applies to lesbians. The prognosis therefore is a favorable one wherever there exists this genuine wish to be helped" (p. 301).

In 1956, Dr. Albert Ellis published the results of his work with 12 homosexual women. He concluded that "The majority of homosexuals who are seriously concerned about their

[34] Friedman & Downey (2002) reference 21 different practitioners publishing a total of 68 case studies on homosexual women between the years 1920 – 1989 (p. 138).

condition and willing to work to improve it may … be distinctly helped to achieve a more satisfactory heterosexual orientation" (p. 194). Dr. Edmund Bergler, a psychiatrist with the Freud Clinic in Vienna Austria and lecturer at the Psychoanalytic Institute in New York, after working with over 100 homosexual men and women boldly announced in 1956 that,

> Homosexuality has an excellent prognosis in psychiatric-psychoanalytic treatment … *provided the patient really wishes to change.* That the favorable results are not based on personal intangibles is proved by the fact that a considerable number of colleagues have achieved similar success. (1956, pp. 176-177)

In 1965, Dr. Daniel Cappon, a professor of psychiatry at the University of Toronto and professor of clinical psychiatry at the University of Maryland, after working with many homosexual men and women proclaims,

> …*homosexuality is curable*. It is, in fact, as curable, remediable, and ameliorable as the *patient wishes his illness to be cured, remedied, or ameliorated.* (p. 252) *When all is said and done, the therapeutic attitude is nothing if it is not utterly optimistic*. (p. 220) That is, in some 40 percent of the patients there is such a decided change as to merit the term 'cure.' (p. viii)

In his book preface, Cappon asserts that the main *bias* of his book is "hope."

Practitioners and researchers continued in their journey of inquiry and discovery.[35] During the late 50s and 60s, Dr. Catherine Bacon, Associate Professor of the University of Pennsylvania Graduate School of Medicine,[36] and Dr. Eva Bene,[37] both presented psychodynamic theories on the development of female homosexuality. The climate was open to discuss clinical features and concerns in working with homosexual women.[38] Researchers worked to test causal theories[39] and explored various personality, social, and sexual developmental features.[40]

More statements were made that change is possible. Dr. Peter Mayerson, Senior Resident Physician in the Department of Psychiatry at Cincinnati General Hospital and Dr. Harold Lief, Professor of Psychiatry at Tulane University School of Medicine and Director of the Hutchinson Memorial Psychiatric Clinic, performed a follow-up study on the effects of treatment with 19

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[35] It is important to point out that many of the historical studies and following reports on change are fraught with methodological flaws, reporting inconsistencies, lack of follow-up and inadequate understanding of what constitutes homosexuality within a woman. Nevertheless, what can be concluded from this body of literature is that *some type of change* in terms of same-sex feelings, thoughts, attractions, behavior or identity *does occur for some type of women.* (See Yarhouse & Throckmorton (2002).) Additionally, many of the historical theories and treatment frameworks were still fledgling and not necessarily comprehensive in their analysis or discussion. However, their existence points to the reality that caring professionals were actively hypothesizing, studying and openly dialoguing within the broader psychological community in an effort to learn about and help homosexual women.

[36] Bacon (1956).

[37] Bene (1965).

[38] See Caprio (1955); Gluckman (1966); Gundlach & Riess (1968); Munzer (1965); Romm (1965); Socarides (1968); Stone, Schengber & Seifried (1966); Wilbur (1965).

[39] See Gundlach & Riess (1967); Kaye et al. (1967); Kremer & Rifkin (1969).

[40] See Armon (1960); Hopkins (1969); Kenyon (1968); Saghir & Robins (1969).

men and women in conflict with same-sex feelings. In the closing remarks of their 1965 article, they encourage therapists to take hope that *change is possible*. (Mayerson & Lief, 1965, p. 332).

Dr. Harvey Kaye of the New York Medical College observed that 50% of the homosexual women with whom he had been working had shifted towards the heterosexual end of the spectrum. "*This indicates a substantial positive treatment potential in homosexual women* [italics added], a potential which should not be lost sight of in evaluating the treatability of female homosexuals who present themselves for therapy" (Kaye et al., 1967, p. 633).

The practitioners working with homosexual women typically went about their work quietly and conscientiously. They did not operate from a moral basis about homosexuality, but from a psychoanalytic framework and an ethical basis, believing it was the patient's right to seek treatment for any inner conflict or lack of a sense of well-being. They were respected within their field and often served on official subcommittees of the American Psychiatric Association (APA) established for the ongoing study and treatment of homosexuality and transgender issues. Their professional papers were regularly accepted and presented at the annual APA conventions.

The American Psychiatric Association and the Gay Rights Movement

But behind the scenes, a pressure cooker was brewing. In 1970, gay rights groups stormed the APA annual convention held in San Francisco. No one had ever seen anything like it. The groups' disruption of the convention became so intense that some of the psychiatrists "demanded that their air fares to San Francisco be refunded" (Bayer, 1987, p. 103). Many heard "their profession denounced as an instrument of oppression and torture" (p. 103).

Ronald Bayer in his book *Homosexuality and American Psychiatry: The Politics of Diagnosis* reviews the history of this monumental moment. "Guerrilla theater tactics and more

straightforward shouting matches characterized" the gay rights group's presence (p. 102). The activists essentially accused psychiatry of harming homosexuals by asserting that homosexuals can be "treated" or "helped." Their disruption of the convention became so intense that some of the psychiatrists in attendance "demanded that their air fares to San Francisco be refunded" (p. 103). Many heard "their professional denounced as an instrument of oppression and torture" (p. 103). The APA had surprisingly become a target for social change.

To stave off another protest, in 1971 the APA decided to host the first panel of active homosexuals wherein *nonprofessionals* could openly speak to psychiatrists of homosexuality as a normal identity. Yet, even with this invitation, gay activists again stormed the convention, demanding that homosexuality be removed from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). They argued that homosexuals were unjustly discriminated against because society at large believed homosexuals had a "mental illness." [41]

[41] Unfortunately, the initial categorization of homosexuality in the American Psychiatric Association's first publication of their *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1952 was under the category of Sociopathic Personality Disturbance. Homosexuality, neither then nor now, has any relationship to a sociopathic disorder. Adding injury to injury, the terminology relied upon by these early psychoanalytic practitioners was based on a medical model and can seem extremely derogatory and prejudicial. For example, when discussing female homosexuality, many used terms such as illness, neurosis, perversion, psychosis, pathological, deviancy and inversion, among others. A woman would therefore be "cured" from her "illness" of same-sex feelings. While I find most of these terms extremely offensive, it is important to note that in the mental health field fifty years ago, they were clinically defined and commonly used to describe a variety of other conditions. The DSM-I and DSM-II made frequent use of the word "neurosis." Nevertheless these terms still left a negative slant on the issue of homosexuality in general. It is indeed unfortunate that homosexual men and women were inappropriately characterized and mislabeled by the mental health community's historical language and diagnostic categorizations.

By 1972, practicing homosexual psychiatrists joined forces with the gay activist groups. Early in 1973, Dr. Robert Spitzer, a member of the APA Nomenclature Committee (the committee responsible for publishing the DSM), arranged a meeting between the activists and the Committee to discuss the request to eliminate homosexuality as a diagnostic category. A political agenda were now penetrating and weaving itself into the very fabric of this scientific community. At the 1973 annual convention, the core group of psychiatrists now seeking to eliminate homosexuality from the DSM reprimanded the psychiatrists who had for decades, successfully worked with homosexual patients. They implied that patients had been forced to "change" by moralizing practitioners. To the contrary, the patients of these practitioners *chose* to enter therapy because they were in distress about their homosexuality. These psychoanalysts had respected their dignity and right to self-determination.

In December of 1973, a small group of psychiatrists (members of the Board of Trustees of the American Psychiatric Association)[42] made a final decision to remove homosexuality from the DSM by replacing it with the phrase "sexual orientation disturbance." Implicit to this new nomenclature is the assertion that homosexuality is not a mental disorder but in fact a normal variation of human sexuality, and therefore, in and of itself, not a treatable condition. The only treatable "problem" was the inner conflict or disturbance within a man or woman with respect to their homosexual feelings or behaviors.[43]

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[42] 13 of the 15 Board members voted, 2 abstained, a far cry from the majority of the APA membership.

[43] The 1980 publication of the DSM (DSM-III) changed the category of "sexual orientation disturbance" to "Ego-Dystonic Homosexuality." This diagnostic category is only for those men and women for whom changing sexual orientation is a persistent concern. Amazingly, it asserts "The factors that predispose to Ego-Dystonic Homosexuality are those negative societal attitudes toward homosexuality that have been internalized" (p. 282). In other words, an *ego-dystonic* homosexual man or woman has simply internalized *society's* conflict with

Generally, a decision of this magnitude would be made based on an overwhelming preponderance of scientific evidence. However, throughout the Committee's deliberations, no conclusive scientific evidence was presented or analyzed:

- proving that homosexuality was inborn or unchangeable,
- refuting previous findings or experiences of clinicians specializing in the treatment of homosexuality, or
- proving that the mental health or overall psychological well-being of homosexuals was the same as non-homosexuals.[44]

Besides being influenced by extremely well organized and persuasive presentations from outside gay activist groups, only a few purportedly scientifically based studies were reviewed.[45] Further, the psychiatrists involved in the review process neither had an extensive background in the theoretical or clinical dimensions of homosexuality nor were experts on the associated body of

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homosexuality, homophobic feelings and attitudes. Therefore, the only logical treatment would be to assist a man or woman to resolve their internalized homophobia and accept and embrace a homosexual identity.

[44] One study that did exist comparing the psychological adjustment of homosexual and heterosexual women by Saghir, Robins, Walbran, & Gentry (1970) was overlooked, as were many others. (See Freedman, 1968; Ohlson & Wilson, 1974; Thompson, McCandless & Strickland, 1971). These studies were not necessarily conclusive, but were still part of the developing scientific record at that time. Saghir et al. (1970) found that homosexual women had sought out psychotherapy much more often than heterosexual women, had greater levels of depression and alcohol dependence and drug use, and a higher number of suicide attempts, findings similar to the current body of research.

[45] The studies examined included the two Kinsey reports (Kinsey, Pomeroy & Martin, 1948; Kinsey, Pomeroy, Martin & Gebhard, 1953), a study on the existence of homosexuality in non-western cultures (Ford & Beach, 1951), and Evelyn Hooker's 1957 study comparing the results of the Rorschach test (*subjective* in nature) administered to a *non-random* sample of 30 homosexual and 30 non-homosexuals (Lortie, 2000).

research and literature (Bayer, 1987). They failed to recognize (or refused to admit) the limitations and bias of the research presented.

Bayer (1987) suggests that the final decision "was *not a conclusion based on an approximation of the scientific truth as dictated by reason* [italics added], but was instead an action demanded by the ideological temper of the times" (pp. 3-4). He reports that many members of the APA believed, at the time, that the Nomenclature Committee was so eager to bring the discussion of homosexuality to a predetermined resolution that they "repeatedly violated accepted procedures for the consideration of such matters" (p. 132). As captives of extraprofessional interests (such as the National Gay Task Force), "they had attempted to short-circuit the institutional framework designed to guarantee the scientific evaluation of issues" (p. 132).

Many psychiatrists mourned the APA's 1973 decision to remove homosexuality from the DSM. According to Bayer (1987, p. 140-141), some claimed that the Board of Trustees had not only disgraced itself but had done society a grave harm. Practitioners were concerned that without a diagnostic category from which to base treatment, the lives of pre-homosexual children and adolescents who are desperately seeking direction, help, and change would be adversely affected. Surprisingly, even the APA's President issued a press release that notably admitted the *limited scientific meaning of the vote* while emphasizing its positive social impact. If homosexuality were not categorized as a mental illness, then perhaps society would no longer discriminate against or mistreat homosexual people (p. 138). Sadly, the foundation of science behind the psychiatric community's decisions and future policies was rapidly eroding.

Clinical Work Continues in the Late 70s and Early 80s

Fortunately, the battle over the DSM did not prevent practitioners from continuing to support women in conflict with homosexuality. In 1983 Dr. Helen Singer Kaplan, a Clinical Professor of Psychiatry at the New York Hospital-Cornell Medical Center, published *The Evaluation of Sexual Disorders: Psychological and Medical Aspects*. The book was not focused on homosexuality but included a short section on ego-dystonic homosexuality. She admits that treatment is not appropriate for homosexuals who are content with a homosexual identity but acknowledges many homosexuals are very distressed about their homosexual feelings. She concludes by "Many clinicians, including this author, consider these persons eminently deserving of a trial of treatment" (Kaplan, 1983, p. 252). Thankfully, many women still found help.

The search for more information about female homosexuality continued as researchers conducted studies on family constellations, developmental and behavioral aspects of homosexual women (Loney, 1973; Thompson, Schwartz, McCandless & Edwards, 1973), childhood sexual experiences (Gundlach, 1977), sexual identity development (Williams, Green & Goodman, 1979), comparative studies (Bell, Weinberg & Hammersmith, 1981), and the possibility of change (Masters & Johnson, 1979). Studies were also conducted on the general mental health of homosexual women.[46] Clinicians continued to offer psychodynamic frameworks for understanding the origin and treatment of female homosexuality.[47] Large survey studies were

[46] See Ohlson & Wilson (1974); Thompson, McCandless & Strickland (1971); Saghir, Robins, Walbran & Gentry (1970). See Mannion (1976) for a comprehensive review of the historic theory and research on female homosexuality.

[47] See Adams & Sturgis (1977); Adler (1978); Barnhouse (1977); Gershman (1975); Greenspoon & Lamal (1987); Hinrichsen & Katahn (1975); Kenyon (1974); McDougall (1970); Moberly (1983); Poole (1972); Rogers, Roback,

conducted comparing homosexual and non-homosexual women (Saghir & Robins, 1973; Bell & Weinberg, 1978).[48]

In 1988, Dr. Elaine Siegel, a supervising and training analyst at the New York Center for Psychoanalytical Training, premiered her groundbreaking book *Female Homosexuality: Choice without Volition* highlighted above. Dr. Houston MacIntosh, a senior faculty member of The Washington School of Psychiatry in Washington, D.C., surveyed 285 psychoanalysts in 1994. Similar to Dr. Siegel, the practitioners did not hold to the belief that homosexuals "should" or even "could" change, yet out of their collective clientele of 1215 men and women with SSA, 23% of their clients experienced a significant change in their same-sex feelings, attractions or behaviors (MacIntosh, 1994).

Alternative Avenues for Treatment and Hope

In 1976, the first organizational meeting of Exodus International was held. Exodus is a Christian referral and resource network based on the belief that freedom from compulsive homosexual feelings and behaviors is possible. There are now hundreds of Exodus referral organizations across the globe. In 1980, Father John Harvey started an organization called Courage within the Roman Catholic Church. Courage now boasts of 100 worldwide Chapters

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McKee, & Calhoun (1976); Saghir & Robins (1971); Socarides (1978); van den Aardweg (1985); Van Wyk & Geist (1984).

[48] In 1987, the revised edition of the DSM (DSM-III-R), eliminates the "ego-dystonic" category by merely listing "persistent and marked distress about one's sexual orientation" (p. 296) under the catchall category called "Sexual disorder not otherwise specified" (p. 296). This change reflects the belief that the only source of a person's inner conflict with homosexuality arises from their internalized homophobia. Therefore, true ego-dystonic homosexuality does not exist. There is no subsequent change in the 1994 or 2000 editions of the DSM.

committed to support homosexual men and women and their loved ones. In 1992, a non-profit organization called Evergreen International was formed as a resource for Latter-Day Saints impacted by same-sex attraction. And most recently, JONAH – Jews Offering New Alternatives to Homosexuality – was formed in 2000. Because of the overwhelming threat of scientific censorship within the APA, in 1992, the National Association of Research and Treatment of Homosexuality (NARTH) was formed for the ongoing psychiatric and psychological study and treatment of homosexuality.

Perhaps due to the developing vacuum of publications within the mental health field, in the 90's a proliferation of books with a spiritual emphasis on hope and change for women began to be published.[49] Today therapists continue to work with women in conflict with homosexuality even though many of their professional associates consider such work taboo. Recent publications continue to support this type of clinical work,[50] however, due to political incorrectness, it is clear that the momentum and support behind open inquiry and dialogue surrounding the nature of the developmental and environmental influences and changeability is waning within many academic communities.

In summary, there is over a *half a century* of documented theories, research, case studies, and successful treatment outcomes that serve as a foundation for our current treatment of women

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[49] See Bergner (1995); Comiskey (1989 & 2003); Dallas (1991); Davies & Rentzel (1993); Davies & Gilbert (2001); Eldridge (1994); Howard (1991 & 2005); Paulk (2003); Payne (1984, 1991 & 1996); Rentzel (1990); and Whitehead (2003).

[50] See Cohen (2000); Jacobs (1990); Jones & Yarhouse (20007); Mesmer (1992); Nicolosi & Byrd (2000b); Nicolosi & Nicolosi (2002); Olesker (1995); Phillips, Psych & Over (1995); Quinodoz (1989); Spitzer (2003); Throckmorton (2002); Throckmorton & Welton (2005); van den Aardweg (1997); Whitehead (1996); Yarhouse (1998); Yarhouse & Burkett (2003); Yarhouse & Throckmorton (2002).

in conflict with homosexual feelings or behaviors. Additionally, there is understanding and experience arising out of discipleship organizations and faith groups, some of whom have been in existence now for over twenty years. Unfortunately, much of this clinical history and associated stories of "change" are being omitted and literally erased from our textbooks. Yet there remains no scientific evidence that refutes these clinical experiences of success.

Gender: Research and Theological Issues

The Genetic Underpinnings of Gender

The maxims that

- *gender* is an intrinsic permanent aspect of a woman's internal *essence* as a human being,
- is directly tied to her biological sex, and
- a woman's greatest levels of psychological and emotional health are experienced when her sense of self or gender identification is *harmonious* with her biological or genetic sex,

arise out of classical developmental psychology, specifically the research surrounding gender and sexual development. Also of interest are the longitudinal studies on children who have undergone surgical sex reassignment at or near birth.

John Money, a researcher and theoretician in the area of gender, sexuality, and gender identification, together with several cohorts, postulated in the 1950's that a person's gender was *socially* constructed and therefore fluid and *not* inherently associated with one's biological sex. Based on a study published in 1957, he concluded that a boy or girl could undergo sex reassignment at birth (due to abnormal development of their genitalia such as hermaphroditism), and if *unambiguously reared* according to their reassigned sex, would resolve into a healthy psychological adjustment and complete gender identification with a non-chromosomally based sex (Money, Hampson & Hampson, 1957). He boldly stated, "The chromosomal sex should not be the ultimate criterion, nor should the gonadal sex" (p. 334). He therefore encouraged doctors to determine the preferred sex assignment based on the surgical ease of genital reconstruction, not the genetic sex of an infant.

Money continued his research and in 1975 published a case study of a baby boy born with intact male genitals at birth but subsequently raised as a girl due to an accidental surgical removal of the penis. Money (1975) alleges that the child had adjusted and identified successfully as a female and again asserted that a child's gender identity will be consistent with the experience (learning and socialization) of being reared a particular sex (p. 66). His theory of course began to cast doubt on any innate quality to gender, gender differences, or normal developmental processes of gender identification. Even Masters & Johnson began to allude to the priority of nurture versus nature in gender formation and identification (Diamond, 1982).

However, in 1982 Milton Diamond, a research fellow at John Hopkins University, discovered that the child reported in Money's 1975 article, now in adolescence, exhibited severe gender uncertainty and psychological difficulties related to their role as a girl. The child had *not* successfully reached gender identification as a female (Diamond, 1982). As later reported in Diamond & Sigmundson (1997), the child eventually disidentified as a female, underwent a surgical reversal, and reidentified with his original chromosomal male sexuality. This personal and tragic story unfolds in the book *As Nature Made Him: The Boy Who Was Raised as a Girl* by John Colapinto (2000).

In conjunction with Diamond's discovery, Imperato-McGinley, Peterson, Gautier, & Sturla (1979) conducted a study involving 18 genetic males with an intersex condition at birth (males with female appearing genitalia) who were unambiguously raised as females. They report that 17 of the 18 boys did *not* successfully gender identify as females, but rather spontaneously and successfully changed to or realigned with their genetically based male-gender identity. All but one of these 17 boys also fully assumed a male gender role (began to dress and live as a

male) in late adolescence or adulthood.[51] Needless to say, the practice of sex reassignment of babies at birth continues to be extremely controversial.[52]

While a person's affective sense of themselves as either male or female is vastly influenced by their social experiences, beliefs, cultural values, etc., there remains an innate foundation for a solid gender definition which is inextricably linked with a person's genetic sex.[53] In other words, there is an inherent blueprint to which a woman can return if she has actively rejected, but now wants to search for and reassociate with her true feminine self. This does not mean that every woman with gender identity confusion or profound gender dysphoria

[51] Also of interest is that these 17 men, after puberty, experienced sexual attraction to women. See also Meyer-Bahlburg (1994). It should also be noted that the surrounding culture may have had an influence in these boys' realignment to their genetic sex. The boys may have perceived greater benefits of being male than their assigned role as female.

[52] Similar to Ronald Bayer's assessment that the APA's decision to remove homosexuality from the DSM "was *not a conclusion based on an approximation of the scientific truth as dictated by reason* [italics added], but was instead an action demanded by the ideological temper of the times" (Bayer, 1987, pp. 3-4), Paul McHugh, Director of the Department of Psychiatry and Behavioral Sciences at the Johns Hopkins University, suggests that the zeal for *sex-change surgery*, "the most radical therapy ever encouraged by twentieth-century psychiatrists - did not derive from critical reasoning or thoughtful assessments. …The energy came from the fashions of the seventies that invaded the clinic - if you can do it and he wants it, why not do it?" (1992, p. 503). Ross (2000) also challenges the prevailing solution to surgically changing and chemically altering a person's body who has been diagnosed with a psychiatric disorder such as GID, especially when there is nothing genetically anomylous with their body (p. 192).

[53] It is interesting to note that the discussion of biological underpinnings for gender parallel those of sexual orientation. Many who assert that gender is fluid and completely malleable based on rearing or socialization, often adhere to a purely biological or genetic explanation of sexual orientation. While those who assert that gender is based on biologic and genetic sex, view sexual orientation as fluid and often tied to developmental milestones.

can ultimately overcome *all sense* of struggle or confusion, but it means that as they attempt to integrate and identify themselves with their biological sex, they are moving towards greater congruency within their entire personhood: body, soul, spirit and cognitive and affective self.

Gender: Research and Theological Issues

Gender Differences and Special Uniqueness

In spite of the trend in the 70's to trivialize gender differences, the subject remains a vital area of scientific inquiry and research. However, exploring gender differences always carries a certain degree of risk since historically, supposed gender differences justified discrimination, oppression or the harmful use of unfair stereotyping. Yet, as mentioned in *The Heart of Female Same-Sex Attraction*, to avoid attempts at understanding and describing the human uniqueness associated with our gender, leaves many women at a loss to understand how or why they should consider themselves "lucky" to be a woman.

There are ongoing debates surrounding the degree of difference between the genders, but most agree there are differences and that these differences are biologically based. For example, current research shows that in response to threats or stress, men typically exhibit physiologically based behaviors related to "fight-or-flight" (attack and conquer if victory is realistic or flee and avoid) while women typically exhibit physiologically based behaviors related to "tend-and-befriend" (care for the vulnerable, strengthen attachments, and gather into groups) (Taylor, Klein, Lewis, Gruenewald, Gurung, & Updegraff, 2000). It occurs to me that both styles of response behavior are absolutely essential for the overarching and ongoing protection of life *and* community.

Since most of my clients are faith-based and may therefore be more sensitive than non faith-based women to the inadvertent theological notions or subtle implications that often stress masculine superiority, I have found it useful to introduce what are often new insights or differing perspectives on the Biblical narratives pertaining to gender, primarily focusing on the creation accounts. Not only do the first man and woman's primal origins differ (earth versus living

tissue), but also their initial experiences and postures towards their new worlds. Yet this diversification does *not* negate their fundamental *equality* in value but enhances the significance and necessity of each.

Recall that in the first creation account, the first man and woman were *both* made in God's image and *blessed and commanded* to "rule and subdue" the outside world (garden and animals)[54] and "fill and multiply" the realm of human relatedness and existence. But in the second account, we immediately see distinctions and differentiations, starting with: Adam or man was created *first*. I believe that this data byte alone has inadvertently created a false emphasis on the priority or superiority of Adam or men in general. For instance, in a foot race, the "best" man wins *first place*. There is a subtle belief often not so subtly communicated to men and women within faith-based communities, that men are "better than," primary or the standard when compared with women. I for one would like to stay closer to this text by reframing it and relying on the word "before." In its most basic meaning, Adam was simply created *before* Eve.

Adam came from the *ground*, and was interestingly specially placed by God on the *ground*, in a garden preplanted by God, to cultivate the *ground* and manage the plants and animals. He was very busy working, moving, co-creating, *ruling and subduing*. But he was completely and wholly unable to fulfill humankind's destiny on his own. He was alone. He needed something *more* than himself. And he did not merely need something to come along to

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[54] The range of meaning for the word *rule* pertains to having dominion and authority or to call something into existence. Adam and Eve were both instructed to "Rule over the fish of the sea and the birds of the air and over every living creature that moves on the ground." Prior to the fall, *ruling* pertained to nature or creation, not other human beings. The range of meaning for the word *subdue* pertains to trodding down or beating down a path as in making a way through a forest. Adam and Eve were both instructed to "fill the earth and subdue it," or exercise dominion over the plants and trees.

help[55] him do what he had already been doing. He was already functioning well in the realm of ruling and subduing. He needed something unique and special in its own right so that he could also function in the realm of *filling and multiplying*.

Adam, having been completely dependent upon God for life, existence and daily bread, became, once again, dependent on God for something more. And God, in His wisdom and astounding creativity, chose to uniquely design another being, created also and fully in the image of Himself: Eve - an equal yet different aspect of God's character and image splashed onto the planet in the form of a female being.

Eve came from the tissue of a living being. Eve is the *only* created being made from another living being. This may explain why Adam was created *before* Eve. His primacy in the creation order does *not* imply superiority but was necessary towards establishing Eve's primal essence of life and human connectedness. Upon her first breath, Eve's initial experience did not revolve around tilling the ground, but in human relatedness. Another *person* was present (unlike Adam who upon his creation, had been alone). As a result, Eve was seen, known, loved, and

[55] The word *helper* (*ezer* in Hebrew), as used in Genesis 2:18: "I will make a helper suitable for him," has often been presented in a way to imply or suggest a lower or subordinate status to women, such as that of a slave or servant. However, according to Webb (2001), the majority of times that this word occurs in the Old Testament (72%), the status of the helper is actually superior to the one being helped. For instance, God (or the King) is referred to as *ezer* or helper in Exodus 18:4, Deut. 33:29, Psalm 10:14, 70:5, 118:7, 121:2, Hosea 13:9. Perhaps the emphasis in the Genesis passage is on the *nature of Adam's need* versus a role, status or function of the one who will help. In other words, Adam could not resolve his dilemma of aloneness (Grenz, 1995). He was utterly dependent upon His Helper (God up until this point) or at least needed an "other" uniquely made in the image of his Helper. Webb (2001) warns that because there are many other usages of *ezer* (28% of all occurrences) that refer to a helper of equal or lower status than the one helped, the word, in and of itself, cannot ultimately determine the status of the individual doing the help. Contextual factors must take precedence.

joined with another who was like her. She was extremely occupied with the activities of *filling and multiplying*. Eve was then ushered into a day of rest. Is it possible that God designed "Adams" with certain masculine qualities that equip them with particular intuitions and strengths in the realm of *ruling and subduing*, while Eves in the realm of *filling and multiplying*?[56]

Arising out of the behavioral sciences, there are also many psychological observations and perspectives that also point to these possible differentiations between genders. For example, in the 1940's, Erik Erikson (1963) conducted a developmental study on preadolescent children using play observation. While he wasn't specifically addressing gender differences in his study, Erikson was struck by the fact that when given a set of blocks and a few toys, little boys and girls built different constructions of living space. The boys' typically built *outside* space (the garden) replete with tall towers and buildings, cars and trucks, with a sense of movement (p. 102). If human figures were present in their setting, they were not enclosed by the structures but on the outside, such as sitting on the *top* of a tall building. Erikson observed that boys seem to be naturally preoccupied with the *outer world* of height (and downfall) and strong motion, possibly exhibiting ruling and subduing strengths.

[56] It should not go unmentioned that the consequences of the fall, as described in Genesis 3, seem to be directed to Adam and Eve's unique strengths. Adams now experience painful toil and frustration as they continuously deal with the thorns and thistles invading the garden or outside world, the realm of ruling and subduing. Eve will now experience pain in bringing forth new life and continuing in human connectedness or the realm of filling and multiplying. These unique sets of pains and frustrations are meant to bring both men and women to a place of need and realization that life is unbearable without the loving embrace and involvement of a compassionate God who seeks their ultimate redemption and restoration to their original design and posture of complete dependence upon Him. The consequences of the fall are meant to be redemptive, not punitive nor perpetuated (Webb, 2001).

The girls' constructions typically involved *inside* space, including circular enclosures that surrounded multiple human figures clearly sitting and communing within close proximity to one another (actually, they are almost on each other's laps). Indeed, there is a sense of closeness and intimacy. Erikson observed that girls seem to be naturally preoccupied with the *inner world* of restful yet open enclosures filled with human relatedness (p. 105), possibly exhibiting filling and multiplying strengths. Karl Stern, in his classic entitled *The Flight From Woman*, observes how our sex organs potentially symbolize our associated internal essence. "In the act of sexual union the male organ is convex and penetrating [moving in an external fashion] and the female organ is concave and receptive [awaiting for an internal union]" (1965, p. 9).

Deborah Tannen in her #1 bestseller *You Just Don't Understand*, notes that women tend to focus on intimacy, men on independence (1990, p. 26). This is supported by research with children. In observing the level of emotional closeness of small children with their mothers during short periods of play, girls demonstrate significantly greater physical proximity and more mutual eye contact with their moms than boys (Benenson, Morash & Petrakos, 1998). When given a variety of toys, boys prefer cars or trucks, girls, dolls. Girls prefer playing house, boys, war (Powlishta, Sen, Serbin, Poulin-Dubois, & Eichstedt, 2001). Male infants (one day old) show a stronger interest in looking at a "physical-mechanical mobile," while females a face (Connellan, Baron-Cohen, Wheelwright, Batki, & Ahluwalia, 2000). These statistical differences of course imply that there is still a lot of overlap between males and females; they cannot therefore be used to support *rigid* definitions or categories of maleness and femaleness. There is always individual diversity within the genders. However, they may still point to the general categories of differentiation and special uniqueness.

Dr. Dean Byrd, Clinical Professor of Medicine at the University of Utah School of Medicine, in discussing the importance of the complementarity of parenting styles of mothers and fathers, reviews research that highlights that mothers are "better able to read an infant's facial expressions, …and soothe with the use of voice," use touch to calm or comfort an infant, play at the child's level, and stress understanding, sympathy, and care. "Fathers tend to emphasize overt play more than caretaking," use touch to stimulate or excite an infant, engage in rough-and-tumble play that coaches a child to learn and grow, and stress justice, fairness and duty. All of these various and unique paternal characteristics are critical for a child's later development.[57]

In summarizing the above theological and psychological observations, perhaps the *masculine* can be understood as having a greater fortitude or inner strength of movement, authority, and courage to face the chaos and complexities of the *outer world*, yet with an inner core of tenderness and compassion to initiate within the realm of human connectedness. Perhaps the *feminine* can be understood as having a greater fortitude or internal core solidness of being, power, and courage to face the chaos and complexities of the *inner world* of human relatedness with the strength to birth, nurture, and sustain life, yet with a restful, open receptivity to the beauty and wonder of the outer world.

Regardless of how we ultimately define or understand these essential human constructs, it remains true that strength and activity in both the outer and inner realms of human existence are absolutely essential for survival. Without cultivating food and shelter, we cannot sustain life. Without cultivating closeness and attachment, we cannot sustain life. One realm of human

[57] Byrd (2004, pp. 214-215) referring to Clarke-Stewart (1980); Gilligan (1982); Rossi (1987), Shapiro (1994), Yogman (1982).

existence can or should never be heralded as more important than the other. Sadly, as noted by Barnhouse in 1984, I still do not believe that as a whole, women's special strengths have been fully "identified and developed in terms that clarify their value to all human activities" (p. 52). For the sake of healing and restoring the man or woman struggling with deep gender confusion and insecurity, it behooves us to continue to expand the definition and valuative judgment of humanity beyond a mere masculine model.

Background Material

Making an Initial Assessment

At the beginning of therapy, I actively assess each client's present psychological state of being and emotional and relational capacities. As her therapist, I want to address *all* of her presenting needs and struggles versus narrowly focusing on same-sex issues. Initially, I want to assess and be sensitive to her:

- *Ego strength*. Can she connect with and articulate her emotions? Can she self-regulate? Can she cope and healthily persevere through deep pain or anxiety?
- *Relational skills*. Does she maintain eye contact? Is she aware of social cueing? What is her interaction style? What is her affect?
- *Level of anxiety*. Does her anxiety merely reflect her nervousness within the counseling setting or does it globalize into all settings and relationships? What does her body language say? What are her typical strategies for dealing with anxiety? Is the anxiety protecting her from other deeper feelings? Are there other clinical symptoms?
- *Defense mechanisms.* When her discomfort increases, does she use avoidance, intellectualization, dissociation, minimization, humor, etc.? How does she defend against danger or threat? To what degree does she defend against closeness and warmth? Are some of her defenses self-destructive?
- *Character patterns.* Is there any indication of a disordered personality? What is the level of her insight? What is her locus of control? Can she integrate new information into a stable yet flexible self and belief system?

- *Self-image*. How does she define herself? What is her internal image of herself? What conclusions has she drawn about herself? Does she even recognize a self?
- *Diagnostic Categories*. Is there Axis I or Axis II involvement?

If a woman enters therapy in crisis or with excessive anxiety and depression, treatment must also be initially focused on stabilization and containment. The techniques recommended in Chapter 6 of *The Heart of Female Same-Sex Attraction* for the purpose of creating safety will also stabilize. If a woman is in the process of losing or ending a same-sex relationship, she may be experiencing a severe inner trauma that is excruciatingly painful. It can trigger posttraumatic stress symptoms and even lead to suicide ideation. In the cases of possible self-injury or harm, standard interventions such as Safety Contracts, psychotropic drugs, 24-hour on-call services, increased sessions, or hospitalization should be used.

If she is indeed in crisis, she will require all the immediate resources available to her, including her existing lesbian partner or friends. I support and encourage her as she accesses help from her existing community and relationships. At this point in time, I never confront or require her to curtail historic coping strategies or change any important parts of her life unless they are immediately life threatening.

The following sample Clinical Assessment offered by Dr. Kristine Falco (1991) in her book entitled *Psychotherapy with Lesbian Clients,* includes many of the common observations I often make with my new clients. Note the amount of unconscious material inferred in this assessment:

> Constricted. Fearful. Uncomfortable accepting empathy. Low expressiveness.
>
> Boundary & contact disturbance with passive-aggressive or narcissistic flavor.
>
> Dependency needs high – actively so, *but unseen*.
>
> Crisis oriented. Lack of self-care & planning.
>
> Few relationship skills.
>
> *Identity unsolid*: both as a lesbian and an inner self/guide.
>
> Values in conflict with *repressed needs*.
>
> High anger and disappointment, *unseen* [italics added]. (p. 70)

In light of the potential unconscious or repressed emotions and conflicts at the beginning of therapy, I gauge all of my interactions and interventions according to my client's immediate reactions and overarching ability to understand, process, and cope.[58] Initially, I work in alliance with her defenses and survival strategies, letting her know I see and respect her. I emphasize the here-and-now quality and strength of our relationship over my insights or suggestions for change. I will not employ any technique that would exceed her ability to self-regulate once she leaves my office.

In conjunction with my clinical observations, I rely on psychological testing to further assess her overarching psychological profile. I administer the *Millon Clinical Multiaxial Inventory-III* (MCMI-III™)[59] and the *Measures of Psychosocial Development* (MPD).[60] When

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[58] As emphasized by Dr. Daniel Hughes, a specialist in childhood attachment disorders, it is the client's responses, "not the therapist's plans, that should dictate the direction of the session" (1997, p. 43).

[59] The *Millon™ Clinical Multiaxial Inventory–III* (MCMI-III™), ©1994, DICANDRIEN, INC., published and distributed by NCS Pearson, Inc., is available through NCS Assessments, 800-627-7271; http://assessments.ncpearson.com

reporting assessment results to my clients, I never use formal diagnostic labels. I carefully summarize and explain the assessment contents in lay language, linking it to their history or symptoms as I currently understand them. Typically, any test anxiety or apprehension about being "labeled" is quickly alleviated as they gain valuable insight into themselves. And the more they are known, and at the same time respected and unconditionally accepted, the sooner they will feel safe.

As therapy proceeds, I adjust my therapeutic techniques and focus of interventions to address my client's legitimate psychological needs and concerns regardless of her level of acceptance of or dissonance with her homosexual feelings, behavior, or identity. The latter will fluctuate and change throughout the process of therapy.

In cases where I do not believe my clinical training or experience is fully adequate to deal with a client's therapeutic issues, I will first explore the possibility of organizing a treatment team made up of a psychiatrist, another therapeutic specialist who can act as my consultant or be brought in at key points during treatment, and myself as the primary therapist or "home base." If I must decline treatment and refer in an effort to secure the best possible care for a client, I will do so sensitively and wisely, always framing my referral in the affirmative, stressing the benefits of the unique skill set of the referred therapist. I do not emphasize that her *diagnoses* are "too difficult for me to handle." She will simply feel rejected. As further explained in Chapter 13 on the protocols for termination, I *always* reassure my client that I am available should a need arise in the future with which I may be able to help. She has experienced far too many "burned bridges." She doesn't need another in her repertoire.

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[60] The *Measures of Psychosocial Development* (MPD), ©1988, Psychological Assessment Resources, Inc., assesses a client's resolution of each developmental stage and is available through PAR, Inc., 1-800-331-TEST.

Background Material

Confused About Both Sexes

By late adolescence, a young woman with SSA may be deeply entrenched in same-sex and opposite sex *ambivalence*—a feeling of simultaneous attraction and aversion to any one thing—even if she has not had a same-sex experience. Many of my clients have difficulty understanding and monitoring the endless and sometimes unpredictable compulsions to draw toward people in one moment and to create distance in the next. This pervasive relational ambivalence might best be explained as follows.

Opposite-sex ambivalence. When relating to males, a young woman may at times *draw close,* identifying with all that *externally* symbolizes the fun and desirability of the masculine, assuming a stereotypical *male role* such as caretaker, protector or achiever. *She gains power and freedom.* But at other times and with certain men, she may *push away,* distancing herself from any *emotional* closeness and protecting herself against potential masculine aggression and anger. *She fears disappointment or violation.*

Same-sex ambivalence. When relating to females, a young woman may at times *push away,* feeling insecure in her own female identity, disidentifying with all that *externally* symbolizes femininity, and rejecting stereotypical *female roles* and traditional appearances. *She fears becoming weak and oppressed.* But at other times and with certain woman, she may *draw close,* feeling her legitimate longing for *emotional* connection and feminine affection as well as her need to embody or internalize the substance of true femininity, often symbolized by nurturing softness and caring mutuality. *She gains nurturing, belonging and identity.*

A woman's ambivalent posturing toward men and women sets her up for a potentially self-perpetuating vicious cycle. For instance, if she experiences rejection from a man, she may increase her resolve to avoid men and *never* be or appear as a vulnerable woman. She simultaneously increases her resolve to model herself after a man. Lost to her true feminine self, her longing to be safe and close to the feminine (or women) will naturally increase, possibly intensifying her SSA.

Therapy with women with SSA will need to be focused on exposing, understanding and resolving the roots of these ambivalences and fears. The associated negative core beliefs that sustain these entrenched patterns of ambivalent relating will also need to be addressed.

Background Material

The Developmental Progression of Female SSA

Chapters 3 through 5 of *The Heart of Female Same-Sex Attraction* hopefully provide the "big picture" or the many common developmental and relational highways and possible intersections that a girl or woman might travel resulting in deep identity and relational issues and possibly an eventual struggle with same-sex attraction. As a summary, I offer the following outline as a hypothesized developmental progression and self-perpetuating nature of female SSA.

1. **The Initial Deficits and Conflicts**

   Absence of nurturing and secure attachment (symbolic realm of feminine)

   Absence of protection and affirmation (symbolic realm of masculine)

   Sense of rejection and abandonment

   Unresolved dependency and individuation needs

   Gender confusion

   Trauma and instability

   Relational isolation

2. **Self-Survival**

   Defensive detachment and disidentification (from femininity and true self)

   Hides inner vulnerable self (defends against reality of initial deficits and conflicts, i.e. grief and loss)

   Over-develops outer tough self based on masculinization or defendedness (self protection) and performance (self affirmation)

Same and opposite sex relational ambivalence (cuts off desire and need for nurturing, attachment, protection, and affirmation)

3. **Profound Sense of Existential Aloneness and Inner Emptiness**

4. **Reality is Felt**

   Young woman eventually connects with primal loneliness, lostness, and relational need (true self).

5. **First Same Sex Attraction**

   Young woman innocently but confusedly sees closeness with another female as the solution to felt need. Her compensations and defensive postures are not recognized.

6. **Emotional Dependency Develops**

   Female partner becomes the "home" a woman never had (historical) nor has (inner).

7. **Reality is Felt**

   Inherent inadequacy and insecurity of emotionally dependent relationship becomes apparent. Loneliness, lostness, and need again become a threat.

8. **Desperation and Erratic Borderline Symptoms Emerge**

   "I hate you" because you are not enough

   "I need you" because I have or am nothing on my own

9. Relationship Deteriorates

10. Woman Cycles back to #3: Profound Sense of Existential Aloneness and Inner Emptiness

11. Cycle Repeats, Deepening a Woman's Sense of Aloneness and Emptiness and Entrenching her Confused Ways of Relating and Being

Many women who are trapped within this cycle of female SSA live with inexpressible confusion, pain, and hopelessness. Those who finally come to see me want help. They want out of what seems like a futile and bleak existence.

12. Change and Healing

A woman can experience healing and transformation in her life when she discovers, embraces, and lives out of her *true* self (embodying weakness and strength, vulnerability and power, etc.) which is impacted, formed, and somewhat molded by the very sorrows, abuses, and losses of her past. It is as she acknowledges and begins to deal with the experiences and themes from her early stages of life, represented as steps numbered 1 and 2 above, facing and grieving her disappointments and losses while *also* abandoning her survival strategies and false ways of living, that she may begin to disrupt the endless and perhaps self perpetuating cycle of female same-sex attraction and emotional dependency. A woman with SSA must ultimately reorient herself to her past, her self, her relationships, how she *does* relationships, and overall, her life

and identity. I have all the respect in the world for the special women who are willing to set out on such a life-changing journey.

Background Material

Emotional Dependency and Love Addiction

The characteristics of *love addiction*, as discussed by Pia Mellody and her coauthors, are strikingly similar to same-sex emotional dependency. "Love Addicts focus almost completely on the person to whom they are addicted; they obsessively think about, want to be with, touch, talk to, and listen to their partners, and want to be cared for and treasured by them" (Mellody, Miller & Miller, 2003, p. 12). They note that love addicts usually lacked appropriate bonding with their caregivers, experienced abandonment or neglect, and therefore carry a deep pain, sadness and emptiness within. They are essentially seeking "The Person who will relieve the stress of the original abandonment experience" (p. 17). Love addicts also carry the belief that "if they do not get close enough they will die" (p. 19) so they "seek to enmesh, to merge, to get completely connected to their partners" (p. 24).

Love Addicts also tend to idealize their love object. They "do not see who the other party really is…" (p. 23), but "assign to their partners all the qualities of their childhood fantasy rescuers" (pp. 23-24) and will try to get their partners "to feel and do the things that match the fantasy" (p. 25). As long as they can remain in fantasy, love addicts "believe they have finally found The Relationship that will make them feel whole" (p. 25).

Similar to how a woman despairs as she attempts to break away from an emotionally dependent relationship, Mellody et al. (2003) state that the withdrawal from an addicted love relationship "can be very serious and so intense that many people cannot endure it long enough to get into recovery" (p. 29). In other words, they often "retreat back into denial rather than face reality and fully enter withdrawal" or abstinence so that they can work through the core

underlying issues (p. 29). They simply reengage in new addictions, a new love obsession, or makes plans on how to get their most recent partner back.

Background Material

The Effects of Attunement and Misattunement

Because of the difficulties and disruptions in her primal attachments with mother and father, as outlined in part one, a woman with SSA may have *lacked consistent moments of caring attunement* as an infant or young child. Daniel Siegel, emphasizing the fundamental significance of emotional communication or attunement, notes "attachment relationships are about the sharing and amplification of positive emotional states (such as joy and elation) and the sharing and reduction of negative states (such as fear or sadness). These emotional transactions allow a child to 'feel felt' " (1999a, p. 49). And as a child "feels felt," they begin to gain a primitive sense of their own core or self.

Parental emotional attunement with a child is when "*both are sharing* [italics added] affect and focused attention on each other in a way such that the child's enjoyable experiences are amplified and his/her stressful experiences are reduced and contained" (Hughes, 2004, p. 1). Attunement is the foundation of empathy, and empathy is the foundation of attachment. Therefore consistent attunement is absolutely essential to a child's experiencing secure attachment.

The impact of misattunement has been graphically shown in the research surrounding the still-face effect on affective regulation and attachment.[61] I reviewed video recordings of one study wherein a mother was initially instructed to emotionally attune and engage with her baby by entering into the baby's emotional states. When baby laughed, mom laughed, affirming the baby's joy and pleasure. As baby became agitated, mom showed her care through her facial expression and reassuring touch. When baby cooed out words and gurgles, mom reflected her

[61]For a comprehensive review of the past 25 years of research on the still-face effect, see Adamson & Frick (2003).

pride and encouragement through her eyes and mirroring gurgles. The baby was engaged and energized.

The mother was then instructed to break attunement by retaining a still-face or neutral expression. Her baby initially continued in their playful joyfulness. But when mom did not mirror the joyfulness, the baby became noticeably agitated. Mom was then told to look away. The baby became increasingly overwhelmed with his own distress and growing insecurity. He tried and tried to engage mom by flailing his limbs and releasing audible whimpers, but to no avail. The baby eventually slumped in his infant seat, lowered his eyes and attempted to find comfort by sucking on one of his little hands. His inner self seemed to literally shut down, at least for the time being. It would require energy and effort on his mom's part to reengage or reawaken him to the previous joyful oneness. When I saw this video, I immediately thought of my clients. Many women with SSA, I believe, had experiences like this child's: breaches in parental attunement that were not adequately repaired. Their core self was neither engaged nor activated in terms of healthy growth and development.

Dr. Daniel Siegel, emphasizing the fundamental significance of emotional communication or attunement, notes that "attachment relationships are about the sharing and amplification of positive emotional states (such as joy and elation) and the sharing and reduction of negative states (such as fear or sadness). These emotional transactions allow a child to 'feel felt' " (1999a, p. 49). Indeed, it is an infant's experience of her mother's (or caretaker's) consistent emotional attunement, reparation of misattunement and affectual regulation (such as reassuring and calming the infant when she is agitated), as well as the infant's own associated positive feeling states that arise from her caregiver's attuned attention, that form the primitive

core of the self.[62] However, if a mother is unable to provide consistent emotional attunement to her baby (perhaps because of depression, distraction or her own deprivation of this basic human connection) or if she fails to repair breaches in attunement and regulating support, an infant will experience some level of helplessness and powerlessness in terms of engaging another's *caring* attention (developing a core sense of relational incompetency); overwhelming negative feeling states, such as aloneness, shame or` emptiness; an inability to regulate these potentially severe and overwhelming negative feelings (developing a core sense of emotional incompetency); and negative internal representations (basic beliefs) of herself and her caregiver(s).

Collectively, these negative affective experiences can create an unstable, obscure or negative core self within a child, not to mention an insecure attachment with her caregiver. Additionally, repeated experiences of misattunement can create such a pervasive sense of shame within a child that it essentially engulfs the whole self. Many of my clients were essentially deprived of the relational environment in which to grow and develop their own positive feeling states and foundational core, possibly developing instead what has been called a disordered or false self (Orcutt, 1995). Alice Miller explains that if a child is deprived of the attuning and validating presence of another, she can literally develop the art of not experiencing feelings (1981, p. 10), often leading to the overall personality development of what has been called "the empty core" (Walant, 1995, p. 10).[63] Regardless of how her inner self is ultimately defined, this

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[62]See Chodorow (1978); Masterson (1985); Schore (1994, 2002); Schwartz & Southern (1999); Siegel (1999); Walant (1995) and Winnicott (1965).

[63]It might also be argued – based on research supporting the idea that female infants are more centered and focused on people (especially the face and eyes) and on emotional interactions than are male infants (Benenson, Morash & Petrakos, 1998; Cahill, 2005; Connellan, Baron-Cohen, Wheelwright, Batki & Ahluwalia, 2000) – that this

little girl, now an adult, remains unaffirmed as a person and still needs the mirror of a mother's face to tell he she *is* and that she *is OK*.[64]

Fortunately, we, as growing and developing human beings—creatures in a perpetual process of *becoming*—can be optimistic that what was seemingly lost or underdeveloped in our previous stages of development, such as trust, can be addressed and appropriated in our future stages of development. In fact, attachment specialists note that as we continue to interact with our environment, we can indeed change our "emotional, behavioral, and social traits and outcomes" (Levy & Orlans, 1998, p. 20). Our inherent capacity to be always growing and developing also "indicates that outside forces, such as effective parenting programs and *therapeutic interventions* [italics added], can go a long way towards attenuating early difficulties" (p. 20).[65]

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deprivation of attention and affectual attunement may affect a female infant's development more severely than it might a male.

[64]Leanne Payne, in *The Broken Image* (1981), also observes that many women with SSA lack not only a sense of being, but also a sense of well-being.

[65]See also Bartholomew, Kwong & Hart (2001, p. 209) and Ross (2000).

Background Material

Always Defer to Empathy

Empathy should be a standard therapeutic protocol in the first, middle and final stages of therapy with women with SSA. Empathy is my home base, and I return to it regularly. Below are several examples of situations in which I use empathy.

When a client feels offended. Learning to use empathy has helped me to be more relaxed as a therapist. I don't need to be so worried about saying or doing something wrong. I am not endorsing carelessness, but I am endorsing empathy as a means to use my flawed humanity as a tool for healing and change.

When defensive behavior is exhibited. If I observe an increase in my client's defensiveness, I gently interrupt our discussion and ask, "On a scale from 1 to 10, with 10 being the safest, how safe are you feeling right now?" If she reports a low score, I use empathy, saying, "Feeling unsafe can be very frightening. You must be having a hard time right now. We are talking about some pretty tough things. Is there something that I could do to help you feel safer?" Note that in the first stage of therapy, I do not confront her defenses directly, because by doing so I risk affirming their substance. My client is much more than her defenses, and I want to affirm her *substance* as a beautiful, albeit wounded, woman. I want to engage her *true* self, not fight her defenses.

Before offering a confrontational intervention. When empathy, seasoned with lightheartedness, is the basis of my work, my clients can experience confrontation as a sign of care and

acceptance. My empathy helps a woman to feel as if I am seeing things through her eyes and understanding her predicament. She is much more apt to appreciate my challenge if she does not have to deal with it alone or apart from me. Consider this exchange:

"So you were written up again for screaming obscenities at your coworker," I said with an accepting smile. "Joyce, I know that's what you used to do as a kid, and I think I understand why. You were just trying so hard to get someone's attention. You wanted someone to hear you. You've been screaming and hitting walls for your whole life. Didn't you tell me that you've even put your fist through several walls?" I asked this in a congratulating tone. You have to give her credit, she has really tried!

"But screaming doesn't seem to be working for you now," I pointed out. "How many times have you been written up now? It makes me sad to think about how hard you've tried to get your coworkers' attention. And I know you don't like being seen as 'the angry woman.' I think there's a better way for you to communicate your feelings, Joyce. I've seen you do it."

At this juncture, I might use a role-play to help her practice how she could have more effectively communicated to her coworker. I incorporate a spirit of fun and play as I act out the part of her obstinate coworker.

When she requires containment and reassurance. If I identify and empathize with the difficult feelings my client might be experiencing at the end of a session, she will leave feeling that she is not alone.

When you don't know what else to do. If I am at a total loss about how to proceed, I might ask a client a question like, "How has this session been for you so far?" or "What are you feeling right now?" As I empathize, I may share my experience of sitting through a bad session or feeling lost. Identification will bolster my client's ego strength. Letting her know that she and I might feel the same in a given situation will help her to realize she is normal.

Parents, Clergy and Friends

Considerations and Support for Religious Communities

I was in a pretty messed up place in my life by the time I began to build a relationship with God. That happened through a professional business relationship. Bill - a man no less - really represented God to me. He knew how I was living. I looked the part and always had my female partner around. But he was very wise. It was over a 3-year friendship with him that I eventually decided to turn my life over to God.

I then found church friends who patiently walked with me as I learned about the scriptures and God's plan for my life. It took another two years for my lover and I to finally separate. But no one condemned us or forced us to move faster than we were able. They loved us unconditionally and prayed and prayed and prayed.

Kris

Over the years, I have heard many incredible stories of women in conflict with same-sex attraction obtaining insightful and compassionate guidance and support from their pastor, elder, Bishop, Rabbi, or religious friends. These women, by far, progress through many therapeutic issues at a much more rapid pace than women who do not have supportive spiritual communities. In fact some, make major transitions without any therapeutic support. Betty, is one of those special women.

Betty, the oldest of four children, was essentially raised by a single mom the first four years of her life. Betty's dad was in the military and was stationed halfway around the world. Once Betty's dad returned from his military service, the family moved and increased in size about every three years. The moving continued throughout Betty's school years, as well as her dad's ongoing traveling because of his new career. During these years, Betty felt a need to know that mom was okay. If mom seemed to be okay, then Betty believed she would be okay, so she did everything she could to help her mom. In a way she became her mom's protector.

As Betty grew, so did her resentment towards her dad. The way Betty saw it, her dad didn't know how to respect women, let alone his little girl. He often drank too much, and even taught Betty how to drink at age 11. When they were drinking, he also inappropriately touched Betty and made sexualized remarks about her body and appearance. Betty's longing for his love and respect turned to confusion and disgust so she avoided him as much as possible.

As Betty matured and moved out on her own, her heart still searched for the attention, care, and affirmation that were missing from her childhood. She longingly gazed into other eyes, male and female, and wondered, "Do *you* see me? Am I important to *you*?" Until one day, she saw the look of recognition on another woman's face. The glance said, "I *do* see you. You are absolutely beautiful and I would love to get to know *you*." Betty's heart melted, and before too long, the two became lovers.

Betty neither "chose" to become a lesbian nor was consciously defiant towards God. Her heart simply followed what seemed the most normal and natural course: to rest in a tender and caring relationship that was finally touching some of the hungriest places in her soul. For the first time, Betty felt known and accepted. Betty lived contentedly in a lesbian relationship for the next 17 years. A spiritual conversion however, led to increasing distress and conflict over her lesbian

identity. She eventually made a decision to end the relationship, but was not sure she could survive without her friend's attention and love.

Betty admits she could not have made such drastic changes in her life had it not been for a pastor who befriended her. For years he sought to *know*, love, and respect her even as she remained in her same-sex relationship while attending his church. He was patient and continually affirmed her dignity and personhood. He never treated her as if she was different. He gently invited her to pursue God and to learn of God's heart of compassion and grace. Under his wise discipleship and respect, Betty grew, changed and blossomed. She would not be the woman she is today without his persevering and loving involvement.

Betty is now 54 years old and her last same-sex relationship was more than 15 years ago. She currently lives a life filled with friendships, community, meaning, service, and reflective solitude. She is single but enjoys a deep intimate relationship with God. Betty is now reassured, beyond a shadow of a doubt, that she is known and unconditionally loved to the core.

Sadly, I have also heard of religious communities deeply wounding these women. A member of one of my therapy groups once reported that when she told a friend that she was involved in a group with other women in conflict with same-sex issues, her friend, who happened to be in full-time Christian work, replied, "I doubt you'll get any help from those dykes!" After she shared this with the group, there was a long silence. I, too, was speechless. I finally asked how everyone in the room was feeling in response to what was just spoken.

Another group member immediately sat up in her chair, turned and directed her comments to the woman who had just shared. She said, "As soon as you finished talking, I asked myself, 'Am I a dyke? Is that all I am, just a good for nothing dyke?'" She then told the group that as she asked herself these questions, she had a picture of her pastor standing next to her. He

said, "No, you are not a *good for nothing dyke.* You are so much more than your struggle with homosexuality." She continued by reassuring the group, emphasizing that if her pastor had *really* been standing here, listening to those comments, he would have stepped forward and spoken those very words in defense of every woman in the room. She went on to say, "So that woman can think whatever she wants about us. I know how my pastor feels about me, and that's all that matters." This woman's pastor had essentially offered her a relationship wherein she not only experienced the best of a father, but the best of God. Church leaders have an amazing opportunity to significantly impact the lives of these women.

Most of the suggestions in *The Heart of Female Same-Sex Attraction* will apply in a pastoral care setting, but some therapeutic attitudes may appear to present a compromise to the role of spiritual director, especially to one who is responsible for the woman struggling with SSA *and* the well-being of all those attending the leader's church or religious organization. In these cases, the leader will be required to search his or her own heart as to the nature of support that can be offered to a woman struggling in their midst. However, I offer some general principles that may be of assistance. When a woman comes and shares her struggle:

- *Do not be surprised!*

If it hasn't already happened, expect that one of these days, a female member or leader within your congregation or organization, will confess.

> *I was growing increasingly more desperate in my same-sex relationship. I was concerned about the church for which I worked, my family, and my friend's family. I felt caught in a fast moving*

wave. I was drowning. I knew it wasn't right to be with this woman, but it felt like I would die without her.

I felt sorry for my pastor because he didn't have a clue as to why I had asked for a meeting. As I sat there, I knew I was doing the most difficult thing I had ever done in my life. I was terrified. I knew that I could lose my job at the church and any respect that my pastor had for me. Yet I had to lay out all my brokenness before him. I needed help. My fear made me hesitant, but my conviction prompted me to finally give a brief, honest, and teary account of my sin and my desire to be forgiven and receive support.

Teresa

One of a woman's greatest fear is that her pastor, friend, or parent will be shocked, disgusted, repulsed, angry, speechless, or numb as she confesses her struggle with SSA. She will only understand these types of responses as a statement of her utter depravity, badness, and perhaps hopelessness, adding to the unbearable weight of confusion and shame under which she is already buckling.

In those first moments after a confession, she needs to be able to look into the mirror of her pastor's face and see that there is grace, love, compassion, and mercy, even for a "sinner" such as she.[66]

[66] Dr. Frank Lake, trained in theology and psychology, bravely declares that "If the pastor cannot, because of obstruction in his own personality see his way to receiving sinners and eating with them, listening to them and talking to them, he could properly consider retiring from his ministry until the grace of God, coming to him in his penitence, showed him that grace which is given to him as a sinner, in spite of his sin of religiosity. Experiencing

> *It was hard for my daughter to tell me about her lesbianism. But the moment was tender. We loved each other, we held each other, we both cried together. Probably for the first time ever*. A mom

- *Treat her the same as you would any one else confessing or being discovered to have a particular struggle, temptation, or sin.*

For instance, affirm and validate her for admitting to her struggle. This may have taken more courage and integrity than most people will ever exhibit in a lifetime. Express sadness over the thought of how hard this struggle must be for her. Welcome her into the human race, admitting that we all have struggles and are in process, growing, healing, and becoming the people God created us to become. Celebrate the fact that her Heavenly Father invites her to come to Him, even in her weakness, confusion, sin, fear and doubt. Pray with her, holding her hands. She is not untouchable.

- *Seek to understand the woman's story and immediate circumstances and provide support with sensitivity and realism.*

These tasks are similar to the initial tasks of a therapist or caring friend. Often, church leaders are so busy with a variety of other responsibilities and people for whom to care, quick fixes or shallow advice may inadvertently be given. I have heard of churches actually attempting to proceed with accountability or church discipline without any more information or

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this grace he would soon delight to give it to all others" (1986, pp. 24-25). Lake's admonition also aptly applies to women serving in ministerial positions.

understanding about a woman's situation than that shared during her initial confession. One woman recounts:

> *After about my fifth unfulfilling relationship and avoiding church for years, I went to my Bishop and told him what I'd been doing. He essentially said, "Just stop doing it and come back to church." So I started going to church, did what I was supposed to do, and kept having crushes on women. I decided that celibacy was evidently my only option. I even tried dating a few guys, because this is what the Church says I'm supposed to do.* Margaret

Imagine if Margaret's pastor had requested that she take her time and unfold more of her story and journey so that they could both begin to understand why she keeps repeating the same familiar relational patterns? Certainly not all pastors will have the time to build a pastoral relationship with each and every woman, but a leader may be able to affirm the woman's desire for help by finding someone else who would have the time to walk with her through her struggle.

- *Protect her privacy*.

After the pastoral care provider and a woman discuss the wisdom of disclosing her struggle to others, she should be honored and respected even if her final decision is to not disclose with anyone else at this point in time. Her decision and confidentiality should be regarded even if a marriage is involved. Together, she and her spiritual advisor may need to map out a strategy and plan so that others close to her can be safely and wisely brought into her inner

circle of confidants. But regardless of her unique situation, she should always be protected from any public broadcasting of her same-sex struggle.

- *Offer authentic relationship versus a watchful eye for the mere sake of "accountability."*

In general, a woman will not usually benefit from an impartial or impersonal group of people commissioned to question her about her behaviors or desires over the last week. This model of accountability, even if offered by well-meaning people, will most likely create a deep fear within the woman, placing her on the defensive.

> *I was grilled on how often my friend and I had contacted each other in the last week. I don't know if my accountability group understood the emotional turmoil that coursed through me. I felt exposed. I was bombarded with more questions and false assumptions. At times, I really did feel as though it was some sort of inquisition. At first, I was quite defensive and I'm sure that came through.* Lindsey

This ostensive defensiveness within a woman may then create a doubt in the mind of her accountability partners about her sincerity in terms of healing and responsible living. This doubt and suspicion may in turn lead them to ask even more probing questions, causing her to retreat or react in anger as an effort to defend herself against their perceived insensitivity and harshness, creating a vicious cycle of misunderstanding and mistrust on both sides. This need not be so.

A woman *will* benefit from caring heart-to-heart relationships focused on her personhood rather than the sole accounting of her same-sex issues. Often, she will not be able to fully face her same-sex struggle until she feels safe enough within a warm and somewhat mutually transparent community.[67]

> *I had people around me that didn't know anything about homosexuality but they did know that God loved me and was working in my life. So they committed themselves to learning how to love me through my process. They were always there to support me no matter what I did or what I was going through.*
>
> Abby

It will be close to impossible for her to share about her deepest confusions and shameful behaviors if she is the only one expected to share on this level. This does not mean that the pastor or Elder should share their deepest darkest secrets, but that the pastor or Elder promote an open and honest environment within their congregation as a whole so that her trusted accountability partners are familiar with and free to enter into discussions about real life and its inherent difficulties.

[67] Many women with SSA face the added burden of being a single person in the midst of family oriented spiritual communities. She may have nowhere to go on holidays or no practical help for her more mundane needs. Offering her fellowship and practical support may go alone way in helping her trust your intentions.

> Honesty and integrity in the pilgrim's struggle towards God will speak volumes to men and women seeking a path through this often difficult existence, and may help them join the worthwhile journey to life. Jeannette Howard (2005, p. 67)

- *Respect her process, her timing, and her ability to discern right and wrong.*

When I was first learning to facilitate support groups for men and women with SSA in a religious setting, I found that I had a tendency to offer more help and assistance than most of the group members really needed or wanted. I would pour out all of my newly found knowledge, suggest aspects of their life they might want to personally explore or reflect upon, recommend books to read, and offer any further advice that came to my mind or that they just seemed willing to listen to. I hadn't yet developed an awareness of their "glazed over" look. Often, just letting a woman know that there are resources available is enough to bolster her strength and commitment to press on. When she is ready, she will ask for more.

- *Love her unconditionally, just as she is.*

I was surprised at how long it took for me to process the conflict between wanting to love my newly found friends with SSA and fearing that I might somehow be encouraging them to "do something wrong" by showing them my love and acceptance. As I speak and educate on this subject, I have come to believe that this is one of the most common dilemmas for faith-based people. But as I contemplate how *my* personal old-time friends have persevered with me over the years, I realized that their love and acceptance did not release me to become more entrenched in

my struggles, but instead, provided the support I needed to be able to challenge and deal with my struggles.

- *Offer any church discipline in a spirit of care versus punitiveness or the belief that others must be protected from her*.

A woman who painfully admits to struggling with a same-sex relationship or merely the presence of SSA, may need to be relieved from some professional ministry responsibilities for the sake of freeing up energy and time to pursue therapy, support groups, education, or other opportunities for her growth and healing. The extra time offered to her should be framed as a means of blessing and support, not as a punishment for wrongs done.

On the other hand, time away from her regular schedule and trusted friends may *not* be in her best interest. She may need the ongoing stability and consistency in her schedule and relationships to be able to pursue the necessary outside help and support. The woman and her spiritual leader should discuss and determine the proper course of action for her particular and unique situation.

She may also need time (perhaps a leave of absence) to order her life in a way that again is consistent with the personal and ethical requirements of the organization for which she works. During this season, she will still need the regular support of her religious community and most likely extra care and involvement from those with whom she feels safe and can trust.

Rarely should church leadership be compelled to impose disciplinarian action as a means to "protect" the congregation, children, or other individuals from a woman or her struggle. The instances where I have heard of such approaches have not only damaged the woman, but the spiritual community as a whole.

First, I suspect there are many other struggles, such as gossip, lying, pretending, and arrogance, that are far more damaging to a community of faith-based men and women than a woman's longing for same-sex closeness, even if that longing has been sexualized or acted upon. Second, women with SSA are not predators. They are not primarily motivated by a need for sex or promiscuity. Women with SSA may have an intense drive to meet some of their legitimate longings for intimacy, but that is why they should be offered love and grace from her spiritual community, and most importantly, genuine relationship, which will give her the support she needs for her ongoing journey.

In a survey study of men and women seeking to alter their same-sex attractions, it was discovered that many of the participants received the most beneficial help from pastoral counselors *not* professional therapists. When asked specifically about what influences aided them in their healing and change, professional counseling accounted for only two factors out of 10, which included friends, support groups, pastors, and mentors (Nicolosi, Byrd, & Potts, 2000b). I too observe the most profound transformation in the lives of my clients who are fully engaged and supported in all of these associated ways. Non-professionals can have a profound influence and life-changing impact on the women seeking support and understanding of her same-sex struggle.

Parents, Clergy and Friends

A Mother's Story

Over a year ago, I received an email from Margie, a mother of a daughter who has struggled with SSA. She wanted to share her story with the hope that it might help other mothers build a safe and healing relationship with their daughters. After finding out about her daughter's struggle, she recommended that her daughter see a counselor. She encouraged her daughter to make more friends and suggested that her daughter move back home to complete college. Margie was focused on "fixing" her daughter's "problem." But none of Margie's good intentions were able to keep her daughter from eventually entering into a committed same-sex relationship.

Then, based on a dream she had, Margie decided to take a different and what felt like a much riskier path. In the dream she had experienced a new way of relating toher daughter. Trusting the dream, Margie intuitively began to "travel" to the place where her daughter was, emotionally and mentally. She first began by asking questions about her daughter's job, friends, and social life in a friendly curious fashion. She did not voice disapproval or disappointment but processed her distressing emotions later. She responded like an interested friend seeking to understand and feel what her daughter was feeling.

Margie eventually asked her daughter to describe the feelings associated with same-sex attraction and why she believed they were in her life. Much to Margie's surprise, her daughter openly shared. Although Margie was way outside of her comfort zone and belief system, she still practiced active listening without judgment. However, she had to constantly battle the fear that her silence would somehow encourage her daughter to further embrace a lesbian identity. Margie's overarching goal was to literally enter and experience her daughter's world by using attunement and empathy. Eventually, Margie's daughter relaxed, knowing that Margie truly

cared about her, her girlfriend, and social community. Margie's daughter also felt known and understood with respect to her same-sex feelings. She began to trust her mom.

After enjoying a season of growing trust and unconditional love, Margie and her daughter were eventually able to converse about her daughter's past and their family dynamics. Together they began to assemble the pieces, which in time led to greater understanding for Margie of her daughter's deep-seated gender identity confusion. But while things appeared to be going fine, Margie and her daughter had an extremely upsetting interaction. Her daughter emotionally withdrew and no longer wanted to discuss personal issues. Yet Margie remained patient, continuing to encourage, support, and empathize with her daughter.

Margie and her daughter lived apart for several years, but Margie maintained appropriate (supportive versus invasive) levels of contact through phone calls and mail. Her daughter eventually shared that she was dating a guy. Margie reacted with the same level of support and casual curiosity as she had in the past, but knew her daughter had been making incredible emotional and mental shifts.

The following year, Margie's daughter began dating men exclusively and expressed a dying interest in romantic relationships with women. After several more years, Margie received her daughter's announcement of her impending marriage to a young man she had been dating. Margie rejoices over her daughter's present life but had prepared herself to journey with her daughter for as long as her daughter needed. She still feels the emotional exhaustion of her nine-year campaign to unite with and enter her daughter's world and heart, but admits it was worth every minute. Margie believes her dream was a gift from God.

I do not share this story as a guarantee that a parent's or therapist's unconditional acceptance and ongoing emotional connection will automatically lead to a daughter's or client's

decision to move away from same-sex relating, but I share it as an encouragement to the parent to persevere in love for as long as their loved one is living. A daughter will always have a need for a healing and loving connection. Love never fails.

Parents, Clergy and Friends

The Nature of a Healthy Father

Ideally, a girl's secure attachment with her father is based on the *father's* solid sense of self, mature ability to love and sacrifice for the sake of others (especially his wife), dedicated purpose and direction in life, and a secure masculine identity. A healthy father confidently and regularly enters a child's world, a girl's world, and a woman's world without threat to his own autonomy and masculine identity. He can sit with his four-year-old daughter and enjoy a make-believe tea party as easily as playing a game of catch.

A father is to provide the "voice" that affirms his daughter's femaleness and growing sense of femininity (Biller, 1981). He is to come alongside her, blessing her, communicating, "It's so good that you are a little girl!" She can then internalize his enjoyment and eventually embrace her self as a female, looking forward to the rewards and benefits of being a woman and being in a relationship with other women and men (Popenoe, 1996, p. 143).

A father is to release those around him, his wife *and* children, to discover their *own* thoughts, feelings, and opinions. He affirms and respects them as separate, unique, and valuable individuals. He maintains a loving and compassionate connection with them even in the face of disagreement or conflict. He does not wait for others to "serve" him or to initiate closeness and conversation, but boldly pursues, initiates, and supports closeness and conversation because he cares about relationship and his loved one's well-being.

A healthy father has personal friends and role models a healthy balance of finding meaning in both relationships and work. A healthy father is a profound gift and an eternal blessing. A healthy father was most likely loved, respected, and securely attached as a child.

Exhaustive Bibliography

Aardweg, G. J. M. van den (1997). *The battle for normality: A guide for (self-) therapy for homosexuality.* San Francisco: Ignatius.

Adams, H.E., & Sturgis, E.T. (1977). Status of behavioral reorientation techniques in the modification of homosexuality: A review. *Psychological Bulletin*, *84*(6)*,* 1171-1188.

Adamson, L. B., & Frick, J. E. (2003). The still face: A history of a shared experimental paradigm. *Infancy, 4*(4), 451-73.

Adelman, M.R. (1977). A comparison of professionally employed lesbians and heterosexual women on the MMPI. *Archives of Sexual Behavior, 6*(3), 193-201.

Adler, A. (1978). *Cooperation between the sexes: Writings on women, love and marriage, sexuality and its disorders* (H.L. Ansbacher & R.A.Ansbacher, Eds. & Trans.). Garden City, NY: Anchor Books.

Ahrens, C. (1991). Childhood trauma and female sexuality. In J. Dallas (Ed.), *Desires in conflict* (pp. 185-212). Eugene, OR: Harvest House Publishers.

Alexander, P. C. (1992). Application of attachment theory to the study of sexual abuse. *Journal of Consulting and Clinical Psychology, 60,* 185-95.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., Revised). Washington DC: Author.

American Psychiatric Association. (1998). *Psychiatric treatment and sexual orientation position statement*. Retrieved October 22, 2007, from http://www.psych.org/edu/other_res/lib_archives/archives/199820.pdf.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. text revision). Washington, DC: Author.

American Psychiatric Association. (2000). *Therapies focused on attempts to change sexual orientation (reparative or conversion therapies) COPP position statement*. Retrieved October 22, 2007, from http://www.psych.org/edu/other_res/lib_archives/archives/200001.pdf.

American Psychological Association. (1997). *Resolution on appropriate therapeutic responses to sexual orientation*. Retrieved October 22, 2007, from http://www.apa.org/pi/sexual.html.

Anderson, J., Martin, J., Mullen, P., Romans, S., & Herbison, P. (1993). Prevalence of childhood sexual abuse experiences in a community sample of women. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*(5), 911-919.

Anthony, B.D. (1982). Lesbian client-lesbian therapist: Opportunities and challenges in working together. In J.C. Gonsiorek (Ed.), *Homosexuality & psychotherapy: A practitioner's handbook of affirmative models. Journal of Homosexuality 7*(2/3), 45-57. New York: The Haworth Press.

Apter, T., & Josselson, R. (1998). *Best friends.* New York: Crown Publishers.

Armon, V. (1960). Some personality variables in overt female homosexuality. *Journal of Projective Techniques*, *24*, 292-309.

Baars, C., & Terruwe, A. (2002). *Healing the unaffirmed*. New York: St. Pauls.

Bacon, C.L. (1956). A developmental theory of female homosexuality. In S. Lorand & M. Balint (Eds.), *Perversions: Psychodynamics, and therapy* (pp. 131-159). New York: Random House.

Bailey, J.M. (1999). Homosexuality and mental illness. *Archives of General Psychiatry, 56*(10), 883-884.

Bailey, J.M., Dunne, M.P. & Martin, N.G. (2000). Genetic and environmental influences on sexual orientation and its correlates in an Australian twin sample. *Journal of Personality and Social Psychology*, *78*(3), 524-536.

Bailey, J.M., Pillard, R.C., Neale, M.C., & Agyei, Y. (1993). Heritable factors influence sexual orientation in women. *Archives of General Psychiatry, 50*, 217-223.

Bailey, J.M., Willerman, L., & Parks, C. (1991). A test of the maternal stress theory of human male homosexuality. *Archives of Sexual Behavior, 20*(3), 277-293.

Bailey, J. M., & Zucker, K. J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology*, *31*(1)*,* 43-55.

Balsam, K.F., Rothblum, E.D. & Beauchaine, T.P. (2005). Victimization over the life span: A comparison of lesbian, gay, bisexual, and heterosexual siblings. *Journal of Consulting and Clinical Psychology, 73*(3), 477-487.

Balswick, J. K., & Balswick, J. O. (1999). *Authentic human sexuality: An integrated Christian approach*. Downers Grove, IL: InterVarsity Press.

Balswick, J. O., King, P. E., & Reimer, K. S. (2005). *The reciprocating self: Human development in theological perspective.* Downers Grove, IL: InterVarsity Press.

Banks, A. & Gartrell, N.K. (1995). Hormones and sexual orientation: A questionable link. In J. DeCecco & D. Parker (Eds.), *Sex, cells, and same-sex desire: The biology of sexual preference* (pp. 247-268). New York: The Haworth Press.

Barnhouse, R.T. (1977). *Homosexuality: A symbolic confusion*. New York: The Seabury Press.

Barnhouse, R.T. (1984). *Identity*. Philadelphia: The Westminster Press.

Bartholomew, K. (1990). Avoidance of intimacy: An attachment perspective. *Journal of Social and Personal Relationships, 7*, 147-78.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*(2), 226-44.

Bartholomew, K., Kwong, M.J., & Hart, S.D. (2001). Attachment. In W.J. Livesley (Ed.), *Handbook of personality disorders: Theory, research, and treatment* (pp. 196-230). New York: The Guilford Press.

Batgos, J., & Leadbeater, B.J. (1994). Parental attachment, peer relations, and dysphoria in adolescence. In M.B. Sperling & W.H. Berman (Eds.), *Attachment in adults: Clinical and developmental perspectives* (pp. 155-161). New York: The Guilford Press.

Baumgardner, J. (2007, March). Why more girls are dating . . . girls. *Glamour Magazine*, 174-175.

Bayer, R. (1987). *Homosexuality and American psychiatry: The politics of diagnosis*. Princeton, NJ: Princeton University Press.

Bearman, P.S. & Bruckner, H. (2002). Opposite-sex twins and adolescent same-sex attraction. *The American Journal of Sociology, 107*(5), 1179-1205.

Beckstead, A.L., & Morrow, S.L. (2004). Mormon clients' experiences of conversion therapy: The need for a new treatment approach. *The Counseling Psychologist, 32*(5), 651-690.

Beitchman, J. H., Zucker, K.J., Hood, J.E., DaCosta, G.A., Akman, D. & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse & Neglect, 16*(1), 101-118.

Bell, A.P. & Weinberg, M.S. (1978). *Homosexualities: A study of diversity among men and women.* New York: Simon and Schuster.

Bell, A.P., Weinberg, M.S. & Hammersmith, S.K. (1981*). Sexual preference: Its development in men and women*. Bloomington, IN: Indiana University Press.

Bem, D. (1996). Exotic becomes erotic: A developmental theory of sexual orientation. *Psychological Review, 103*(2), 320-335.

Bene, E. (1965). On the genesis of female homosexuality. *British Journal of Psychiatry, 111*, 815-821.

Benenson, J. F., Morash, D. & Petrakos, H. (1998). Gender differences in emotional closeness between preschool children and their mothers. *Sex Roles, 38*, 975-985.

Bergin, A.E., Payne, I.R., & Richards, P.S. (1996). Values in psychotherapy. In E.P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp.297-325). Washington, DC: American Psychological Association.

Bergler, E. (1956). *Homosexuality: Disease or way of life?* New York: Collier Books.

Bergner, M. (1995). *Setting love in order: Hope and healing for the homosexual.* Grand Rapids, MI: Hamewith Books.

Bergner, M. (2004, Autumn). Watching the lord heal lesbian attractions. *Redeemed Lives News, 5*(3), 3-6.

Biernbaum, M., & Ruscio, M. (2004). Differences between matched heterosexual and non-heterosexual college students on defense mechanisms and psychopathological symptoms. *Journal of Homosexuality, 48*(1), 125-41.

Bieschke, K., McClanahan, M., Tozer, E., Grzegorek, J., & Park, J. (2000). Programmatic research on the treatment of lesbian, gay and bisexual clients: The past, the present and the course of the future. In R. M. Perez, K. A. DeBord & K. J. Bieschke (Eds.), *Handbook of*

counseling and psychotherapy with lesbian, gay and bisexual clients (pp. 309-35). Washington, DC: American Psychological Association.

Biller, H.B. (1981). The father and sex role development. In M. Lamb (Ed.), *The role of the father in child development* (pp. 319-359). New York: John Wiley & Sons.

Blumstein, P. & Schwartz, P. (1983). *American couples: Money, work, sex*. New York: William Morrow and Co.

Bowlby, J. (1988). *A secure base*. New York: Basic Books.

Bradford, J., Ryan, C. & Rothblum, E.D. (1994). National lesbian health care survey: Implications for mental health care. *Journal of Consulting and Clinical Psychology, 62*(2), 228-242.

Brand, P. & Kidd, A. (1986). Frequency of physical aggression in heterosexual and female homosexual dyads. *Psychological Reports, 59*(3), 1307-1313.

Brand, P.A., Rothblum, E.D., & Solomon, L.J. (1992). A comparison of lesbians, gay men, and heterosexuals on weight and restrained eating. *International Journal of Eating Disorders, 11*(3), 253 -259.

Brannock, J. C., & Chapman, B. E. (1990). Negative sexual experiences with men among heterosexual women and lesbians. *Journal of Homosexuality, 19*(1), 105-10.

Brestin, D. (1997). *The friendships of women.* **[city]**: Chariot Victor.

Brickner, S.L. (1993). *Comparing the psychosocial development of homosexual and lesbian women*. Unpublished doctoral dissertation, Trinity Theological Seminary, Newberg.

Bridges, K.L. and Croteau, J.M. (1994). Once married lesbians: Facilitating changing life patterns. *Journal of Counseling and Development*, *73,* 134-139.

Brodzinsky, D.M., Schechter, M.D. & Henig, R.M. (1992). *Being adopted: The lifelong search for self.* New York: Anchor Books.

Brooks, B. (1985). Sexually abused children and adolescent identity development. *American Journal of Psychotherapy, 39*(3), 401-410.

Brown, L. (1987). Lesbians, weight, and eating: New analyses and perspectives. In Boston Lesbian Psychologies Collective (Eds.), *Lesbian psychologies: Exploration and challenges* (pp. 294 - 309). Chicago: University of Illinois Press.

Burch, B. (1987). Barriers to intimacy: Conflicts over power, dependency, and nurturing in lesbian relationships. In Boston Lesbian Psychologies Collective (Eds.), *Lesbian Psychologies* (pp.126-141). Chicago: University of Illinois Press.

Byne, W. (1995). Science and belief: Psychobiological research on sexual orientation. *Journal of Homosexuality, 28*(3/4), 303-44.

Byne, W. (1997). Why we cannot conclude that sexual orientation is primarily a biological phenomenon. *Journal of Homosexuality, 34*(1), 73-80.

Byne, W., & Parsons, B. (1993). Human sexual orientation: The biologic theories reappraised. *Archives of General Psychiatry*, *50*, 228-239.

Byrd, A.D. (2004). Gender complementarityand child-rearing: Where tradition and science agree. *Journal of Law and Family Studies, 6*(2), 213-235.

Byrd, A.D. (2005, August). *Special report* [Review of the book, *Destructive trends in mental health: The well-intentioned path to harm*]. Narth Bulletin, 13(2), 3-10.

Cahill, L. (2005, April). *His brain, her brain.* Retrieved October 22, 2007, from the Scientific American website: http://www.sciam.com/article.cfm?articleID=00054E47-24CF-1264-980683414B7F0000&sc=I100322.

Cameron, K. & Cameron, P. (1995). Does incest cause homosexuality? *Psychological Report, 76,* 611-621.

Cappon, D. (1965). *Toward an understanding of homosexuality.* Englewood Cliffs, NJ: Prentice-Hall, Inc.

Caprio, F.S. (1954). *Female homosexuality: A psychodynamic study of lesbianism.* New York: Citadel.

Caprio, F. (1955). *Variations in sexual behavior: A psychodynamic study of deviations in various expressions of sexual behavior.* New York: The Citadel Press.

Chamberlain, D. B. (1999). Life in the womb: Dangers and opportunities. *Journal of Perinatal Psychology and Health, 14*(1/2), 31-43.

Chodorow, N. (1978). *The reproduction of mothering: Psychoanalysis and the sociology of gender.* Berkeley: University of California Press.

Clarke-Stewart, K.A. (1980). The father's contribution to children's cognitive and social development in early childhood. In F.A. Pedersen (Ed.), *The father-infant relationship: Observational studies in the family setting*. New York: Praeger.

Clausen, J. (1999). *Apples and oranges: My journey through sexual identity.* New York: Houghton Mifflin Co.

Cloud, J. (2005, October 10). The battle over gay teens. *Time, 166*(15), 42-51.

Cloud, H. and Townsend, J. (1992). *Boundaries*. Grand Rapids, MI: Zondervan.

Cochran, S. D. (2001). Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter? *American Psychologist, 56*(11), 931-47.

Cochran, S.D. & Mays, V.M. (2000). Relation between psychiatric syndromes and behaviorally defined sexual orientation in a sample of the US population. *American Journal of Epidemiology, 151*(5), 516-523.

Cochran, S.D., Sullivan, J.G. & Mays, V.M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*(1), 53-61.

Cohen, R. (2000). *Coming out straight.* Winchester, VA: Oakhill Press.

Cohen, R. (2007). *Gay children, straight parents: A plan for family healing.* Downers Grove, IL: IVP Books.

Coleman, V.E. (1990). *Violence between lesbian couples: A between groups comparison*. Unpublished doctoral dissertation. University Microfilms International, 9109022.

Collins, F. (2006). The Language of God: A Scientist Presents Evidence for Belief. New York, NY: Free Press.

Colt, G.H. (1998, April). Were you born that way? *Life,* 39-50.

Comiskey, A. (1989). *Pursuing sexual wholeness.* Lake Mary, FL: Creation House.

Comiskey, A. (2003). *Strength in weakness: Healing sexual and relational brokenness.* Downers Grove, IL: InterVarsity Press.

Confessions of a LUG. (1999, August 26-September 1) *City Beat*. Retrieved October 22, 2007, from http://www.citybeat.com/1999-08-26/cover3.shtml.

Connellan, J., Baron-Cohen, S., Wheelwright, S., Batki, A. & Ahluwalia, J. (2000). Sex differences in human neonatal social perception. *Infant Behavior & Development, 23*, 113-118.

Corey, G., Corey, M. S., Callanan, P., & Russell, J. M. (2004). *Group techniques* (3rd ed.). Pacific Grove, CA: Brooks/Cole-Thomson Learning.

Corliss, H. L., Cochran, S. D., & Mays, V. M. (2002). Reports of parental maltreatment during childhood in a United States population-based survey of homosexual, bisexual and heterosexual adults. *Child Abuse & Neglect, 26*, 1165-78.

Cosentino, C.E., Meyer-Bahlburg, H.F.L., Alpert, J.L., & Gaines, R. (1993). Cross-gender behavior and gender conflict in sexually abused girls. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*(5), 940-947.

Cooper, A.J. (1974). Aetiology of homosexuality. In J.A. Loraine (Ed.), *Understanding homosexuality: Its biological and psychological bases* (pp. 1-23). New York: American Elsevier Publishing Co., Inc.

Cox, S.E., & Dant, D.R. (1999). *Developing genuine friendships: A guide for women struggling with same-sex attractions*. Salt Lake City, UT: Evergreen International.

Cytron, S., & Malinowitz, H. (1999). Butch in a tutu. In M. Rottnek (Ed.), *Sissies and tomboys* (pp. 209-25). New York: New York University Press.

Dallas, J. (1991). *Desires in conflict*. Eugene, OR: Harvest House.

Dallas, J. (1996). In defense of clinical treatment for homosexuality. *Journal of Psychology and Christianity, 15*(4), 369-372.

Dancey, C.P. (1990a). Sexual orientation in women: An investigation of hormonal and personality variables. *Biological Psychology, 30,* 251-264.

Dancey, C. P. (1990b). The influence of familial and personality variables on sexual orientation in women. *Psychological Record*, *40,* 437-449.

Davies, B. & Gilbert, L. (2001). *Portraits of freedom.* Downers Grove, IL: InterVarsity Press.

Davies, B. & Rentzel, L. (1993). *Coming out of homosexuality.* Downers Grove, IL: InterVarsity Press.

Davis, M., Eshelman, E. R., & McKay, M. (2000). *The Relaxation and Stress Reduction Workbook* (5th ed.). Oakland, CA: New Harbinger Publications.

Deddo, G. W. (2006, November). *Why we're gendered beings—a trinitarian perspective: The difference difference makes*. Paper presented at the meeting of the Evangelical Theological Society, Washington, DC. Retrieved October 22, 2007, from the Trinity Study Center website: http://www.trinitystudycenter.com/topical/trinityandgender.pdf.

Diamond, L. (1998). Development of sexual orientation among adolescent and young adult women. *Developmental Psychology, 34*(5), 1085-1095.

Diamond, L. (2000). Sexual identity, attractions, and behavior among young sexual-minority women over a 2-year period. *Developmental Psychology, 36*(2). 241-250.

Diamond, M. (1982). Sexual identity, monozygotic twins reared in discordant sex roles and a BBC follow-up. *Archives of Sexual Behavior, 11*, 181-186.

Diamond, M., & Sigmundson, H.K. (1997). Sex reassignment at birth: Long-term review and clinical implications. *Archives of Pediatrics & Adolescent Medicine, 151*, 298-304.

Dixon, J.K. (1985). Sexuality and relationship changes in married females following the commencement of bisexual activity. *Journal of Homosexuality, 11*(1/2), 115-134.

Downey, J., Ehrhardt, A.A., Schiffman, M., Dyrenfurth, I., & Becker, J. (1987). Sex hormones in lesbian and heterosexual women. *Hormones and Behaviors, 21*(3), 347-357.

Dunne, M. P., Bailey, J. M., Kirk, K. M., & Martin, N. G. (2000). The subtlety of sex-atypicality. *Archives of Sexual Behavior, 29*(6), 549-65.

Eckert, E. D., Bouchard, T.J., Bohlen, J., & Heston, L.L. (1986). Homosexuality in monozygotic twins reared apart. *British Journal of Psychiatry, 148,* 421-425.

Eckleberry-Hunt, J.G. & Dohrenwend, A. (2005). Sociocultural interpretations of social phobia in a non-heterosexual female. *Journal of Homosexuality, 49*(2), 103-117.

Edelman, H. (1994). *Motherless Daughters*. New York: Dell Publishing.

Eeden-Moorefield, B. van, & Lindsey, E. W. (2005). Intergenerational effects of parental personality and relationship traits on mate choice among gay male and lesbian offspring. *Journal of Homosexuality, 49*(1), 123-43.

Ehrhardt, A., Meyer-Bahlburg, H., Rosen, L., Feldman, J., et al. (1989). The development of gender-related behavior in females following prenatal exposure to diethylstilbestrol (DES). *Hormones and Behavior, 23*(4), 526-541.

Eldridge, E. (1994). *Born that way? A true story of overcoming same-sex attraction with insights for friends, families and leaders.* Salt Lake City, UT: Deseret Book Company.

Ellis, A. (1956). The effectiveness of psychotherapy with individuals who have severe homosexual problems. *Journal of Consulting Psychology*, *20*(3)*,* 191-195.

Ellis, L. & Hellberg, J. (2005). Fetal exposure to prescription drugs and adult sexual orientation. *Personality and Individual Differences, 38*, 225-236.

Emerson, W. R. (1996). The vulnerable prenate. *Pre- & Perinatal Psychology Journal, 10*(3), 125-42. Retrieved October 22, 2007, from the Association for Prenatal & Perinatal Psychology and Health website: http://birthpsychology.com/healing/emerson.html.

Epstein, R. (2006, February/March). Do gays have a choice? *Scientific American Mind,* 51-57.

Erikson, E.H. (1963). *Childhood and society*. New York: W.W. Norton & Co.

Erikson, E. H. (1980). *Identity and the life cycle*. New York: W.W. Norton & Company.

Erickson, M. (2002). *Christian theology.* Grand Rapids, MI: Baker.

Faderman, L. (1991). *Odd girls and twilight lovers: A history of lesbian life in twentieth-century America.* New York: Columbia University Press.

Falco, K. (1991). *Psychotherapy with lesbian clients.* New York: Brunner/Mazel.

Fergusson, D.M., Horwood, L.J. & Beautrais, A.L. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry, 56*(10), 876-880.

Fergusson, D.M., Horwood, L.J., Ridder, E.M., & Beautrais, A.L. (2005). Sexual orientation and mental health in a birth cohort of young adults. *Psychological Medicine, 35*, 971-981.

Fergusson, D.M., Lynskey, M.T., & Horwood, L.J. (1996). Childhood sexual abuse and psychiatric disorder in young adulthood: Prevalence of sexual abuse and factors associated with sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(10), 1355-1364.

Fogel, A. (2002). Remembering infancy: Accessing our earliest experiences. In G. Bremmer & A. Slater (Eds.), *Theories of Infant Development (no pp#'s given).* Cambridge: Blackwell.

Ford, C.S. & Beach, F.A. (1951). *Patterns of sexual behavior*. New York: Harper and Brothers.

Fraley, R. C., Davis, K. E., & Shaver, P. R. (1998). Dismissing-avoidance and the defensive organization of emotion, cognition and behavior. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 249-79). New York: Guilford Press.

Freedman, M. (1968). Homosexuality among women and psychological adjustment. *Dissertation Abstracts International, 28*(10-B), 4294-4295.

Friedman, R.C. & Downey, J.I. (1993a). Neurobiology and sexual orientation: Current relationships. *Journal of Neuropsychiatry and Clinical Neurosciences, 5*, 131-153.

Friedman, R.C. & Downey, J.I. (1993b). Psychoanalysis, psychobiology, and homosexuality. *Journal of the American Psychoanalytic Association, 41*(4), 1159-1197.

Friedman, R.C. & Downey, J.I. (2002). *Sexual orientation and psychoanalysis: Sexual science and clinical practice.* New York: Columbia University Press.

Frisch, M. & Hviid, A. (2006). Childhood family correlates of heterosexual and homosexual marriages: A national cohort study of two million danes. *Archives of Sexual Behavior, 35*, 533-547.

Garnets, L., Hancock, K., Cochran, S., Goodchilds, J., & Peplau, L. A. (1991). Issues in psychotherapy with lesbians and gay men: A survey of psychologists. *American Psychologist, 46*(9), 964-72.

Gartrell, N. (1981). The lesbian as a "single" woman. *American Journal of Psychotherapy, 35*(4), 502-509.

Gartrell, N.K., Loriaux, L. & Chase, T.N. (1977). Plasma testosterone in homosexual and heterosexual women. *American Journal of Psychiatry, 134*(10), 1117-1119.

Gendlin, E. T. (1981). *Focusing.* New York: Bantam Books.

Gershman, H. (1975). The effect of group therapy on compulsive homosexuality in men and women. *The American Journal of Psychoanalysis*, *35,* 303-312.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Gilligan, C., Lyons, N., & Hanmer, T. (Eds.). (1990). *Making Connections*. Cambridge, MA: Harvard University Press.

Gluckman, L. (1966). Lesbianism: A clinical approach. *The New Zealand Medical Journal, 65*, 443-449.

Gold, S. N., & Seifer, R. E. (2002). Dissociation and sexual addiction/compulsivity: A contextual approach to conceptualization and treatment. In J. A. Chu & E. S. Bowman (Eds.), *Trauma and sexuality* (pp. 59-82). Binghampton, NY: Haworth Medical Press.

Gonsiorek, J.C. (1982). The use of diagnostic concepts in working with gay and lesbian populations. In J.C. Gonsiorek (Ed.) *Homosexuality & psychotherapy: A practitioner's handbook of affirmative models, Journal of Homosexuality 7*(2/3), (pp. 9-20). New York: The Haworth Press.

Gonsiorek, J. C., Sell, R. L., & Weinrich, J. D. (1995). Definition and measurement of sexual orientation. *Suicide and Life-Threatening Behavior, 25*(Suppl.), 40-51.

Goode, E. & Haber, L. (1977). Sexual correlates of homosexual experience. *The Journal of Sex Research, 13*(1), 12-21.

Green, R. (1980). Patterns of sexual identity in childhood: Relationship to subsequent sexual partner preference. In J. Marmor (Ed.), *Homosexual behavior: A modern reappraisal* (pp. 255-66). New York: Basic Books.

Green, R., Williams, K., & Goodman, M. (1982). Ninety-nine “tomboys” and “non-tomboys”: Behavioral contrasts and demographic similarities. *Archives of Sexual Behavior, 11*(3), 247-66.

Greenspoon, J. & Lamal, P.A. (1987). A behavioristic approach. In L. Diamant (Ed.), *Male and female homosexuality: Psychological approaches* (pp. 109-127). Washington: Hemisphere Publishing Co.

Greer, M. (2004). Labels may oversimplify women’s sexual identity, experiences. *Monitor on Psychology, 35*(9), 28.

Grenz, S. J. (1995). *Women in the church: A Biblical theology of women in ministry*. Downers Grove, IL: InterVarsity Press.

Gundlach, R.H. (1977). Sexual molestation and rape reported by homosexual and heterosexual women. *Journal of Homosexuality*, *2*(4), 367-384.

Gundlach, R.H. & Riess, B.F. (1967). Birth order and sex of siblings in a sample of lesbians and non-lesbians. *Psychological Reports, 20*, 61-62.

Gundlach, R.H. & Riess, B.F. (1968). Self and sexual identity in the female: A study of female homosexuals. In B.F. Riess (Ed.), *New directions in mental health* (Vol. 1, pp. 205-231). New York: Grune & Stratton.

Gundlach, R.H. & Riess, B.F. (1973). The range of problems in the treatment of lesbians. In D.S. Milman & G.D. Goldman (Eds.), *The neurosis of our time: Acting out* (pp. 147-169). Springfield, IL: Charles C. Thomas Publisher.

Haldeman, D. (2002). Gay rights, patient rights: The implications of sexual orientation conversion therapy. *Professional Psychology: Research and Practice, 33*(3), 260-264.

Haldeman, D. (2004). When sexual and religious orientation collide: Considerations in working with conflicted same-sex attracted male clients. *The Counseling Psychologist, 32*(5), 691-715.

Hall, J.M. (1994). Lesbians recovering from alcohol problems: An ethnographic study of health care experiences. *Nursing Research, 43*(4), 238-244.

Hall, J.M. (1996). Pervasive effects of childhood sexual abuse in lesbians' recovery from alcohol problems. *Substance Use & Misuse, 31*(2), 225-239.

Hall, L.S. & Love, C.T. (2003). Finger-length ratios in female monozygotic twins discordant for sexual orientation. *Archives of Sexual Behavior, 32*(1), 23-28.

Hamer, D., & Copeland, P. (1994). *The science of desire: The search for the gay gene and the biology of behavior.* New York: Simon & Schuster.

Hawley, G. A. (1988). *Measures of psychosocial development* (MPD). Odessa, FL: Psychological Assessment Resources, 1-800-331-TEST.

Hemfelt, R., Minirth, F., & Meier. P. (1989). *Love is a Choice*. Nashville: Thomas Nelson.

Henderson, A.F. (1979). College age lesbianism as a developmental phenomenon. *Journal of the American College Health Association, 28*(3), 176-178.

Henderson, A.F. (1984). Homosexuality in the college years: Developmental differences between men and women. *Journal of American College Health, 32*(5), 216-219.

Herrell, R., Goldberg, J., True, W.R., Ramakrishnan, V., Lyons, M., Eisen, S., et al. (1999). Sexual orientation and suicidality: A co-twin control study in adult men. *Archives of General Psychiatry, 56*(10), 867-874.

Hersh, S. (2006). *Mom, sex is no big deal! Becoming your daughter's ally in developing a healthy sexual identity*. Colorado Springs, CO: Shaw Books.

Hershberger, S. (1997). A twin registry study of male and female sexual orientation. *The Journal of Sex Research*, *34*(2), 212-222.

Hess, R. S. (2004). Equality with and without innocence. In R. Pierce & R. Groothuis (Eds.), *Discovery biblical equality: Complementarity without hierarchy* (pp. 79-95). Downers Grove, IL: InterVarsity Press.

Hindy, C. G., & Schwarz, J. C. (1994). Anxious romantic attachment in adult relationships. In M. E. Sperling & W. H. Berman (Eds.), *Attachment in adults: Clinical and developmental perspectives* (pp. 179-95). New York, London: Guilford Press.

Hines, M., Brook, C., & Conway, G. S. (2004). Androgen and psychosexual development: Core gender identity, sexual orientation and recalled childhood gender role behavior in women and men with congenital adrenal hyperplasia (CAH). *The Journal of Sex Research, 41*(1), 75-81.

Hines, M., Johnston, K. J., Golombok, S., Rust, J., Stevens, M., Golding, J., & the ALSPAC Study Teams. (2002). Prenatal stress and gender role behavior in girls and boys: A longitudinal population study, *Hormones and Behavior, 42,* 126-34.

Hinrichsen, J.J & Katahn, M. (1975). Recent trends and new developments in the treatment of homosexuality. *Psychotherapy: Theory, Research and Practice, 12*(1), 83-92.

Hoffman, R. M. (2006). Gender self-definition and gender self-acceptance in women: Intersections with feminist, womanist, and ethnic identities. *Journal of Counseling & Development, 84*(3), 358-72.

Hogan, R.A., Fox, A.N. & Kirchner, J.H. (1977). Attitudes, opinions, and sexual development of 205 homosexual women. *Journal of Homosexuality, 3*(2), 123-136.

Hooker, E. (1957). The adjustment of the male overt homosexual. *Journal of Projective Techniques, 21*, 18-31.

Hopkins, J.H. (1969). The lesbian personality. *British Journal of Psychiatry, 115*, 1433-1436.

Howard, J. (2005). *Into the promised land: Beyond the lesbian struggle.* Grand Rapids, MI: Monarch Books.

Howard, J. (1991). *Out of Egypt: Leaving lesbianism behind.* Tunbridge Wells: Monarch Publications.

Hughes, D.A. (1997). *Facilitating developmental attachment.* Lanham, MD: Jason Aronson, Inc.

Hughes, D.A. (2004). *Attachment focused therapy for children, adolescents and families*. Booklet from R. Cassidy Seminars, Santa Rosa, CA.

Hughes, T.L., Haas, A.P., Razzano, L., Cassidy, R., & Matthews, A. (2000). Comparing lesbians and heterosexual women's mental health: Results from a multi-site women's health survey. *Journal of Gay and Lesbian Social Services, 11*(1), 57-76.

Hughes, T.L., Johnson, T. & Wilsnack, S.C. (2001). Sexual assault and alcohol abuse: A comparison of lesbians and heterosexual women. *Journal of Substance Abuse, 13*, 515-532.

Imperato-McGinley, J., Peterson, R. E., Gautier, T., & Sturla, E. (1979). Androgens and the evolution of male-gender identity among male pseudohermaphrodites with 5-alpha-reductase deficiency. *New England Journal of Medicine, 300*(22), 1233-1237.

Jack, D.C. (1991). *Silencing the self: Women and depression*. New York: HarperCollins.

Jacobs, L.P. (1990). Preoedipal determinants of female homosexuality. In C. Socarides & V. Volkan (Eds.), *The homosexualities: Reality, fantasy, and the arts* (pp.139-160). Madison, CT: International University Press.

Jay, K., & Young, A. (1979). *The gay report: Lesbians and gay men speak out about sexual experiences and lifestyles*. New York: Summit Books.

Jones, E. (1927). The early development of female sexuality. *International Journal of Psychoanalysis, 8*(4), 459-72.

Jones, S.L. & Kwee, A.W. (2005). Scientific research, homosexuality, and the church's moral debate: An update. *Journal of Psychology and Christianity, 24*(4), 304-316.

Jones, S., & Yarhouse, M. (2000). *Homosexuality: The use of scientific research in the church's moral debate*. Downers Grove, IL: InterVarsity Press.

Jones, S. & Yarhouse, M. (2007). *Ex-gays? A longitudinal study of religiously mediated change in sexual orientation.* Downers Grove, IL: IVP Academic.

Jordan, J.V. & Surrey, J.L. (1989). The self-in-relation: Empathy and the mother-daughter relationship. In T. Bernay & D.W. Cantor (Eds.), *The psychology of today's woman: New psychoanalytic visions* (pp.81-104). Cambridge, MA: Harvard University Press.

Jordan, J.V., Surrey, J.L., Kaplan, A.G. (1991). Women and empathy: Implications for psychological development and psychotherapy. In J. V. Jordan, A.G. Kaplan, J.B. Miller, I.P. Stiver & J.L. Surrey, (Eds.), *Women's growth in connection: Writings from the Stone Center* (pp. 27-50). New York: The Guilford Press.

Kaplan, H. S. (1983). *The evaluation of sexual disorders: Psychological and medical aspects*. New York: Brunner/Mazel.

Kaplan, A.G., Gleason, N. & Klein, R. (1991). Womens' self development in late adolescence. In J.V. Jordan, A.G. Kaplan, J.B. Miller, I.P Stiver & J.L. Surrey (Eds.), *Women's growth and connection* (pp.122-140). New York: The Guilford Press.

Kaplan, H. & Sadock, B. (1991). *Comprehensive Glossary of Psychiatry and Psychology.* Baltimore: Williams & Wilkins.

Kaschak, E. (2001). Intimate betrayal: Domestic violence in lesbian relationships. In E. Kaschak, (Ed.), *Intimate betrayal: Domestic violence in lesbian relationships* (pp. 1-5). New York: Haworth Press.

Kaufman, P.A., Harrison, E. & Hyde, M.L. (1984). Distancing for intimacy in lesbian relationships. *American Journal of Psychiatry, 141*(4), 530 - 533.

Kaye, H.E., Berl, S., Clare, J., Eleston, M.R., Gershwin, B.S., Gershwin, P., et al. (1967). Homosexuality in women. *Archives of General Psychiatry, 17*, 626-634.

Kelsey, M. (1996). *Set your hearts on the greatest gift*. Hyde Park, NY: New City Press.

Kendler, K.S., Thornton, L.M., Gilman, S.E. & Kessler, R.C. (2000). Sexual orientation in a U.S. national sample of twin and nontwin sibling pairs. *American Journal of Psychiatry, 157*(11), 1843-1846.

Kenyon, F. (1968). Studies in female homosexuality: IV. Social and psychiatric aspects. *British Journal of Psychiatry, 114,* 1337-50.

Kenyon, F. (1974). Female homosexuality—a review. In J.A. Loraine (Ed.), *Understanding homosexuality: Its biological and psychological bases* (pp. 83-119). New York: American Elsevier.

Kenyon, F. (1968). Studies in female homosexuality: IV. Social and psychiatric aspects. *British Journal of Psychiatry, 114*, 1337-1350.

King, M. & McDonald, E. (1992.) Homosexuals who are twins: A study of 46 probands. *The British Journal of Psychiatry, 160,* 407-409.

Kinnish, K. K., Strassberg, D. S., & Turner, C. W. (2005, April). Sex differences in the flexibility of sexual orientation: A multidimensional retrospective assessment. *Archives of Sexual Behavior, 34*(2), 173-83.

Kinsey, A.C., Pomeroy, W.B. & Martin, C.E. (1948). *Sexual behavior in the human male.* Philadelphia: W.B. Saunders Company.

Kinsey, A.C., Pomeroy, W.B., Martin, C.E. & Gebhard, P.H. (1953). *Sexual behavior in the human female*. Philadelphia: W.B. Saunders Company.

Klein, R. (1989). Introduction to the disorders of the self. In J.F. Masterson & R. Klein (Eds.), *Psychotherapy of the disorders of the self: The Masterson approach* (pp. 30-46). New York: Brunner/Mazel, Publishers.

Kneisl, C. R. (1991). Healing the wounded, neglected inner child of the past. *Nursing Clinics of North America, 26*(3), 745-52.

Koh, A.S. & Ross, L.K. (2006). Mental health issues: A comparison of lesbian, bisexual and heterosexual women. *Journal of Homosexuality, 51*(1), 33-57.

Krajeski, J. (1984). Psychotherapy with gay and lesbian patients. In E. Hetrick & T. Stein (Eds.), *Innovations in psychotherapy with homosexuals* (pp. 75-88). Washington, DC: American Psychiatric Press.

Kremer, M.W. & Rifkin, A.H. (1969). The early development of homosexuality: A study of adolescent lesbians. *American Journal of Psychiatry, 126*(1), 91–96.

Krestan, J. & Bepko, C. (1980). The problem of fusion in lesbian relationship. *Fam Process, 19*(3): 277-289.

Lake, F. (1986). *Clinical theology: A theological and psychological basis to clinical pastoral care.* Abridged by M.H. Yeomans. London: Darton, Longman and Todd.

Lalumiere, M.L., Blanchard, R., & Zucker, K.J. (2000). Sexual orientation and handedness in men and women: A meta-analysis. *Psychological Bulletin, 126*(4), 575-592.

Laumann, E.O., Gagnon, J.H., Michael, R.T. & Michaels S. (1994). *The social organization of sexuality: Sexual practices in the United States*. Chicago, IL: University of Chicago Press.

Lechner, M.E., Vogel, M.E., Garcia-Shelton, L.M., Leichter, J.L. & Steibel, K.R. (1993). Self-reported medical problems of adult female survivors of childhood sexual abuse. *The Journal of Family Practice, 36*(6), 633-638.

Legler, G. (2001). Fishergirl. In C. Reid & H. K. Iglesias (Eds.), *His hands, his tools, his sex, his dress: Lesbian writers on their fathers* (pp. 170-98). New York: Harrington Park Press.

Lerner, R. (1900). *Affirmations for the inner child*. Deerfield Beach, FL: Health Communications.

Lester, G.W. (1999). *Personality disorders in social work & healthcare*. Nashville, TN: Cross Country University.

Levy, T.M. & Orlans, M. (1998). *Attachment, trauma, and healing.* Washington, DC: CWLA Press.

Lewis, C.S. (1960). *The four loves*. New York: Harcourt Brace Jovanovich, Inc.

Lie, G. & Gentlewarrior, S. (1991). Intimate violence in lesbian relationships: Discussion of survey findings and practice implications. *Journal of Social Service Research, 15*(1/2), 41-59.

Lie, G., Schilit, R., Bush, J., Montagne, M. & Reyes, L. (1991). Lesbians in currently aggressive relationships: How frequently do they report aggressive past relationships? *Violence and Victims, 6*(2), 121-135.

Lindenbaum, J.P. (1985). The shattering of an illusion: The problem of competition in lesbian relationships. *Feminist Studies, 11*(1), 85-103.

Linehan, M. M. (1993). *Cognitve-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Lippa, R. A. (2000). Gender-related traits in gay men, lesbian women, and heterosexual men and women: The virtual identity of homosexual-heterosexual diagnosticity and gender diagnosticity. *Journal of Personality, 68,* 899-926.

Lippa, R. A., & Arad, S. (1997). The structure of sexual orientation and its relation to masculinity, femininity and gender diagnosticity: Different for men and women. *Sex Roles, 37*(3/4), 187-208.

Lipton, B. H. (1995). *Maternal emotions and human development.* Retrieved October 22, 2007, from the Association for Prenatal & Perinatal Psychology and Health website: http://www.birthpsychology.com/lifebefore/early8.html.

Lipton, B.H. (1998, Fall). Nature, nurture and the power of love. *Journal of Prenatal and Perinatal Psychology and Health, 13*(1), 3-10.

Liszcz, A. M., & Yarhouse, M. A. (2005). A survey on views of how to assist with coming out as gay, changing same-sex behavior or orientation and navigating sexual identity confusion. *Ethics & Behavior, 15*(2), 159-79.

Livesley, W.J. (2001). Conceptual and taxonomic issues. In W.J. Livesley (Ed.), *Handbook of personality disorders* (pp. 3-38). New York: The Guilford Press.

Lockhart, L., White, B., Causby, V. & Isaac, A. (1994). Letting out the secret: Violence in lesbian relationships. *Journal of Interpersonal Violence. 9*(4), 469-492.

Loehlin, J.C. & McFadden, D. (2003). Otoacoustic emissions, auditory evoked potentials, and traits related to sex and sexual orientation. *Archives of Sexual Behavior, (32)*2, 115-127.

Loney, J. (1973). Family dynamics in homosexual women. *Archives of Sexual Behavior, 2*(4), 343-350.

Lortie, C. (2000). *Defining change in sexual orientation: A qualitative view.* Unpublished masters thesis, University of Colorado at Denver.

Love, P., & Robinson, J. (1990). *The emotional incest syndrome: What to do when a parent's love rules your life.* New York: Bantam Books.

MacIntosh, H. (1994). Attitudes and experiences of psychoanalysts in analyzing homosexual patients. *Journal of the American Psychoanalytic Association, 42*(4), 1183-1205.

MacIntosh, H. (2002). The psychoanalysis of a homosexual woman. In C. W. Socarides & A. Freedman (Eds.), *Objects of desire: The sexual deviations* (pp. 217-49). Madison, CT: International Universities Press.

Manning, B. (2000). *Ruthless Trust*. San Francisco: HarperCollins Publishers.

Mannion, K. (1976, University of Idaho). Female homosexuality: A comprehensive review of theory and research. Abstracted in the *JSAS Catalog of Selected documents in Psychology, 6*(1), 44.

Mara, J. (1983). A lesbian perspective. In J.H. Robbins & R.J. Siegel (Eds.), *Women Changing Therapy* (pp.145-155). New York: Haworth Press.

Masters, W.H. & Johnson, V.E. (1979). *Homosexuality in Perspective*. Boston: Little, Brown and Company.

Masterson, J.F. (1985). *The real self*. New York: Brunner/Mazel.

Masterson, J. F. (1988). *The search for the real self*. New York: The Free Press.

Matthews, A.K., Hughes, T.L., Johnson, T.J., Razzano, L.A. & Cassidy, R. (2002, July). Prediction of depressive distress in a community sample of women: The role of sexual orientation. *American Journal of Public Health, 92*(7), 1131-1139.

Mattingly, D. (2005, February). My path to lesbianism. *Christianity Today, 49*(2), 62-65.

Mayerson, P. & Lief, H.I. (1965). Psychotherapy of homosexuals: A follow-up study of nineteen cases. In J. Marmor (Ed.), *Sexual inversion: The multiple roots of homosexuality* (pp. 302-344). New York: Basic Books.

McCandlish, B.M. (1982). Therapeutic issues with lesbian couples. In J.C. Gonsiorek (Ed.), *Homosexuality & psychotherapy: A practitioner's handbook of affirmative models* (pp. 71-78.) New York: The Haworth Press.

McCarty, W. A. (n.d.). *What babies teach us: Supporting the integrated self from the beginning.* Retrieved August 22, 2005, from the Wondrous Beginnings website: http://www.wondrousbeginnings.com/html/resources.html.

McDougall, J. (1970). Homosexuality in women. In Chasseguet-Smirgel (Ed.), *Female sexuality: New psychoanalytic views* (pp. 171-212). Ann Arbor, MI: University of Michigan Press.

McDougall, J. (1980). *Plea for a measure of abnormality*. New York, NY: International Universities Press, Inc.

McDougall, J. (1989). The dead father: On early psychic trauma and its relation to disturbance in sexual identity and in creative activity. *International Journal of Psycho-Analysis, 70*, 205-219.

McFadden, D. & Pasanen, E.G. (1998). Comparison of the auditory systems of heterosexuals and homosexuals: Click-evoked otoacoustic emissions. *Proceedings of the National Academy of Sciences of the United States of America, 95*(5), 2709-2713.

McGinnis, A. L. (2004). *The Friendship Factor.* (25th anniv. ed.) Minneapolis: Augsburg Fortress.

McHugh, P.H. (1992). Psychiatric misadventures. *The American Scholar, 61*(4), 497-510.

McIntyre, V. J. (1999). *Sheep in wolves' clothing*. Grand Rapids, MI: Baker Books.

McWilliams, N. (1994). *Psychoanalytic diagnosis*. New York: Guildford Press.

Mellody, P., Miller, A.W. & Miller, J.K. (2003). *Facing love addiction.* San Francisco: HarperCollins Publishers.

Menasche, A.E. (1998). *Leaving the life: Lesbians, ex-lesbians and the heterosexual imperative.* London: Onlywomen Press, Limited.

Mesmer, R. (1992). Homosexuals who change lifestyles. *The Journal of Christian Healing, 14*(1)*,* 12-17.

Meyer-Bahlburg, H. F. L. (1994). Intersexuality and the diagnosis of gender identity disorder. *Archives of Sexual Behavior, 23*, 21-40.

Meyer-Bahlburg, H.F.L. (1984). Psychoendocrine research on sexual orientation: Current status and future options. *Progressive Brain Research, 61,* 375-398.

Meyer-Bahlburg, H.F.L., Ehrhardt, A.A., Rosen, L.R., Gruen, R.S., Veridiano, N.P., Vann, F H., et al. (1995). Prenatal estrogens and the development of homosexual orientation. *Developmental Psychology, 31*(1), 12-21.

Michael, R.T., Gagnon, J.H., Laumann, E.O. & Kolata, G. (1994). *Sex in America: A definitive survey*. New York: Warner Books.

Miller, A. (1981). *The drama of the gifted child*. New York: Basic Books.

Miller, D.H., Greene, K., Causby, V., White, B.W. & Lockhart, L.L. (2001). Domestic violence in lesbian relationships. In E. Kaschak (Ed.), *Intimate betrayal: Domestic violence in lesbian relationships* (pp. 107-127). New York: The Haworth Press.

Miller, J. B. (1976). *Toward a new psychology of women*. Boston: Beacon.

Miller, J.B. (1991). The development of women's sense of self. In Jordan, J., Kaplan, A., Miller, J., Stiver, I. & Surrey, J. (Eds.) *Women's growth in connection* (pp. 11-26). New York: The Guilford Press.

Millon, T. & Davis, R.D. (Eds.). (1996). *Disorders of personality: DSM-IV and beyond* (2nd ed.). New York: John Wiley and Sons, Inc.

Millon, T., Millon, C., Davis, R., & Grossman, S. (1994). *Millon clinical multiaxial inventory-III* (MCMI-III™). Minneapolis: Diacandrien. Available from Pearson Assessments, 1-800-268-6011.

Miville, M. L., & Ferguson, A. D. (2004). *Impossible "choices": Identity and values at a crossroads. The Counseling Psychologist, 32*(5), 760-70.

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

Moberly, E. (1983). *Homosexuality: A new Christian ethic*. Greenwood, SC: The Attic Press.

Money, J. (1975). Ablatio penis: Normal male infant sex-reassigned as a girl. *Archives of Sexual Behavior, 4*(1), 65-71.

Money, J., Hampson, J.G., & Hampson, J.L. (1957). Imprinting and the establishment of gender role. *Archives of Neurology and Psychiatry, 77*, 333-336.

Money, J., Schwartz, M. & Lewis, V.G. (1984). Adult erotosexual status and fetal hormonal masculinization and demasculinization: 46, XX congenital virilizing adrenal hyperplasia and 46, XY androgen-insensitivity syndrome compared. *Psychoneuroendocrinology, 9*(4), 405-414.

Morris, A. (2006, February 6). The cuddle puddle of Stuyvesant high school. Retrieved October 22, 2007, from the New York magazine website: http://www.nymag.com/news/features/15589.

Mulaikal, R.M., Migeon, C.J. & Rock, J.A. (1987). Fertility rates in female patients with congenital adrenal hyperplasia due to 21-hydroxylase deficiency. *The New England Journal of Medicine, 316*(4), 178-182.

Mullins, H. (1995). Evolution of a tomboy. In L. Yamaguchi & K. Barber (Eds.), *Tomboys: Tales of dyke derring-do* (pp. 40-49). Los Angeles: Alyson Publications, Inc.

Munzer, J. (1965). The treatment of the homosexual in group psychotherapy. *Topical Problems in Psychotherapy,* 5, 164-169.

Nichols, M. (1982). The treatment of inhibited sexual desire (ISD) in lesbian couples. *Women & Therapy, 1*(4), 49-66.

Nichols, M. (1987). Lesbian sexuality: Issues and developing theory. In Boston Lesbian Psychologies Collective (Eds.), *Lesbian psychologies* (pp. 97-123). Chicago: University of Illinois Press.

Nichols, M. (1988a). Bisexuality in women: Myths, realities and implications for therapy. *Women and Therapy, 7,* 235-252.

Nichols, M. (1988b). Bisexuality in women: Myths, realities and implications for therapy. *Women and Therapy, 7,* 235-252.

Nichols, M. (1990). Lesbian relationships: Implications for the study of sexuality and gender. In D.P. McWhirter, S.A. Sanders & J.M. Reinisch (Eds.), *Homosexuality/heterosexuality: Concepts of sexual orientation* (pp. 350-364). New York: Oxford University Press.

Nicolosi, J. (1993). *Healing homosexuality*. Northvale, NJ: Jason Aronson, Inc.

Nicolosi, J., Byrd, A., & Potts, R. (2000a). Beliefs and practices of therapists who practice sexual reorientation psychotherapy. *Psychological Reports, 86,* 689-702.

Nicolosi, J., Byrd, A., & Potts, R. (2000b). Retrospective self-reports of changes in sexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports, 86*, 1071-1088.

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

Nouwen, H. (1975). *Reaching Out*. New York: Doubleday.

Oberstone, A.K. & Sukoneck, H. (1976). Psychological adjustment and life style of single lesbians and single heterosexual women. *Psychology of Women Quarterly, 1*(2), 172-188.

Ogilvie, B. (2004). *Mother-daughter incest: A guide for helping professionals*. New York: The Haworth Maltreatment and Trauma Press.

Ohlson, E.L. & Wilson, M. (1974). Differentiating female homosexuals from female heterosexuals by use of the MMPI. *The Journal of Sex Research*, *10*(4)*,* 308-315.

Olesker, W. (1995). Unconscious fantasy and compromise formation in a case of adolescent female homosexuality. *Journal of Clinical Psychoanalysis, 4*(3), 361-382.

Orcutt, C. (1995). The influence of early trauma on the developing self. In J. Masterson & R. Klein (Eds.), *Disorders of the self* (pp. 194-97). New York: Brunner/Mazel.

Paris, J., Zweig-Frank, H., & Guzder, J. (1995). Psychological factors associated with homosexuality in males with borderline personality disorder. *Journal of Personality Disorders, 9*(1), 56-61.

Pattatucci, A. (1998). Biopsychosocial interactions and the development of sexual orientation. In C. Patterson & A. D'Augelli (Eds.), *Lesbian, gay and bisexual identities in families: Psychological perspectives* (pp. 19-39). New York: Oxford University Press.

Pattatucci, A.M.L. & Hamer, D.H. (1995). Development and familiality of sexual orientation in females. *Behavior Genetics, 25*(5), 407-420.

Paulk, A. (2003). *Restoring sexual identity*. Eugene, OR: Harvest House Publishers.

Payne, L. (1981). *The broken image*. Grand Rapids, MI: Baker Books.

Payne, L. (1991). *Restoring the Christian soul*. Wheaton, IL: Crossway Books.

Payne, L. (1996). *The broken image*. Grand Rapids, MI: BakerBooks.

Payne, L. (1984). *The healing of the homosexual*. Westchester, IL: Crossway Books.

Pearlman, S. (1989). Distancing and connectedness: Impact on couple formation in lesbian relationships. In E. D. Rothblum & E. Cole (Eds.), *Loving boldly: Issues facing lesbians* (pp. 77-88). New York: Harrington Park Press.

Peters, D.K. & Cantrell, P.J. (1991). Factors distinguishing samples of lesbian and heterosexual women. *Journal of Homosexuality, 21*(4), 1-15.

Phillips, G., Psych, M., & Over, R. (1995). Differences between heterosexual, bisexual and lesbian women in recalled childhood experiences. *Archives of Sexual Behavior, 24*(1), 1-20.

Pipher, M. (1994). *Reviving Ophelia: Saving the selves of adolescent girls*. New York: Ballantine.

Ponticelli, C. (1999). Crafting stories of sexual identity reconstruction. *Social Psychology Quarterly, 62*(2), 157-72.

Poole, K. (1972). The etiology of gender identity and the lesbian. *The Journal of Social Psychology, 87,* 51-57.

Popenoe, D. (1996). *Life without father: Compelling new evidence that fatherhood and marriage are indispensable for the good of children and society.* New York: The Free Press.

Post, R. D. (1982). Dependency conflicts in high-achieving women: Toward an integration. *Psychotherapy: Theory, Research & Practice, 19*(1), 82-87.

Powlishta, K., Sen, M., Serbin, L., Poulin-Dubois, D. & Eichstedt, J. (2001). From infancy through middle childhood: The role of cognitive and social factors in becoming gendered. In R.K.Unger (Ed.), *Handbook of the psychology of women and gender* (pp. 116-132). New York: John Wiley and Sons, Inc.

Prescott, J.W., LaFortune, M., Levy, J., & Wallace, D. (1980). Affectional deprivation in childhood and adolescence in the United States and Quebec, Canada: A cross-cultural study

of sexual alienation and violence. In R. Forleo & W. Pasini (Eds.), *Medical sexology: The third international congress* (pp. 169-181). Littleton, MA: PSG Publishing Company.

Price, D. A. (1996). Inner child work: What is really happening? *Dissociation, 9*(1), 68-73.

Quinodoz, J.M. (1989). Female homosexual patients in psychoanalysis. *International Journal of Psychoanalysis, 70*, 55-63.

Rand, M.L. (1996). As it was in the beginning: The significance of infant bonding in the development of self and relationships [Electronic version]. Reprinted from *Journal of Child Care and Youth Care, 10*(4), 1-8. Retrieved September 22, 2005 from, the Association for Pre- & Perinatal Psychology and Health website: http://www.birthpsychology.com/birthscene/ppic2.html#asitwas

Razzano, L.A., Matthews, A. & Hughes, T.L. (2002). Utilization of mental health services: A comparison of lesbian and heterosexual women. *Journal of Gay & Lesbian Services, 14*(1), 51-66.

Rentzel, L.T. (1990). *Emotional dependency.* Downers Grove, IL: InterVarsity Press.

Renzetti, C.M. (1992). *Violent betrayal: Partner abuse in lesbian relationships.* London: Sage Publications.

Renzetti, C.M. (1988). Violence in lesbian relationships: A preliminary analysis of causal factors. *Journal of Interpersonal Violence, 3*(4), 381-399.

Ridge, S. R., & Feeney, J. A. (1998). Relationship history and relationship attitudes in gay males and lesbians: Attachment style and gender differences. *Australian and New Zealand Journal of Psychiatry, 32*, 848-59.

Risman, B., & Schwartz, P. (1988). Sociological research on male and female homosexuality. *Annual Review Sociology, 14*, 125-47.

Rivera, M. (1996). Treating the lesbian and gay survivor of abuse. In M. Rivera (Ed.), *More alike than different: Treating severely dissociative trauma survivors* (pp. 190-208). Toronto: University of Toronto Press.

Rivera, M. (2002). Informed and supportive treatment for lesbian, gay, bisexual and transgendered trauma survivors. In J.A. Chu & E.S. Bowman (Eds.) *Trauma and Sexuality: The effects of childhood sexual, physical, and emotional abuse on sexual identity and behavior* (pp. 33-58). Binghamton, NY: The Haworth Medical Press.

Roberts S.J. & Sorensen, L. (1999). Prevalence of childhood sexual abuse and related sequelae in a lesbian population. *Journal of the Gay and Lesbian Medical Association, 3*(1), 11-19.

Rogers, C., Roback, H., McKee, E. & Calhoun, D. (1976). Group psychotherapy with homosexuals: A review. *International Journal of Group Psychotherapy, 26*(1), 3-27.

Romm, M. (1965). Sexuality and homosexuality in women. In J. Marmor (Ed.), *Sexual inversion: The multiple roots of homosexuality* (pp. 282-301). New York: Basic Books.

Rosik, C. H. (2003). Motivational, ethical, and epistemological foundations in the treatment of unwanted homoerotic attraction. *Journal of Marital and Family Therapy, 29*(1), 13-28.

Ross, C. (2002). Sexual orientation conflict in the dissociative disorders. In J.A. Chu & E.S. Bowman (Eds.), *Trauma and sexuality* (pp. 137-146). New York: The Haworth Press, Inc.

Ross, C. (2000). *The trauma model: A solution to the problem of comorbidity in psychiatry.* Richardson, TX: Manitou Communications, Inc.

Ross, C. A., & Durkin, V. (2005). Childhood trauma, dissociation and alcohol/other drug abuse among lesbian women. *Alcohol Treatment Quarterly, 23*(1), 99-105.

Rossi, A.S. (1987). Parenthood in transition: From lineage to child to self-orientation. In J.B. Lancaster, J. Altman, A.S. Rossi, & L.R. Sherrod (Eds.), *Parenting across the life span: Biosocial dimensions* (pp. 31-81). New York: Aldene de Gruyter.

Roth, S. (1984). Psychotherapy with lesbian couples: The interrelationships of individual issues, female socialization, and the social context. In E.S. Hetrick & T.S. Stein (Eds.), *Innovations in psychotherapy with homosexuals* (pp. 90-114). Washington, D.C.: American Psychiatric Press.

Rothblum, E.D., Balsam, K.F. & Mickey, R.M. (2004). Brothers and sisters of lesbians, gay men, and bisexuals as a demographic comparison group: An innovative research methodology to examine social change. *The Journal of Applied Behavioral Science, 40*(3), 283-301.

Rothblum, E.D. & Factor, R. (2001). Lesbians and their sisters as a control group: Demographic and mental health factors. *Psychological Science, 12*(1), 63-69.

Saghir, M.T. & Robins, E. (1969). Homosexuality: I. Sexual behavior of the female homosexual. *Archives of General Psychiatry, 20*, 192-201.

Saghir, M. T., & Robins, E. (1971). Male and female homosexuality: Natural history. *Comprehensive Psychiatry, 12*(6), 503-10.

Saghir, M.T. & Robins, E. (1973). *Male and female homosexuality: A comprehensive investigation*. Baltimore, MD: Williams & Wilkins.

Saghir, M.T. & Robins, E. (1971). Male and female homosexuality: Natural history. *Comprehensive Psychiatry, 12*(6), 503-510.

Saghir, M.T., Robins, E., Walbran, B. & Gentry, K. (1970). Homosexuality: IV. Psychiatric disorders and disability in the female homosexual. *American Journal of Psychiatry, 127*(2), 65-72.

Sandfort, T.G.M., de Graaf, R., Bijl, R.V. & Schnabel, P. (2001). Same-sex sexual behavior and psychiatric disorders: Findings from the Netherlands mental health survey and incidence study (NEMESIS). *Archives of General Psychiatry, 58*(1), 85-91.

Saphira, M. & Glover, M. (2000). New Zealand national lesbian health survey. *Journal of the Gay and Lesbian Medical Association, 4*(2), 49-56.

Satinover, J. (1996a). *Homosexuality and the politics of truth*. Grand Rapids, MI: Baker Books.

Satinover, J. (1996b). *Homosexuality and the politics of truth*. Grand Rapids, MI: Baker Books.

Schaeffer, K. W., Hyde, R. A., Kroencke, T., McCormick, B., & Nottebaum, L. (2000). Religiously-motivated sexual orientation change. *Journal of Psychology and Christianity, 19*(1), 61-70.

Schaeffer, K. W., Nottebaum, L., Smith, P., Dech, K., & Krawczyk, J. (1999). Religiously-motivated sexual orientation change: A follow-up study. *Journal of Psychology and Theology, 27*(4), 329-37.

Schaffner, B. (2003). Questioning some traditional "rules" in psychotherapy. In J. Drescher, A. D'Ercole, & E. Schoenberg (Eds.), *Psychotherapy with gay men and lesbians: Contemporary dynamic approaches* (pp. 237-248). New York: Harrington Park Press.

Schecter, E. (2004). Women-loving-women loving men: Sexual fluidity and sexual identity in midlife lesbians. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 64*(12B), 6341.

Schneider, M.S. (1986). The relationships of cohabiting lesbian and heterosexual couples: A comparison. *Psychology of Women Quarterly, 10*, 234-239.

Schneider, M.S., Brown, L.S. & Glassgold, J.M. (2002). Implementing the resolution on appropriate therapeutic responses to sexual orientation: A guide for the perplexed. *Professional Psychology: Research and Practice, 33*(3), 265-276.

Schneider, J.A., O'Leary, A. & Jenkins, S.R. (1995). Gender, sexual orientation, and disordered eating. *Psychology and Health, 10*, 113-128.

Schore, A. N. (1994). *Affect regulation and the origin of the self.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Schore, A. N. (2002). The neurobiology of attachment and early personality organization. *Journal of Prenatal and Perinatal Psychology and Health, 16*(3), 249-63. Retrieved October 22, 2007, from the Association for Prenatal & Perinatal Psychology and Health website: http://www.birthpsychology.com/birthscene/ppic2.html.

Schwartz, M.F. & Southern, S. (1999). Manifestations of damaged development of the human affectional systems and developmentally based psychotherapies. *Sexual Addiction & Compulsivity, 6,* 163-175.

Shapiro, J.L. (1994, June). Letting dads be dads. *Parents*, 165, 168.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd ed.). New York: Guilford Press.

Sheehy, S. (2000). *Connecting: The enduring power of female friendship.* New York: William Morrow.

Shidlo, A. & Schroeder, M. (2002). Changing sexual orientation: A consumers' report. *Professional Psychology: Research and Practice, 33*(3), 249-259.

Siegel, D. J. (1999a, November). Relationships and the developing mind. *Child Care Information Exchange, 130,* 48-51.

Siegel, D. (1999b). *The developing mind.* New York: The Guilford Press.

Siegel, E. (1988). *Female homosexuality: Choice without volition*. Hillsdale, NJ: The Analytic Press.

Siegelman, M. (1972). Adjustment of homosexual and heterosexual women. *British Journal of Psychiatry, 120*, 477-481.

Siever, M.D. (1994). Sexual orientation and gender as factors in socioculturally acquired vulnerability to body dissatisfaction and eating disorders. *Journal of Consulting and Clinical Psychology, 62*(2), 252-260.

Silverstein, B. & Lynch, A.D. (1998). Gender differences in depression: The role played by paternal attitudes of male superiority and maternal modeling of gender-related limitations. *Sex Roles: A Journal of Research*. Retrieved February 11, 2002, from http: www.findarticles.com/cf_dls/m2294/n7-8_v38/20914077/print.jhtml

Silverstein, B., Perlick, D., Clauson, J. & McKoy, E. (1993). Depression combined with somatic symptomatology among adolescent females who report concerns regarding maternal achievement. *Sex Roles, 28*(11/12), 637-653.

Skegg, K., Nada-Raja, S., Dickson, N., Paul, C., Williams, S. (2003). Sexual orientation and self harm in men and women. *American Journal of Psychiatry, 160*, 541-546.

Smalley, S. (1987). Dependency issues in lesbian relationships. *Journal of Homosexuality, 14*(1/2), 125-135.

Socarides, C. W. (1963). The historical development of theoretical and clinical concepts of overt female homosexuality. *Journal of the American Psychoanalytic Association, 11*(2), 386-414.

Socarides, C.W. (1968). *The overt homosexual.* New York: Grune & Stratton.

Socarides, C.W. (1978). *Homosexuality*. New York: Jason Aronson.

Socarides, C. W. (2002). The female homosexual: Causative process and clinical picture. In C. W. Socarides & A. Freedman (Eds.), *Objects of desire: The sexual deviations* (pp. 145-64). International Universities Press.

Solomon, A. (2001). *The noonday demon*. New York: Simon & Schuster.

Solomon, S. E., Rothblum, E. D., & Balsam, K. F. (2004). Pioneers in partnership: Lesbian and gay male couples in civil unions compared with those not in civil unions and married heterosexual siblings. *Journal of Family Psychology, 18*(2), 275-86.

Sophie, J. (1986). A critical examination of stage theories of lesbian identity development. *Journal of Homosexuality, 12*(2), 39-51.

Spitzer, R. (2001, May 23). Commentary: Psychiatry and homosexuality. *Wall Street Journal*.

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

Stein, E. (1999). *The mismeasure of desire: The science, theory, and ethics of sexual orientation*. New York: Oxford University Press.

Stepp, L. (2004, January 4). Partway gay? For some teen girls, sexual preference is a shifting concept. *Washington Post,* p. D1.

Stern, K. (1965). *The flight from woman*. New York: Paragon House.

Stevens, P.E. (1992). Lesbian health care research: A review of the literature from 1970 to 1990. *Health Care for Women International*, *13*, 91-120.

Stone, W.N., Schengber, J. & Seifried, F.S. (1966). The treatment of a homosexual woman in a mixed group. *International Journal of Group Psychotherapy*, *16*, 425-433.

Striegel-Moore, R.H., Tucker, N., & Hsu, J. (1990). Body image dissatisfaction and disordered eating in lesbian college students. *International Journal of Eating Disorders, 9*(5), 493-500.

Surrey, J.L. (1991a). The relational self in women: Clinical implications. In J.V. Jordan, A.G. Kaplan, J.B. Miller, I.P. Stiver & J.L. Surrey (Eds.), *Women's growth in connection* (pp. 35-43). New York: The Guilford Press.

Surrey, J. L. (1991b). The self-in-relation: A theory of women's development. In J. V. Jordan, A. G. Kaplan, J. B. Miller, I. P. Stiver & J. L. Surrey (Eds.), *Women's growth in connection* (pp. 51-66). New York: Guilford Press.

Swanson, Loomis, Lukesh, Cronin & Smith (1972). Clinical features of the female homosexual patient. *The Journal of Nervous and Mental Disease, 155*(2), 119-124.

Tannen, D. (1990). *You just don't understand*. New York: Ballantine Books.

Taylor, S.E., Klein, L.C., Lewis, B.P., Gruenewald, T.L., Gurung, R.A.R. & Updegraff, J.A. (2000). Biobehavioral responses to stress in females: Tend-and-befriend, not fight-or-flight. *Psychological Review, 107*(3), 411-429.

Thomson, P. (2004). The impact of trauma on the embryo and fetus: An application of the diathesis-stress model and the neurovulnerability-neurotoxicity model. *Journal of Prenatal and Perinatal Psychology and Health, 19*(1), 9-63.

Thompson, N.L., McCandless, B.R., & Strickland, B.R. (1971). Personal adjustment of male and female homosexuals and heterosexuals. *Journal of Abnormal Psychology, 78*(2), 237-240.

Thompson, N.L. Schwartz, D.M., McCandless, B.R. & Edwards, D.A. (1973). Parent-child relationships and sexual identity in male and female homosexuals and heterosexuals. *Journal of Consulting and Clinical Psychology, 41*(1), 120-127.

Throckmorton, W. (2002). Initial empirical and clinical findings concerning the change process for ex-gays. *Professional Psychology: Research and Practice, 33*(3), 242-48.

Throckmorton, W., & Welton, G. (2005). Counseling practices as they relate to ratings of helpfulness by consumers of sexual reorientation therapy. *Journal of Psychology and Christianity, 24*(4), 332-42.

Throckmorton, W., & Yarhouse, M. (2006) *Sexual identity therapy: Practice guidelines for managing sexual identity conflicts.* Unpublished manuscript. Retrieved October 22, 2007, from the Institute for the Study of Sexual Identity website: www.sexualidentityinstitute.org/documents/sexualidentitytherapyframework0506_000.pdf.

Tigert, L.M. (2001). The power of shame: Lesbian battering as a manifestation of homophobia. In E. Kaschak (Ed.), *Intimate betrayal: Domestic violence in lesbian relationships* (pp. 73-85). New York: The Haworth Press.

Tjaden, P., Thoennes, N., & Allison, C.J. (1999). Comparing violence over the life span in samples of same-sex and opposite-sex cohabitants. *Violence and Victims, 14*(4), 413-425.

Tomeo, M.E., Templer, D.I., Anderson, S. & Kotler, D. (2001). Comparative data of childhood and adolescence molestation in heterosexual and homosexual persons. *Archives of Sexual behavior, 30*(5), 535-541.

Toufexis, A. (1995, November 13) New evidence of a "gay gene." *Time*. Retrieved October 22, 2007, from http://www.time.com/time/magazine/article/0,9171,983713,00.html.

Tower, C.C. (1988). *Secret scars: A guide for survivors of child sexual abuse*. New York: Viking Penguin Inc.

Tozer, E.E. & McClanahan, M.K. (1999). Treating the purple menace: Ethical considerations of conversion therapy and affirmative alternatives. *The Counseling Psychologist, 27*(5), 722-742.

Tronick, E.Z. (1989, February). Emotions and emotional communication in infants. *American Psychologist, 44(*2), 112-119.

van den Aardweg, G. (1985). *Homosexuality & hope*. Ann Arbor, MI: Servant Books.

van den Aardweg, G. (1997). *The battle for normality: A guide for (self-) therapy for homosexuality.* San Francisco: Ignatius Press.

Van Wyk, P. H., & Geist, C. S. (1984). Psychosocial development of heterosexual, bisexual and homosexual behavior. *Archives of Sexual Behavior, 13*(6), 505-544.

Vogelmann-Sine, S. (1998). Healing hidden pain: Resolving the effects of childhood abuse and neglect. In P. Manfield (Ed.), *Extending EMDR* (pp. 167-190). New York: W.W. Norton & Company.

Vogeltanz, N.D., Wilsnack, S.C., Harris, T.R., Wilsnack, R.W., Wonderlich, S.A., & Kristjanson, A.F. (1999). Prevalence and risk factors for childhood sexual abuse in women: National survey findings. *Child Abuse & Neglect, 23*(6), 579-592.

Wakerman, E. (1984). *Father loss*. New York: Henry Holt.

Walant, K.B. (1995). *Creating the capacity for attachment.* Northvale, NJ: Jason Aronson, Inc.

Ward, A.J. (1991). Prenatal stress and childhood psychopathology. *Child Psychiatry and Human Development, 22*(2), 97-110.

Warner, J., McKeown, E., Griffin, M., Johnson, K., Ramsay, A., Cort, C. & King, M. (2004). Rates and predictors of mental illness in gay men, lesbians and bisexual men and women. *British Journal of Psychiatry, 185*, 479-485.

Webb, W. J. (2001). Slaves, women & homosexuals: Exploring the hermeneutics of cultural analysis. Downers Grove, IL: InterVarsity Press.

Weinraub, M., Clemens, L. P., Sockloff, A., Ethridge, T., Gracely, E., & Myers, B. (1984). The development of sex role stereotypes in the third year: Relationships to gender labeling, gender identity, sex-typed toy preference and family characteristics. *Child Development, 55*, 1493-1503.

Weinrich, J. D. (1978). Nonreproduction, homosexuality, transsexualism and intelligence: I. A systematic literature search. *Journal of Homosexuality, 3*(8), 275-89.

Welch, S., Collings, S. & Howden-Chapman, P. (2000). Lesbians in New Zealand: their mental health and satisfaction with mental health services. *Australian and New Zealand Journal of Psychiatry*, 34, 256-263.

Wells, G. B. (2003). Lesbians in psychotherapy: Relationship of shame and attachment style. *Journal of Psychology & Human Sexuality, 15*(2/3), 101-16.

Wells, G. B., & Hansen, N. D. (2003). Lesbian shame: Its relationship to identity integration and attachment. *Journal of Homosexuality, 45*(1), 93-110.

Whitam, F., Diamond, M. & Martin, J. (1993). Homosexual orientation in twins: A report on 61 pairs and three triplet sets. *Archives of Sexual Behavior*, *22*, 187-206.

Whitehead, B.K. (1996). Lesbianism: Causality and compassion. *Journal of Psychology and Christianity, 15*(4), 348-363.

Whitehead, B.K. (2003). *Craving for love*. Grand Rapids, MI: Monarch.

Whitehead, N.E. & Whitehead, B.K. (1999). *My genes made me do it!* Lafayette, LA: Huntington House Publishers.

Whitfield, C.L. (1987). *Healing the child within*. Deerfield Beach, FL: Health Communications, Inc.

Wilbur, C.B. (1965). Clinical aspects of female homosexuality. In J. Marmor (Ed.), *Sexual inversion: The multiple roots of homosexuality* (pp. 268-281). New York: Basic Books, Inc.

Williams, K., Goodman, M., & Green, R. (1985). Parent-child factors in gender role socialization in girls. *Journal of the American Academy of Child Psychiatry, 26*(6)*,* 720-31.

Williams, K., Green, R., & Goodman, M. (1979). Patterns of sexual identity development: A preliminary report on the "tomboy." *Research in Community and Mental Health*, 1, 103-123.

Williams, T.J., Pepitone, M.E., Christensen, S.E., Cooke, B.M., Huberman, A.D., Breedlove, N.J. et al. (2000). Finger-length ratios and sexual orientation: Measuring people's finger patterns may reveal some surprising information. *Nature, 404,* 455-456.

Winnicott, D.W. (1965). *The maturational processes and the facilitating environmentt.* New York: International Universities Press, Inc.

Wise, L.A., Zierler, S., Krieger, N. & Harlow, B.L. (2001, September 15). Adult onset of major depressive disorder in relation to early life violent victimisation: A case-control study. *The Lancet, 358*, 881-887.

Yalom, I.D. (2002). *The gift of therapy*. New York: HarperCollins.

Yamaguchi, L. & Barber, K. (Eds.). (1995). *Tomboys: Tales of dyke derring-do.* Los Angeles: Alyson Publications.

Yarhouse, M.A. (1998). When clients seek treatment for same-sex attraction: Ethical issues in the “right to choose” debate. *Psychotherapy, 35*, 248-259.

Yarhouse, M. A. (2001). *Expanding alternatives to same-sex attraction and behavior: Clinical modules for informed consent, assessment and intervention*. Self-published manuscript. Retrieved October 22, 2007, from the Institute for the Study of Sexual Identity website: http://www.sexualidentityinstitute.org/resources.php. **[I do not see this at the website.]**

Yarhouse, M. A., Brooke, H. L., Pisano, P., & Tan, E. S. N. (2005). Project inner compass: Young adults experiencing sexual identity confusion. *Journal of Psychology & Christianity, 24*(4), 352-60.

Yarhouse, M. A., & Burkett, L. A. (2003). *Sexual Identity: A guide to living in the time between the times.* Lanham, MD: University Press of America.

Yarhouse, M. A., Tan, E. S. N., & Pawlowski, L. M. (2005). Sexual identity development and synthesis among LGB-identified and LGB dis-identified persons. *Journal of Psychology and Theology, 33*(1), 3-16.

Yarhouse, M.A. & Throckmorton, W. (2002). Ethical issues in attempts to ban reorientation therapies. *Psychotherapy: Theory, Research, Practice, Training, 39*(1), 66-75.

Yogman, M.W. (1982). Development of the father-infant relationship. In H.E. Fitzgerald, B.M. Lester, & M.W. Yogman (Eds.), *Theory and research in behavioral pediatrics*. New York: Plenum Press.

Zubenko, G. S., George, A. W., Soloff, P. H., & Schulz, P. (1987, June). Sexual practices among patients with borderline personality disorder. *American Journal of Psychiatry, 144*(6), 748-52.

Zucker, K.J. & Bradley, S. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: The Guilford Press.

Zucker, K. J. (2001). Biological Influences on Psychosexual Differentation. In R. Unger (Ed.), *Handbook of the Psychology of Women and Gender* (pp. 101-115). Hoboken, NJ: John Wiley & Sons, Inc.

Zur, Ofer (2007). *Boundaries in psychotherapy: ethical and clinical explorations.* Washington, DC: American Psychological Association.