

Sin and Sexuality: Psychobiology and the Development of Homosexuality

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IN THE FALL OF 1970, I was a young psychiatrist with five years of clinical experience in private practice. I had been certified by the American Board of Psychiatry and Neurology, and I felt that I grasped the basic and latest theories concerning the cause and cure of homosexuality and other so-called sexual deviations. I had been asked to participate in examining this provocative subject in a televised panel discussion on the local public television station, KUED. In preparation, I reviewed various texts on the subject, which almost universally presented the prevailing thesis: Homosexuality is a learned behavior, an illness to be treated and corrected, and can with proper therapy be cured in over 25 percent of cases. Homosexuals have failed, psychoanalytically speaking, to successfully traverse the pitfalls of psychosexual development as outlined by Sigmund Freud. To be sure, scattered reports in the literature suggested a genetic or hormonal basis for the disorder but did not convince the majority of clinicians, including myself. That panel of 1970 certainly understood, even if they did not openly discuss, that homosexuality was, and still is, considered a major sexual sin by my church, culture, and the entire Judeo-Christian tradition stretching back more than two thousand years.

After presenting my views and reviewing current literature on the subject, I felt satisfied, confident, and correct. There was no serious debate on the issue, and I returned home to the congratulations of my wife, friends, and colleagues. Sixteen years later, I can state that what I presented was wrong and simplistic. The evolving change in my views came by examining new research, gaining more clinical experience, and looking for alternate explanations to clarify some of the mystery surrounding the development of human sexuality and specifically homosexuality. Understanding these issues has enormous implications for our

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perception of sin and moral responsibility. No one should ignore the dilemma, for perhaps one in ten of all men and a smaller percentage of women are not heterosexual.

No consensus exists regarding the causes of homosexuality. As with virtually all other aspects of human behavior, we see a spectrum of opinions, theories, and conjecture. Different scientific disciplines advocate different points of view and bias and ignore important contributions from other disciplines. Behaviorists, biologists, sociologists, anthropologists, geneticists, historians, lawyers, and political scientists have all offered explanations. Judd Marmor, a highly respected psychiatrist, psychoanalyst, and authority on homosexuality, has observed:

The most influential theory in modern psychiatry has been that of Sigmund Freud, who believed that homosexuality was the expression of a universal trend in all human beings, stemming from a biologically rooted bisexual predisposition. Freud, in line with the strong Darwinian influence on his thinking, believed that all human beings went through an inevitable "homoerotic" phase in the process of achieving heterosexuality. Certain kinds of life experience could arrest the evolutionary process, and the individual would then remain "fixated" at a homosexual level. Furthermore, even if the development were to proceed normally, certain vestiges of homosexuality would remain as permanent aspects of the personality, and these universal "latent homosexual" tendencies would be reflected in "sublimated" expressions of friendship for members of one's own sex and in patterns in behavior or interest more appropriate to the opposite sex — for example, artistic or culinary interests or "passive" attitudes in males and athletic or professional interests or "aggressive" attitudes in females (Marmor 1965, p. 2).

Now, almost fifty years after his death, many continue to advocate Freud's controversial theories; but I suspect that he would be the first to revise those theories, given new information on human sexuality.

My own thinking on this subject has been influenced by a major shift in psychiatry's "nature-versus-nurture" debate of the past two decades. Behaviors once thought to be entirely psychological in origin have been demonstrated to be profoundly influenced by genes and neurochemistry. Disorders such as schizophrenia, manic-depression, panic attacks, and debilitating anxiety have now been shown to have strong biological causes and can no longer be adequately explained by the theoretical models of intrapsychic conflict, poor parenting, and social learning defects. A prominent psychoanalyst discussing the relationship between neurobiology and psychoanalysis, including research in sexuality, recently warned, "We should be extremely uncomfortable with any theory that is incongruent with neurobiologic discovery" (Cooper 1985, p. 1402).

THE COMPLEXITIES OF HUMAN SEXUALITY

Few subjects arouse, confuse, intrigue, and provoke like the study of human sexuality. The search for understanding extends from the book of Genesis to Freud, Masters and Johnson, and Desmond Morris's *The Naked Ape*. The music of sexuality plays from infancy to senescence, waxing and waning, reaching moments of intensity and long periods of plateau. Sexuality binds and

splits relationships, confuses and enlightens, produces profound ecstasy and unbearable guilt.

Only in the twentieth century, using the scientific method, have we been able to study sexuality with sophisticated neurobiological, anatomical, and hormonal research. Much folklore surrounds this subject, and we are in the process of trying to separate fact from fiction. The brain is the ultimate sexual organ, and everything else flows from it. A complex interplay among the neocortex (cerebrum), the limbic system and hypothalamus, and the brain stem contributes to the sexual experience. Hormones, especially testosterone, fuel this interaction in both males and females (Hales 1984).

EMBRYOLOGY (EFFECTS OF NATURE)

Sexual differentiation begins when by chance a sperm meets an egg and initiates a chain of events that ultimately produces a sexually oriented male or female. To understand human sexuality, one must understand embryology, the science of intrauterine development of the fetus. John Money, founder of the Johns Hopkins Psychohormonal Research Unit, says that the basic embryonic plan, at least for mammals, is inherently female — the “Eve principle,” as he calls it (Money 1984). In embryo, we all start out female, then a little more than one-half of us respond to the Adam principle as the result of the Y chromosome, which acts on undifferentiated fetal gonads to create testes. Thereafter, the change to male is controlled by male hormones, the androgens. Nature seems to have more difficulty creating male sexual identity and anatomy, which helps explain why many more males than females experience sexual variations (Morano 1979). Testosterone makes the brain less feminine and more masculine. Animal studies have demonstrated that “depending on the amount of testosterone present in the environment, we can produce effeminate males, fully capable of male sexual function but with female behavioral traits, or we can produce demasculinized males, incapable of male sexual behavior later even in the presence of testosterone; the converse can be done to females. The fetal mouse brain is exquisitely sensitive to the organizing effect of hormones” (Cooper 1985, 1400).

A recent hypothesis suggests that neural pathways imprinted at crucial stages of brain development later profoundly affect sexual behavior and choice of a sexual object. Certainly, without the secretions from the embryonic testis no male organs can develop. It now seems possible that subsequent sexual feelings and behavior will also be influenced by testosterone produced in utero. Variations in the amount secreted or blocking of the hormone’s actions by maternal stress or drugs have been shown to make major differences in the eventual sexual life of the developing embryo (Dorner 1983). Animal studies, although difficult to generalize to humans, have confirmed the crucial role that prenatal androgens have in sex-role behavior when puberty arrives (MacCulloch and Waddington 1981).

A recent, unconfirmed study by Zuger suggested that early effeminate behavior in male children is congenital and is the best single indicator of later homosexuality (Zuger 1984). A new book has suggested the same conclusion.

Richard Green, a UCLA psychiatrist in *The Sissy Boy Syndrome and the Development of Homosexuality* chronicles the development of forty-four boys who preferred traditionally feminine activities at an early age. Three-fourths of them grew up to be gay or bisexual, Green found. He felt that these boys' early preference for feminine activities may reflect an innate tendency toward homosexuality. A reviewer summarized:

They were chosen for the study because from very early childhood, their behavior was considered out of the mainstream of normal sexual development. Many dressed up in girls' or women's clothing and reported that they wanted to be girls, not boys. When asked to draw pictures of people, they would often draw females rather than males . . . Many scientists agree that the causes are complex and involve a combination of biological and environmental factors—some beyond parents' control. Green's research and similar studies contradicts the belief that homosexuality is simply the result of a domineering mother and a weak father" ("Sissy" 1986).

The effect of hormones on the brain is not inevitably all-or-nothing. It is possible to be masculine without being also completely unfeminine, or conversely, to be feminine without also remaining completely unmasculine (Money 1984). This may help explain why we see such a wide spectrum of human sexual behavior and appearance.

Duane Jeffery has examined the problem of intersex developmental defects in humans. He states that primitive gonads, the "ovotestes," are each part female tissue (ovarian) and part male (testicular). Genetic and developmental conditions can produce syndromes of intersex confusion that lead to both medical and theological difficulties. He does not explore the question of homosexuality and limits his discussion to the anatomical and gender identity disorders, concluding, "The very existence of human intersexes poses some interesting unanswered questions in LDS traditions and beliefs (Jeffery 1979, 108).

Jeffrey Keller recently (1986) addressed the question "Is sexual gender eternal?" Despite reassurances from various General Authorities that "there is no mismatching of bodies and spirits," modern biology has demonstrated numerous examples of physical and hormonal miscues that challenge our theological concepts.

In a few females, the excessive production of testosterone by the adrenal glands during gestation causes a relatively rare condition called the androgenital syndrome (AGS). These girls are born with masculine genitalia that can be mistaken at birth for that of a boy. The condition can be surgically repaired and treated with hormones, and the girls develop a normal feminine physique and undergo normal puberty. Yet, a large percentage of these girls grow up as tomboys who show little interest as teenagers in dating. As adults, "a startling 37 percent are homosexual or bisexual or have sexual fantasies about women" (Hales 1984, 23). Again, testosterone is the powerful hormone of desire that affects the developing male and female prior to birth. Significantly, it is well known that testosterone given after puberty does not alter the direction of sexual choice but may intensify the general libido.

The regulation of testosterone in utero is a biological, congenital, developmental event and does not represent a true genetic disorder (that is, coded, specific, preembryonic information carried by DNA in the genes of chromosomes). The genetic (inherited) transmission of homosexuality has been suggested by some investigators, but current research, with the exception of a single study, does not seem to favor this thesis. Kallman (1952) studied eighty-five homosexuals who were twins; and although the concordance rates for overt homosexual behavior were only slightly higher than normal for the forty-five dizygotic pairs, the rate was 100 percent for the forty monozygotic pairs. This finding suggests the presence of a definite and decisive genetic factor in homosexuality, but Kallman's findings have not been confirmed by other researchers. On the contrary, quite the opposite was found by Kolb (1963), showing no concordance in his identical twin study (Marmor 1976). The development of sexual identity comes after conception and is unlikely to be the result of specific information carried in the chromosomes. I believe that the crucial factor is the timing and amount of testosterone released in utero by the developing embryo. We will all have to wait for further studies to illuminate these various biological hypotheses.

THE ENVIRONMENT (EFFECTS OF NURTURE)

It has long been argued that behavioral sex in human beings is learned. It has long been assumed that infants have a neutral gender role. Toys, dress, and play patterns all begin working to determine ultimate sexual orientation. Little girls are supposed to like pink, and boys are inclined to blue. Girls are given dolls, and boys receive toy trains and trucks. Sex roles are supposed to work out just fine if the child is given clear and unambiguous messages about his or her sexual destiny.

As early as 1905, Sigmund Freud began probing the family backgrounds that could produce homosexuality and other sexual deviations (Marmor 1976). Every clinician, including myself, learned that passive, weak, or absent fathers, coupled with strong, dominant, and castrating mothers set up the perfect climate for the induction of homosexuality. Inability to form a satisfactory identification with an adequate father figure and development of a strong, unconscious fear or hatred of women was the prerequisite for this psychosexual disorder. Indeed, many cases seemed to bear out Freud's observations, but all of these clinical studies are by their nature retrospective and in selected populations. Recent research on large, randomly selected populations of homosexuals shows no valid statistical correlation with this family pattern. Many men with backgrounds similar to those supposed to produce homosexuality do not grow up to become gay.

A similar type of reasoning regarding the cause of schizophrenia was suggested in the 1960s and was widely accepted. "Schizophrenogenic" mothers were accused of giving repeated double-bind messages to their offspring, creating bizarre thinking, delusions, and hallucinations. Few psychiatrists familiar with current research in genetics and brain chemistry would advocate the

1960s kind of explanation for a disorder that is now clearly seen as a brain disease.

Other learning theories and behavioral hypotheses have been suggested but generally are subject to flaws similar to those that we see in Freud's original postulates. A study from the Eastern Highlands of New Guinea involving Sambia men and boys revealed that strong homosexual conditioning did not result in adult homoerotic behavior. Despite heavy reinforcing of unlimited fellatio in prepubertal boys and youths and powerful teachings that female bodies are poisonously dangerous, Sambia men are almost always heterosexual. As youngsters, the boys are very close to their mothers and are told the secret of masculinity — a man is only the shell of a man unless he drinks plenty of semen. The boys engage in homosexual activities, which they regard as pleasant, and sexual relations with women are strictly taboo. As marriage time approaches, the young men develop the "desire for women as gripping for these tribesmen as it is anywhere else." Upon marriage, in the late teens or early twenties, the taboo is reversed — homosexuality is forbidden (Stoller 1985). This is a rather troublesome outcome for behaviorists who insist that positive and negative reinforcement shapes sexual preference. The results also imply that teaching or recruiting young males to become homosexual is unlikely to produce homosexuality except in those who are biologically predisposed. In addition, these learning theories blame parents and families, implying that in some mysterious way they cause or can prevent the emergence of homoerotic behavior. Although fascinating, these speculations ignore much of the biological basis for human sexuality.

However, environmental factors are not unimportant. On the contrary, we can say that homosexuality, transsexuality, and transvestitism are probably determined by many psychodynamic, biological, sociocultural, and situational factors. Environmental factors can profoundly shape the style, expression, and quality of sexual behavior in all of us, whether straight or gay. Yet, as we have seen, considerable evidence exists for the fundamental biological determination of sexual identity and object choice, and evidence for core, environmental causes is questionable. Apparently environment fine tunes the instrument of sexuality but neither creates nor organizes its direction. More difficult research is needed, but the evidence accumulated over the past two decades for the biological causality of sexual and gender identity, although inconclusive, is persuasive.

SIN, SEXUALITY, AND RELIGION

Religions have a vested interest in advocating a sexual code of conduct. The Judeo-Christian tradition has long regarded the monogamous human family as the finest and best way to provide offspring loving security and moral integrity. Anything that threatens this goal threatens achievement of a moral universe; it is not surprising that homosexuality and other sexual variations are met with such antipathy in our culture. Religious leaders from the Apostle Paul to modern-day prophets have strongly condemned sexual deviancy. For many years in the Mormon church, homosexuality was referred to as "the sin

that has no name” (Anonymous 1978). Homosexuals have found no home in Christian or Jewish faiths.

In other cultures, attitudes toward homosexual activities vary widely. A 1952 study of seventy-six societies observed that in 64 percent of the societies homosexuality was considered normal and acceptable, at least for some members of the community. In the remaining 36 percent homosexuality, though condemned, continued to occur secretly (Marmor 1976).

The accepted assumption has been that homosexuals have chosen their lifestyle and have knowingly entered into sin. Spencer W. Kimball has written, “Homosexuality is an ugly sin, repugnant to those who find no temptation in it, as well as to many past offenders who are seeking a way out of its clutches” (Kimball 1969, 78). Society at large has generally agreed with this conclusion. Patrick J. Buchanan, now a White House staffer, implied divine punishment in the AIDS plague. In 1983 he wrote, “The poor homosexuals — they have declared war on nature, and now nature is exacting an awful retribution” (Clark et al. 1985, 20). He apparently made no reference to the plight of innocent children, hemophiliacs, and others who contracted the disease.

Do homosexuals consciously choose their sexual identities? Are they more capable of doing this than those of us who are heterosexual? Is not sexual identity something to which we awaken rather than something that we decide by some rational, moral process? Do you remember choosing to be straight when you were thirteen? I have never met or treated a homosexual who felt that he or she had a choice in the matter. From their earliest recollections, they knew that in some way they “were different,” and all felt confused, guilty, and frightened.

Mormon homosexuals experience a special, poignant pain. How can they fit into the celestial plan of things? Where do they go to resolve the conflicts surging within their realm of moral responsibility? How do they reconcile their feelings with divine revelation?

Sensitive and thoughtful articles in *Sunstone* and *DIALOGUE* have examined this issue. Marvin Rytting acknowledges, “I do not know *the* answer. But I do know that I cannot condemn my gay friends. Nor can I insist that they change nor that they should forgo love. All I can do is care about them — and accept them. I am convinced that the Gospel of Jesus Christ has room for them. I hope that some day the Church can make room, too” (Rytting 1983, 78). The problem is illustrated in John Bennion’s fictional interview between a tormented young man and his stake president, who expresses acceptance, love, and empathy but offers no resolution to the agonizing dilemma of the young man’s homosexuality (Bennion 1985).

THE CLINICAL SPECTRUM

The personality spectrum among homosexuals is as diverse and complex as it is among heterosexuals — “from passive ones to aggressive ones; from shy introverts to loud raucous extroverts; from theatrical, hysterical personalities to rigid, compulsive-obsessive ones; from sexually inhibited, timid types to sexually promiscuous, flamboyant ones; from radical activists to staunch conservatives;

from defiant atheists to devout churchgoers; and from unconscionable socio-paths to highly responsible, law-abiding citizens" (Marmor 1976, 382). The homosexual stereotype of the limp-wristed, effeminate fag is as distorted as is the Rambo stereotype for heterosexual men.

Every occupation, social class, race, and creed is represented in the gay and lesbian world. Many are married, have children, and lead quiet, conservative lives. Sexual drive and the exclusivity of homosexual interest vary widely. A 1970 study of participants in the impersonal sex of public restrooms found that 54 percent were married and living with their wives and children in middle-class homes and were, for all intents and purposes, just "average guys next door" (Humphreys 1970).

The same variations occur among Mormons. In an anonymous monograph published in 1978, a homosexual author states, "We belong to your priesthood quorum, we teach your Sunday school class, we pass the sacrament to you each Sunday, we attend your primary classes, your faculty meetings, your family reunions and your youth conferences. We sell you your groceries, we keep your books, we police your streets and we teach your children in school. We preside over your wards and even your stakes. We are your sons, your brothers, your grandsons, and who knows but by some riddle of nature, we would be you" (Anonymous 1978, 56). From my own clinical experience of twenty-four years, I can attest to this diversity.

The families of homosexuals, whether parents, wives, husbands, siblings, or children must often live with confusion, anger, shame, and sorrow. They feel helpless and guilty. Perhaps several million homosexuals and lesbians have chosen marriage as the "perfect closet" in which to hide their secret. *Married and Gay* chronicles the poignant struggles experienced by those who find themselves living in these unions (Maddox 1982). Single-parent mothers worry that lack of a strong male figure will foster the development of sexual inversion in their sons. Yet, in his famous "Letter to an American Mother" Sigmund Freud wrote, "Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness; we consider it to be a variation of the sexual functions produced by a certain arrest of sexual development" (Marmor 1976, 385).

Some men struggle for years to change their orientation or to experience an inkling of heterosexual interest. Beyond traditional psychotherapy, scripture reading, and Church counseling, some have sat for hours viewing pictures of naked men while receiving painful electric shocks for negative behavioral conditioning. Some claim a cure, which many view with skepticism. Others resignedly accept their situation, while still others become bitter, disillusioned, and nihilistic. Some claim they have found love, comfort, and self-acceptance in their homosexuality. The spectre of excommunication looms over all who refuse to change their ways. The most tragic cases seek the ultimate out of suicide. A minority choose to lead abstinate, celibate, or morally neutral lives. The capacity to choose this solution varies widely, just as it does for heterosexuals.

In addition to many homosexuals, I have worked with a few transsexuals and transvestites. These situations represent a different level of core sexual

identity and sex role behavior, respectively. A female transsexual may live with the absolute belief that she is male and be willing to undergo multiple, painful surgical procedures to achieve this end. A pseudohermaphrodite, known to be genetically female, received hormonal therapy and a hysterectomy and eventually proceeded, as a male, to priesthood ordination and a temple marriage.

How can we understand and ultimately reconcile the biological, social, religious, and moral questions posed by such situations? Clearly, there is no easy solution to these most intimate of human circumstances.

MORAL RESPONSIBILITY AND TREATABILITY

Confusion and misunderstanding surround homosexuality, and blatant hostility, rejection, and scorn are often directed toward those involved. Critics are often unable to find any redeeming qualities in the homosexual and often see the lifestyle as chosen and learned, refusing to acknowledge possible biological origins. A *Church News* editorial observed in 1978, "Then on what basis do the adherents to this practice demand special privilege? Who are they that they should parade their debauchery and call it clean? They even form their own churches and profess to worship the very God who denounces their behavior — and they do not repent. They form their own political groups and seek to compel the public to respect them. Do other violators of the law of God receive special consideration? Do the robbers, the thieves, the adulterers?" (16 Dec. 1978, 16). Many gays internalize and accept religion and society's abhorrence of their sexual preference and become their own persecutors.

What lies behind these reactions to the homosexual? The severe homophobic is perhaps easiest to understand. These people often harbor serious fears about their own sexual identity. They overcompensate by bullying and brutally teasing gays. Projecting and displacing hatred is a common and convenient way to run from one's own inner conflict.

Many people, in and out of the Church, seem to want homosexuals held fully accountable for their sexual feelings and behavior. Yet, if conscious choice is not involved, can we legitimately invoke the charge of sin? And, if homosexuals do not act on these sexual feelings, have they morally transgressed? Does the revealed word of God in the scriptures supersede the experience and reality of millions of homoerotic individuals? Is it morally responsible to offer promises of cure? What of the larger question in some minds: Would God have anything to do with the creation of homosexuals or transsexuals? What kind of tricks has nature played on us humans? Does the new psychobiology challenge our treasured concepts of human responsibility and free will? Does man's (or woman's) destiny reside in the intricate workings of the hormones and the spiral helix of DNA?

The question of treatment and curability of homosexuality is just as controversial as is its causes. "Treatment implies disease. Disease implies cure and the duty to seek or to strive for cure. Many ordinary people, as well as those judges who sentence homosexuals to some form of therapy in lieu of prison, believe that homosexuality is like dandruff, a condition that one can get rid of if one will only take the trouble" (Maddox 1982, 156). In 1973 the Ameri-

can Psychiatric Association (APA) voted to remove homosexuality from its diagnostic manual of mental disorders. Gay activists demonstrated in San Francisco in support of this decision. Homosexuals were to be distinguished from heterosexuals only by their choice of an erotic object. This variation of human sexuality implied no impairment in judgment, stability, or reliability. An APA statement issued after the vote said of the resolution, "This is not to say that homosexuality is 'normal' or that it is as desirable as heterosexuality" (Roche Report 1974, 8). The debate over treatment issues was never settled by the landmark decision, and attempts to change orientation and behavior of homosexuals continues.

Masters and Johnson's 1979 book, *Homosexuality in Perspective*, has been applauded for its aims but ridiculed for the secrecy surrounding the research techniques and claims of a nearly 75 percent cure rate. Treatment was concentrated in a fourteen-day format with a strong emphasis on behavioral change with a heterosexual partner of the opposite sex. Thoughtful critics suggested that Masters and Johnson were actually treating bisexuals or maladjusted heterosexuals and ignored the psychological aspects of fantasies, emotional attachments and crushes, and arousal patterns of true homosexuals (Marano 1979). Aversion therapy treats subjects with electric shocks or drugs designed to induce vomiting when they are shown pornographic male photos. Many homosexuals find these methods especially onerous. As poet W. H. Auden said, "Of course, Behaviourism 'works.' So does torture" (In Maddox 1982, 167).

In one elaborately structured, four-part study N. McConaghy, of the University of New South Wales, Sydney, Australia, asserted that while homosexual arousal and behavior can be reduced by aversive therapy, a true homosexual orientation cannot be reversed. One hundred and fifty-seven homosexual patients were treated with various forms of behavior therapy. The majority desired to have conscious homosexual feelings reduced or eliminated. The homosexuals lost their strong arousal patterns and sensed a resultant weakening of homosexual feelings. Their basic orientation, however, remained unaltered. No evidence indicates that other treatments are more effective in reducing homosexual and increasing heterosexual behavior (Coogan 1977).

In recent years attempts to cure homosexuality have been replaced by therapeutic goals and strategies designed to improve the quality of life for homosexuals (Lowenstein 1984; Davison 1976). My clinical experience demonstrates that fewer persons enter treatment seeking to change their sexual orientation; rather they come to deal with the anxiety, depression, and conflict attendant to their specific interpersonal struggles, losses, and fears. From my perspective, changing a patient's homosexual nature presents the same challenge as would changing the orientation of a committed heterosexual. Yet, since sexuality represents a spectrum of feelings and behaviors, some individuals can plausibly shift along that spectrum to some degree. The cure reports in the literature come most likely from those people who are both highly motivated to change and have a relatively modest move to make along the continuum between homosexuality and heterosexuality.

Where does this leave the majority of homosexuals, male and female, who have never experienced significant heterosexual feelings or fantasies even though they may have struggled in vain to arouse them? They have been told, "Homosexuality and like practices are deep sins; they can be cured; they can be forgiven. Sin is still sin and always will be. It will not change. Society might relax in its expectations; it may accept improprieties but that does not make such right and approved. Total transformation in ideas, standards, actions, thoughts, and programs can cleanse you" (*Church News*, 16 Dec. 1978, 16).

To remain active, loyal, guilt-free, and accepted in the Mormon church, homosexuals must do two things — remain celibate and abstain from engaging in eroticism with a member of one's own sex. This is *the* moral choice with which they are faced. They did not choose to be homosexual with any conscious, reasoned intent. Nor, for that matter, did any heterosexual choose to be straight. As I have argued, we all awaken to our sexual identity. The questions of moral responsibility come after this awakening. The moral agony for the committed Latter-day Saint who happens to be gay will often last for a lifetime. As Brenda Maddox has stated, "Those who want their gayness and God too are going to have a long struggle. They are asking that the churches, by nature conservative, give up their interest in the personal life of their clergymen and change their philosophy of the purpose of marriage. For full equality under the sacrament, gay Christians [Mormons] may have to wait until easier questions are settled, questions like the ordination of women and the gender of God" (Maddox 1982, 194).

My clinical experience has indicated that the majority of Mormon homosexuals eventually drift away from their faith, live tenuously in the closet, or react with angry disillusionment. They ask, "Why did God make me this way?" That question should trouble all of us. Granted, we do live in a natural universe where biological uncertainties and ambiguities are obvious. Biological equality at birth is a myth. Intelligence, athletic skill, handedness, musical and artistic talent, and a host of other characteristics vary widely among *Homo sapiens*. Yet, the Mormon homosexual faces a peculiar distress. He or she is commanded to reject the behavior as well as the feelings and fantasies that invade the consciousness of sexual awareness.

Marvin Rytting challenges us to imagine being a confirmed heterosexual suddenly transported to a culture where homosexuality is the norm. Consider the dilemma of facing a hostile majority who insists that, "I must be erotically aroused by men and that it is a sin, a crime, and an illness for me to be attracted to women." He describes the fantasy of going into therapy with a good behaviorist and submitting to multiple shocks to suppress his attraction to naked women. "I can picture myself claiming to be cured to avoid the shocks, but I cannot imagine really being cured," he admits. He describes the attempts to play a passive role, forcing his body to do something that his mind cannot enjoy. He reflects on what it might be like to be a Mormon in this alien culture. "I not only have to deal with the guilt of wanting to have sex with a woman but also the shame of not being married to a man." He

realizes that he would lose any standing in the Church and be told to “grow up and stop being selfish and get married.” The fantasy ends as he is filled with unresolvable guilt, withdraws into a lonely and asexual shell, and loses any happiness he had with the Church. His article concludes, “For a while I was comfortable with the position that it was OK to have homoerotic feelings but not to act upon them. After all, the rest of us have to live without sex outside marriage. But even that answer does not fit any more. For me to have sex only with my wife is simply not the same as being eternally celibate.” The most difficult part for Rytting in this mythical culture is not giving up sex. “I would go crazy if I had to give up the love and affection and romance — the touching, the hugging, the cuddling. Is it really moral to ask people not to love?” (Rytting 1983, 78).

In many minds, homosexuals do not love but only indulge their sexual appetites in an endless orgy of promiscuous encounters. During the pre-AIDS era, a substantial number of homosexuals did exhibit this behavior. A Kinsey Institute study completed on a large sample of San Francisco gays revealed that “the average male subject had had more than five hundred sexual partners in his lifetime. Among the white males in the study, 28 percent reported more than a thousand” (Maddox 1982, 195). I know of no post-AIDS figures, but I would suspect a significant drop in such behavior.

Such findings are repugnant to most people and reinforce the hostility to the homosexual population as a whole. Yet San Francisco is not Provo, and sensitive, quiet, industrious gay people live in both communities. Love, commitment, sharing, and caring are not virtues restricted to heterosexuals.

Homosexuality is a part of the human condition. Concerns about responsibility swirl around this issue and range from the conviction that “everything is your fault” to “nothing is your fault.” The same can be said for a myriad of other human conditions as diverse as poverty, mental illness, drug abuse, and obesity. Clearly, pursuing an extreme position is pointless. We sometimes labor under the illusion that we have more free choice than we can sensibly expect. We are slowly learning the limitations that our biological nature imposes on us. Yet, we are also intentional, rational, spiritual, and moral beings who cannot escape the freedom that consciousness and agency grants to us. How we balance this uneasy alliance between our nature and our nurture is what makes us human.

I do not know the answers, and I suspect that no one among us does. Perhaps the best we can hope for is the willingness to reject prejudice, ignorance, and self-righteousness and to embrace tolerance and understanding. Finally, only fools will fail to recognize that the world brims with such existential and spiritual dilemmas, and the vast majority of these riddles have no simple, tidy solutions. My final question is, “Which of you wishes to shoulder the ultimate moral responsibility when dealing with such profound mysteries?”

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