Authorized excerpt from *Walking the Bridgeless Canyon — Repairing the Breach Between the Church and the LGBT Community* by Kathy Baldock, published by Canyonwalker Press, 2014, canyonwalkerconnections.com

Available at CanyonwalkerPress.com and on Amazon, Kindle and Audible.

The Myth of a Pink and Blue World

Sex, Gender, and Sexual Orientation

God made male and female

In the preceding chapters, we've explored the historical, cultural, and conjoined religious and political filters through which we view the lesbian, gay, bisexual, and transgender (LGBT) community. Finally, we're inching toward looking at the six passages of Scripture involving same-sex behavior. First, however, we need to better understand sex, gender, and sexual orientation. Since many of the Bible verses are rooted in male and female language, let's start with what the ancients believed about the creation of male and female.

In the fourth century BC, Aristotle argued that a woman was merely the fertile planting ground in which the male seed, containing all the ingredients needed to produce a human, grew. If the "heat" of a man's semen could overcome the "coldness" of the woman's body, a male child would form; in instances of failing male dominance, a female (of lesser value) would form.

Historically, a multitude of "abnormalities" in babies were thought to be the curse of God. In fact, in ancient Israel, those born with or acquiring defects, deformities, or illnesses were denied access to the temple area.[1] Babies born with both male and female genitals were thought to be mythical.[2]

We don't know much about "abnormal" births historically because medical records weren't kept until the 1800s. The little we do know and can find in various documents informs us that when babies were born with genitalia neither fully male nor fully female, they were categorized as "monstrous births."[3] The "monsters," it was believed, were sent by God as a divine warning and judgment on immoral behavior, such as a mother having "unclean and unnatural" sex during her menstruation. After all, God created only male and female, and the "monster" was surely God's punishment.

Three revolutionary breakthroughs happened in the 1870s that would eventually influence our understanding of sex, gender, and sexual orientation. Oscar Hertwig (1849–1922), a German zoologist, discovered that a human embryo was formed when a male sperm fertilized a female egg. Fellow German Walther Flemming (1843–1905) discovered that human cells had pairs of chromosomes carrying genetic code. And, as we discussed in Chapter 1, Karl Kertbeny noted and grouped people together by the sex to which they were attracted.

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[1] Leviticus 21:18-21 (NIV) reads: "No man who has any defect may come near [the temple]: no man who is blind or lame, disfigured or deformed; no man with a crippled foot or hand, or who is a hunchback or a dwarf, or who has any eye defect, or who has festering or running sores or damaged testicles. No descendent of Aaron the priest who has any defect is to come near to present the food offerings to the LORD. He has a defect; he must not come near to offer the food of his God."

[2] Elizabeth Reis, "Intersex in America, 1620–1960," *University of Oregon Blog*, 415, http://blogs.uoregon.edu/healarts/files/2014/04/Hermaphrodites_Reis-24qs8ss.pdf.

[3] Ibid., 415.

God made male and female and . . .

The Bible says, "Male and female, he created them."[4] People often assume the verse says "male or female." This interpretation is really an oversimplification of God's design. The diversity of ways in which people are created is beginning to be understood as never before. Let's take a fresh look at sex and gender.

Did God make only male or female? Some folks have difficulty accommodating anything beyond the tidiness of "male plus female equals God's perfect will." But sometimes males are born with ovaries, female brains are placed in male bodies, and individuals are attracted to people of the same sex. These aren't defects or the curse of God for immoral behavior, as the ancients would have seen them; they are normal variations of human development.

"But," you may object, "an omniscient God knew and inspired the biblical writers to pen what they did." Of course God did. Though a full understanding of the diversity of human sexuality and the richness of God's creation only began to unfold over the last century (as has much of our knowledge of human development, psychology, and sexuality), it all fits beautifully into God's timeless truths and complex creation.

Here's where the challenge begins. Some people view science as scary, or as a threat to the truths in the Word of God, so they avoid scientific research and knowledge, or simply dismiss it. But science and faith aren't mutually exclusive. Both are necessary for thoughtful consideration of important theological questions pertaining to life sciences and human behavior, as well as to sex, gender, gender identity, and sexual orientation. Wading through some basic biology will give us a broader understanding and appreciation of the vastness of God and His design. For the sake of this discussion, I have simplified the complexity of the science. (If you'd like to go further and do more in-depth study, I have found that *Sex/Gender Biology in a Social World* [5] by Anne Fausto-

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[4] Genesis 1:27 (NIV).

[5] Anne Fausto-Sterling, *Sex/Gender Biology in a Social World* (Oxford: Routledge), 2012.

Sterling, Professor of Biology and Gender Studies at Brown University, uses humor and excellent graphics to make biochemistry, neurobiology, and social constructs of gender accessible to most readers.)

For starters, some definitions will prove helpful: "Sex" refers to a person's biological status and is typically associated with male or female as indicated by physical factors: sex chromosomes, reproductive systems, gonads (ovaries and/or testicles), and genitalia. "Gender" is a set of social, psychological, and emotional traits influenced by societal expectations that classify a person as being male or female, or even somewhere along the spectrum from male to female.[6]

Every human cell has genes containing hereditary coding. The genes, either alone or in combination, express a person's physical traits. It is estimated that there are 150 different genes that influence height. So, if you ask, "Is there a gene for being tall?" the answer would be no, there is not just *one gene* for being tall, but that doesn't mean there is no genetic influence for height.[7]

In the past five years, scientists have discovered chemicals called epigenes which sit on top of genes (*epi,* meaning "on top of") and act like "on" and "off" switches. Epigenes don't change the genetic coding, but they can affect whether genetic code is expressed or not. Epigenes can be temporary and untraceable, or they may imprint a gene and pass the effects of the on-off switch from one generation to the next. Epigenes influence vast numbers of traits, including sex, gender, sexual orientation, and even disease. Geneticists are only beginning to understand the effects of epigenes.

Genes are arranged along strands of DNA on chromosomes. Humans have twenty-three pairs of chromosomes. The twenty-third pair determines whether a person is chromosomally male, designated as XY in genetics, or female, designated XX. When a sperm cell fertilizes an egg,

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[6] Laura Erickson-Schroth, *Trans Bodies, Trans Selves* (New York: Oxford University Press, 2014), 614.

[7] Wayne Besen, "Real Scientists Debunk JONAH's Junk Science" (video), September 24, 2012, https://www.youtube.com/watch?v=bjCj7i87dM0#t=139.

the resultant embryo receives chromosomes from each parent. Right from the start, some of the genes from the parents may have been modified by the on-off switches caused by epigenes.

When the embryo's twenty-third chromosome is formed, most of the time it's either female XX or male XY, but in one out of 1,666 instances, it's not.[8] The cell may not divide properly; rather than carrying two Xs or one Y and one X, there may be extra Xs or Ys, or fewer Xs or Ys in the embryo. Besides XX and XY, other naturally occurring variations of the twenty-third chromosome include XXY, XO (the O indicates that neither an X or a Y is present), XXX, r , and XXXY. The twenty-third chromosome is, therefore, not female XX or male XY; this individual is a third sex, or intersex.

So, it turns out, God created male and female, and intersex. Non-XX and non-XY chromosomes are only one way in which intersex people are created; there are others.

First, let's look at the most common way. Female XX embryos typically produce estrogen that stimulates the beginnings of ovaries from the fetal gonad. Male XY embryos typically produce male hormones called androgens that include testosterone and DHT. Male androgens shut down development of the female reproductive system, which is the initial "default" structure for every embryo. Male androgens begin to turn the undifferentiated fetal gonad into testes rather than the ovaries they otherwise would have become.

As early as between the eighth and the twelfth week of gestation, genes typically "know" to produce male hormones or female hormones that will work to differentiate the gonads into either testes or ovaries. Yet sometimes variations arise. Here's an instance where epigenes can modify the genetic messages which control appropriate levels of hormone production: While a fetus might be strictly XX or XY from a chromosomal standpoint, a female might develop testes, or both testes

[8] "How Common Is Intersex?" Intersex Society of North America, http://www.isna.org/ faq/ frequency.

and ovaries, and a male might develop ovaries, or both ovaries and testes. I know it sounds confusing! The external genitals can still appear strictly male or female, yet the person is neither male nor female, but intersex.

Is intersex common?

During the third month of gestational development, external genitals form; their formation is controlled by hormone production and levels. Depending on the measurements and standards used, one in every 1,500–2,000 births results in a baby born with ambiguous genitalia.[9] These babies are intersex.

So what exactly is intersex? Recall that sex is determined by chromosomes, internal reproductive systems, ovaries and/or testicles, and external genitalia. When at least one of those components is out of alignment with the others, a person is intersex. God created male and female, and intersex.

As mentioned above, until the 1900s, babies born with ambiguous genitalia were considered monsters and a curse from God for the mother's or father's immorality. We no longer view babies who are born intersex as defects or monsters because now we understand the science behind intersex births.

Before we see what doctors today advise for treatment of intersex babies, let's look at what was done with them between the 1950s and 2000, which led directly to the initial (mis)understanding of the concept of gender, and even sexual orientation.

Treatment of transsexuals and intersex people leads to discoveries about gender

Throughout history, there have been people who did not fit gender stereotypes. The Native American culture honored those recognized as both male and female as Two-Spirit people thought to possess great

[9] Ibid.

power.[10] The modern American culture, however, has seen things quite differently. Until the late 1940s, psychiatrists viewed people who wanted to change their outward expression to express the opposite sex as "mentally ill deviants."[11]

The science of understanding individuals who are born with their gender in conflict with their genital sex began in Europe. The earliest sex change surgeries took place in Austria and Germany in the 1920s. When sex changes became known through the American media, the public was immediately fascinated. In 1952, the *New York Daily News* announced: "Ex-G.I. Becomes Blonde Bombshell."[12] Twenty-six-year-old George Jorgensen (1926–1989), a former soldier in the Army, had undergone a sex change operation in Denmark and returned home as Christine Jorgensen. New York City–based endocrinologist Dr. Harry Benjamin (1885– 1986) was Jorgensen's doctor in the United States. Benjamin helped his patients bring their birth sex into alignment with their internal sense of being a man or a woman, even before gender was understood as some- thing different from sex. This process of gender and sex alignment could never have been medically successful prior to the 1950s. What changed was that newly created synthetic hormones became widely available, and advancements were made in plastic surgery during World War II. Medical help became accessible for people who felt that their biological sex was not in accordance with their internal sense of identity.

Jorgensen had undergone surgery in Denmark to remove her testes and penis. Upon her return to New York City, she continued hormone therapy under the care of Dr. Benjamin, who also scheduled her for vaginoplasty, the creation of a vagina. The work was scheduled at Johns Hopkins Medical Center, where the earliest American sex reassignment surgeries were performed.

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[10] "What Are Two-Spirits/Berdaches?" American Indian, First Nations, Aboriginal Two Spirit/GLBTQ Internet Resources, http://people.ucalgary.ca/~ptrembla/aboriginal/two-spirited-american-indian-resources.htm.

[11] Lynn Conway, "What Causes Transsexualism?" University of Michigan, April 7, 2003, http://ai.eecs.umich.edu/people/conway/TS/TScauses.html.

[12] *Trans Bodies, Trans Selves*, 508-509.

Jorgensen's transition was highly successful. She spent the rest of her life living publicly as a role model, educating and lecturing on college campuses. She summed up her transformation in a letter to her friends: "Remember the shy, miserable person who left America? Well, that person is no more and, as you can see, I am in marvelous spirits."[13]

Dr. John Money (1921–2006), a New Zealand–born psychologist and professor of pediatrics and medical psychology, was also on staff at Johns Hopkins from 1951 until his death in 2006. He assisted in many of the adult sex reassignment surgeries. While working in the Sexual Behaviors Unit, Money and his colleagues developed theories about behavioral traits and social conventions as they related to being either male or female. The behavioral differences had previously been referred to as "sex roles." Money wanted terminology to distinguish erotic and genital sex activities from typical male or female nonsexual activities. In 1955, he appropriated the word "gender," previously used to distin- guish masculine and feminine nouns in some languages, to differentiate social roles from sexual roles.

Money creates protocol for intersex children

While progress was being made in the field of medicine and sex change surgeries, there were, unfortunately, some major setbacks when it came to decisions made for babies born with ambiguous genitalia. Prior to the 1950s, babies born neither 100% male nor 100% female were thought to have a birth defect. Sometimes, often without even discussing the birth oddity with the parents, doctors did "minor" surgeries to "correct" the infant's genital anomalies. Besides his work with adult genital surgeries, Dr. Money became a pioneer in the virtually unexplored field of infants born with ambiguous genitalia.

Despite the fact that there was almost no evidence of adults who had been born with ambiguous genitalia suffering mental health problems

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[13] Christine Jorgensen, *Christine Jorgensen: A Personal Autobiography* (New York: Bantam Books, 1967), 105.

beyond the normal range, Money theorized that re-engineering the ambiguous genitalia of babies would shape them into happier, healthier adults. He further postulated that a person's internal sense of being, male or female, was not established until age three.

He had no evidence for this theory; it was simply a hunch. When asked about the gender of a child, Money said, "It seems that every child is born with some predisposition to go both ways. Which way it finally goes is determined by its environment."[14] Money popularized the "nur- ture over nature" argument with relation to gender. Though this theory has long since been dismissed in the scientific community, it persists to this day in some conservative circles where a person's—and in particu- lar, a child's—environment is blamed as the reason a person might be gay or transgender.

Money and his colleagues combined the practical experience they had gained in overseeing adult sex reassignment surgeries and Money's "genderless before age three" theory to help create a "best practices" regimen for babies born with ambiguous genitalia. Routine surgeries by doctors to "correct" ambiguous genitalia on infants commenced on a wider scale because they thought this would fix the "problem."

If an infant's genitals were not clearly male or female, doctors were taught to make their sex-of-the-baby decision based on the length of the infant's penis. If the penis was longer than an inch, the baby was a boy. If the penis was shorter than an inch, surgery was performed to make the genitals look like a girl's. More girls were "created" than were boys because it was "easier to dig a hole than build a pole."[15]

Parents of these babies were instructed to raise the child as the sex and in the gender role correlating with the corrective surgery. Sometimes, when doctors performed "slight corrective surgeries" on infants, they never explained what the birth complications were or gave options to parents; they cut first and told later, if at all. At the time, this medical

[14] "Hopkins Pioneer in Gender Identity," *Baltimore Sun*, July 9, 2006.

[15] Morgan Holmes, I*ntersex: A Perilous Difference* (London: Associated University Press, 2008), 148.

practice did not violate ethical standards. People didn't question doctors; they trusted medical professionals to make the best decisions for their children. Parents complied with "expert" advice.

Dr. Money fabricates and "proves" a theory about gender

Dr. Money wanted the fame of his "genderless until age three," "nurture over nature" theory to be solidified in a seminal research paper, but he needed the perfect case study. He got his break in 1967 from a tragic event in a family of Canadian farmers. Twin sons, born in 1965 to Janet and Ronald Reimer, had been suffering urination difficulties caused by non-retracting foreskins on their uncircumcised penises. When brothers Bruce and Brian were eight months old, their pediatrician recommended they be circumcised. During the procedure on Bruce, the machine used to cauterize his circumcision wound malfunctioned and his penis was burned to a stump beyond repair. Alarmed, the parents did not allow the procedure to be performed on Brian and took both children home.

Fourteen months later, Janet Reimer saw Dr. Money on a television interview where he was speaking about his extensive work with children born with ambiguous genitalia. He claimed that such an infant should undergo corrective surgery to make the baby distinguishable as either male or female. He said the child would become a well-functioning boy or girl and, hence, a healthy adult as a result of surgically altering the genitals and socially adapting the child to the gender role matching the external sex.

Concerned about Bruce's happiness and his future ability to function sexually as a man, Janet Reimer contacted John Money at the Johns Hopkins Medical Center. Money tried to persuade the Reimers to have 22-month-old Bruce undergo immediate sex reassignment surgery; they didn't go for it. As a step-down, Money recommended the removal of Bruce's penile stump and testicles and the introduction of an immediate

regimen of female hormones. Additionally, Money instructed the parents to change Bruce's name to a female name, to never again speak about him as a boy, and to begin raising him as a girl.

The Reimers complied with several of Money's suggestions. They stopped short of vaginoplasty and the removal of his penile stump, but they did have Bruce's testicles removed, changed his name to Brenda, began to raise him as a girl, and exposed the newly named Brenda to exclusively female-gender activities and roles.

Money flew the family back to Johns Hopkins once a year to interview Brenda and her twin, Brian. The Reimers had no idea Dr. Money was writing a medical journal documenting the progress and "success" of Brenda's gender role reassignment. In his writings, Money referred to the study as the John/Joan case.

Brenda's gender reassignment was an utter failure. She never displayed any naturally typical feminine behaviors. Contrary to the overwhelming evidence of failure, Dr. Money continued to report the gender reassignment as a success. He wrote: "The child's behavior is so clearly that of an active little girl and so different from the boyish ways of her twin brother."[16]

As she approached the onset of puberty, Brenda's body began to masculinize and Money knew time was running out to perform a vaginoplasty. He told Brenda she would feel and look more like a girl and, to his purposes, act more like a girl. She consistently refused.

In 1978, Money made an aggressive effort to convince 13-year-old Brenda into surgery by inviting a transsexual[17] woman who had undergone adult corrective surgery to help coerce the child. The effort backfired. Brenda ran out of the appointment and told her parents that if they ever tried to force her to go back to Money, she would kill herself. Faced with a suicidal 13-year-old, the parents ended the family si- lence and told Brenda and Brian the truth. Brenda, who had recalled

[16] Diane F. Halpern, *Sex Differences in Cognitive Abilities* (Psychology Press, 2013), 163.

[17] Transwomen were called transsexuals at the time.

distinctly feeling like a boy since age nine, immediately became David. As an adult, in retrospect, David remembered being happy at this point for the first time in his life. For twin Brian, the revelation triggered the onset of mental illness, which intensified over the years. When David grew older, he sued the pediatrician who had circumcised him for dam- ages, got a penile implant, and married a woman.

Money's lies exposed

Outrageously, seventeen years later, Money was still reporting about the "successful" gender reassignment in medical journals! In 1997, at the age of thirty-two, David discovered that Money had been reporting lies about the supposed success of the John/Joan case. By then, Dr. Money's theory was established and had created "best practices" and medical standards that had been in use for four decades.

Not wanting another person to be destroyed by Money's theories, David encouraged his brother to participate in an exposé in *Rolling Stone* magazine detailing Money's false reporting. Soon after the story broke, Brian's mental illness worsened. He committed suicide by overdosing on his schizophrenia medication. Two years later, David Reimer, experiencing marital problems and never able to recover from lifelong depression, also committed suicide. Mother Janet Reimer blamed Money for the deaths of her sons and for using them as guinea pigs to test his gender theories.

In the United States, from the 1950s through the late 1990s, babies born with ambiguous genitalia were treated according to Money's assumption that gender was not inborn but could be nurtured by the child's environment before age three. Even when publicly exposed for lying, Dr. John Money never again commented on the case.

Fortunately, there have been other expert voices in the field of gender research. Beginning in 1972, Dr. Milton Diamond (1934–), a professor of anatomy and human sexuality, professionally challenged Money's "nurture over nature" gender theories. Diamond's research and findings

could not get the necessary attention from the public to challenge Money's entrenched policies until after Money was finally exposed as a fraud in 1997. Now, however, Diamond and the Pacific Center for Sex and Society continue to produce well-respected research papers on sex- uality, gender, transgenderism, and sexual orientation.

Besides a fascinating story, the John/Joan/David Reimer case highlights several issues of prime importance about sex and gender that can be applied to questions surrounding sexual orientation. First, the body of evidence collected over several decades from adults who underwent unnecessary and wrong gender assignment and sex reassignment surgeries teaches us that trying to match gender to genitals should not be a standard. Gender and genitals do not necessarily align. Gender is an innate trait established within the fetal brain.

Furthermore, the attempt to change what is natural and inborn in a person has devastating effects on lives. Rather than collect mental health information directly from adults who had been born with ambiguous genitalia, Dr. Money created theories based on his own flawed assumptions. Scientific research would not have validated Money's theories. The same neglectful methods had been used in the psychoanalytic community in dealing with gay men and women. Doctors talked *about* gay men and lesbians and decided how to "fix" them without talking *to* them or conducting any kind of fact-based research.

Without intentional malice, doctors invariably made incorrect decisions for four decades by following Money's protocol for assigning sex and gender to babies born with ambiguous genitalia. Corrective geni- tal surgery was done in at least one in every thousand births.[18] Using even the most conservative estimates, at least one quarter of a million Americans now over eighteen years of age were subjected to these flawed, unethical, and *standard* practices. Many children were raised in genders unnatural to them.

[18] "How Common Is Intersex?"

Michael's story

This is the story of my friend Michael, who is in his late forties and is a medical doctor. He was one of the hundreds of thousands of children caught in the Money trap.

Michael identifies as male but was assigned female sex and gender at birth. Michael was born with no testes in his scrotum, a small vaginal opening with fused labia, and the opening to his urethra misplaced on the underside of his penile shaft. Because his genitals were ambiguous, initial chromosomal testing was done and he was diagnosed as an XX pseudohermaphrodite.[19]

Michael's parents were told to have his penis removed, consent to vaginoplasty, put him on hormones, and raise him as a girl. They agreed to a female gender assignment and hormone treatment, but not to female sex reassignment surgery, as it was then called.

Michael's chromosomes were tested again at age eight. He was diagnosed as 46 XY/XX mosaic male with male and female genitalia being raised as a female. Growing up, he was never at ease with his non–gender-conforming body. He felt very uncomfortable naked; he was very conscious that physically, he looked different from other girls, and he had always struggled with living as a girl. He preferred short hair and never wanted to wear feminine clothes. At the onset of puberty, he was attracted to females, yet the label "lesbian" did not make sense to him.

At sixteen, Michael asked his parents and doctor about his physical differences. Once he became aware of his intersex condition, he refused any further hormonal treatment.

Michael now lives as a man. His body is androgynous due to the intake of synthetic female hormones until age sixteen. He went to college and medical school as a female, so all his professional licensing is under his female name. In the past, potential employers assumed that

[19] "Pseudohermaphrodite" is an outdated term for a condition in which a person has the primary sex organs of one sex, but develops the secondary sex characteristics of the other sex. In Michael's case, he was born with an organ classified as a clitoris, yet had a scrotum, though without testicles.

he was transgender, and this prejudice has impacted his professional career. As an adult, he has suffered with trust and intimacy issues, depression, and thoughts of suicide. Past medical and social attempts to change Michael into a girl have had grave consequences on his life—consequences that still linger today.

Treatment of intersex babies today

There are thirty-one known intersex conditions, one of which is called XXY Klinefelter condition; one in one thousand babies is born with Klinefelter's.[20] Before the new standards, virtually all Klinefelter babies were raised as girls. Now, with the benefit of better research, two-thirds of Klinefelter babies are being raised as boys. That's quite a significant adjustment in standards and an important corrective concerning mistaken gender.

Only since 2004, through the work and education of intersex advocates, have the secrecy and shame been lifting off the intersex population and their families. In 2005, a group of pediatric endocrinologists recommended calling intersex conditions "disorders of sex development" or DSD. The most informative site I've found is Intersex Society of North America (ISNA).[21] The advocacy group associated with ISNA is Accord Alliance.

New medical standards of care for intersex babies were established in 2006. Somewhat reliable data is being collected to allow more informed conversations to take place at the birth of such babies. Because there is no way to know the gender of an intersex baby, experts recommend that intersex children be allowed to manifest their natural, innate gender, which may be witnessed as early as two years of age, usually by age three, and almost universally by age six. Not identifying a gender in an intersex baby may be socially difficult for parents, causing them

[20] Klinefelter Syndrome," Intersex Society of North America, http://www.isna.org/faq/conditions/klinefelter.

[21] Intersex Society of North America, http://www.isna.org.

uneasiness or even hostility on the part of others, but it can save the intersex person from a life of frustration, and mental and emotional anguish.

Transgender—when gender and sex are not in alignment

Misgendering tens of thousands of children over a half-century period has proven that people have an internal sense of gender. The positive outcome of the Money debacle is that it led to a body of knowledge about sex and gender that has added to our understanding of people whose sex doesn't align with their internal sense of who they are.

For 99.5% of people, biological sex and gender are aligned; the term for this is "cisgender." For the 0.5% whose gender does not match their sex, the term is "transgender."[22] The word "transgender" was coined in 1965 by psychiatrist John Oliven to differentiate between transvestites, those who for sexual arousal or emotional comfort dress in the cloth- ing opposite to their birth sex, and transsexuals, those who have an internal sense that their gender is opposite to their birth sex and desire to express the internal sense in their dress and behavior. Although Oliven's intent was to differentiate the two concepts, the word "trans- gender" was picked up and used in the transvestite community, making it a confusing term until the end of the 1990s. The words "transgen- der," "transsexual," and "transvestite" were often used interchangeably for decades. "Transgender" evolved both into a larger umbrella term for many groups expressing gender variance,[23] and into the term for a

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[22] Gary Gates, "How Many People Are Lesbian, Gay, Bisexual and Transgender?" The Williams Institute, April 2011, http://william-sinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/how-many-people-are-lesbian-gay-bisexual-and-transgender/.

[23] *Cross-dresser* – A person who, either part- or full-time, dresses as the gender they were not assigned at birth. People cross-dress for a variety of reasons, including comfort, eroticism, and even shock value. A cross-dresser may be male, female, or intersex. A cross-dresser may have any one of a variety of sexual orientations.
Transvestite – A person who dresses in the clothing of the other gender, sometimes for sexual pleasure; the term is no longer in common usage.

specific group—those who experience dissonance between their birth sex and their internal sense of gender. The latter is the meaning I use throughout this book.

So, why are people transgender? Just as with those who are intersex, there is no single reason why about one in every thousand people is transgender.[24] Back to our basic biology lesson:

Researchers believe gender is likely established as a result of the release of hormones during fetal development once biological sex is set. This occurs in the fourth month when the brain circuitry is developing. Both genetics and hormones influence the fetal brain. The amount or lack of particular hormones released may be enough to establish the genitals of one sex or the other, but not enough to genderize the brain to match the sex. We don't know absolutely for sure how gender is established. What researchers do know is that the fetal brain is hardwired by the end of the fourth month of gestation and that gendering is part of that process.

When a baby is born, the doctor and family can know the baby's sex: male, female, or intersex. At that point, though, nobody can know the gender of the child. As babies develop into toddlers, they pick up cues from their environment and begin comparing themselves to peers and to adults. Unconsciously they begin wondering, "Who am I like, and who am I not like?"[25]

By age two, without the language skills to communicate it or the words to verbalize it, children know the difference between female and male. Researchers have created fascinating tests to prove just how much

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Drag queen or drag king – A performance artist who has a stage persona often not part of their daily life.

Androgynous – A person who blends both male and female characteristics in their appearance.

Genderqueer – A person who does not stay within the confines of masculine or feminine dress; one who blurs the lines and often invents their own expressions of gender. People who identify in this group may also be termed "gender benders."

[24] "How Many People."

[25] Alix Spiegel, "Q&A: Therapists on Gender Identity Issues in Kids," NPR, May 7, 2008, http://www.npr.org/templates/story/story.php?storyId=90229789.

toddlers are aware of. By age five, a child knows if he or she belongs to male or female groups, and into which group he or she most comfortably fits. Most boys fit in with boys and men, and most girls know they "belong" with girls and women. However, not all children fit into the group corresponding with their biological sex. By age five, those who don't fit in are aware that something is "different" about them.

Lisa Salazar's story

When I set up the Board of Directors for Canyonwalker Connections Ministry, I intentionally asked Lisa Salazar, a Christian transwoman, to join me so I would have strong representation from the "T" in LGBT. Lisa was born Santiago Salazar in the early 1950s in Colombia, grew up in California with the nickname Jim, and now lives in Vancouver, British Columbia. Ever since Lisa can remember, she felt a disconnect with her body:

> From my earliest memory, I felt something was amiss. I didn't like to see my private parts and avoided looking down when I was naked. I distinctly remember sitting in the bathtub in three inches of water and carefully laying a washcloth over my genitals to hide them from my eyes as I played with my bath toys. I surmise I could not have been more than three years old at the time.
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> This feeling that something wasn't right wasn't based on me having seen a girl's body and deciding I had extra parts. I was probably ten years old before I ever saw an image in a textbook of what a girl's body looked like. By the time I understood what some of the anatomical differences were, I was already estranged from my body. So where did this disconnection come from, and what did it mean?

> The few times I tried getting answers, I didn't have the language for it. The questions kept piling up inside, but I just kept my mouth shut.
>
> My childhood prayers to wake up as a girl had been abandoned by high school, and I started to most fear that someone might find out how messed up I felt inside. I was careful not to say anything or ask any questions that could betray my secret struggle. I even worried when I had sleepovers with friends that I might talk in my sleep and say something and my life would be over. Adding to the confusion, I thought, "If I am really a girl, then I should be attracted to boys," but I wasn't [attracted] to boys.

When Jim was a junior at San Jose State, he became a Christian and believed that, with God's power, his internal struggle of feeling like a woman would finally come to an end. Despite his best efforts, those feelings never went away. Thinking it was an attack from Satan, Jim used his "thorn in the flesh" to draw closer to God.

When he fell in love with a young woman he met at a Bible study, it seemed as though his prayers to be "normal" were being answered. Five years into the marriage, and by then a father of two, Jim still felt his body was the wrong sex. The shame and burden of his struggle were overwhelming. He reasoned that the burden hadn't gone away because he hadn't shared the secret with his wife; so he did. Together they committed themselves over the next eight years to raising their sons while seeking God in earnest for healing.

In the early 1990s, Jim turned forty and, full of despair and shame, sought help from a psychiatrist, who recommended he go to the newly opened Gender Clinic at Vancouver General Hospital. Jim did not take the advice; as a Christian, he believed that God only created male or female. He chose to carry the burden for nine more years and constantly

thought about death as a way to end the internal pain. Finally, Jim decided to go to the Gender Clinic, hoping that nine additional years of gender research had finally found a cure. Following a six-month evaluation, it was recommended that Jim undergo a regimen of hormones and genital reassignment surgery and live as a woman. Afraid of the social, religious, and familial costs, Jim again walked away.

Eight more years passed. The internal pain was intense. Jim was faced with a decision: transition or commit suicide. The psychiatrist assured Jim that, given the choice, people would rather he be alive as a woman than dead as a man. This time, Jim invested the time he needed to study the Bible in depth to reconcile his transition process with God's Word. In 2007, unsure of when he would begin living full-time as Lisa, Jim began to disclose to family and friends about the changes to come. In early 2008, Lisa started hormone treatment and, six months later, began living full-time as a woman. By March 2010, Lisa had completed her surgical transition.

Lisa's wife, who had been supportive of Lisa's struggles, waited one more year before asking for a divorce. For her, the marriage was over; she wanted a husband. Had they stayed together, people would see them as a lesbian couple, which was a deal breaker for the woman who had married Jim. Lisa, who identifies as a lesbian, still loved her wife and would have preferred to stay married. Lisa has covered the details of the entire story in her book *Transparently.*[26]

More about transgender people

There are about 1.5 million transgender Americans, or approximately 0.5% of the population. Whereas 65%[27] of Americans know someone who is gay or lesbian, only 9%[28] know someone who is transgender.

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[26] Lisa Salazar, T*ransparently: Behind the Scenes of a Good Life* (Self-published, 2011).

[27] "Survey: A Shifting Landscape: A Decade of Change in American Attitudes about Same-Sex Marriage and LGBT Issues," Public Religion Research Institute, February 26, 2014, http://publicreligion.org/site/wp-content/uploads/2014/02/2014.LGBT_REPORT. pdf.

[28] Ibid.

Transgender adults and children are coming into self-awareness and becoming more public about their identity than they did in the past. Realization of transgender issues and the wider availability of resources is making it easier for parents to assist their children into gender and sex congruence at earlier ages.

As classified in 2013 by the American Psychiatric Association's *Diagnostic and Statistical Manual-5* (DSM-5), transgender people have a condition known as gender dysphoria. Until this most recent DSM revision, the diagnosis had been gender identity disorder (GID). Reclassification to gender dysphoria accomplishes two things: It recognizes the significant social distress associated with having the condition, and it helps decrease social, occupational, and legal stigmatization by eliminating the word "disorder." Although transgender people have a naturally occurring condition, keeping gender dysphoria listed as a condition in the DSM ensures that access to proper care under medical insurance plans is protected.

People assigned male at birth, but who more closely identify with being female, are known as transwomen, male-to-female, MTF, or, as some of my trans*[29] friends remind me, simply women. Conversely, people assigned female at birth, but who more closely identify with being male, are known as transmen, female-to-male, FTM, or, again, simply men. I've noticed that those in the trans* community who work to raise awareness often refer to themselves as transmen, transwomen, or transgender persons. Those who want to live a more obscure life simply identify as a man or a woman, dropping the modifier "trans."

Transitioning is when a person begins the process of expressing a gender not in alignment with their birth sex. Corrective surgery is referred to as genital reassignment, or reconstruction, surgery (GRS). In the past, it was referred to as sex reassignment surgery (SRS), but this term is not technically accurate. As we've learned, sex is a combina- tion of chromosomes, reproductive systems, and genitals. Corrective

[29] "Trans*" is shorthand for "transman," "transwoman," and "transgender."

surgery for a transgender person doesn't change the sex chromosomes; therefore it is properly known as GRS.

Nonsurgical transitioning may be a person's only option or their personal choice. Not every transperson wants to go through or can afford GRS. Nonsurgical options include implementing a combination of any or all of the following: change of clothing, makeup, hairstyle, and mannerisms, or hormone therapy. A birth male transitioning to a female gender expression may bind down his genitals, remove body hair, take estrogen, and grow a longer hairstyle. Others have their Adam's apple shaved and even their faces and chin line feminized. A birth female transitioning to a male gender expression will likely bind her breasts, begin taking testosterone, and cut her hair in a masculine style.

The way in which transpersons choose to physically express themselves is highly personal. Some elect to go through few external changes while others opt for more elaborate makeovers. For a transperson, trying to fall within the socially prescribed typical male or female gender expressions may be extremely difficult, if not impossible. The effects of a lifetime of other-sex hormones on the body are often irreversible. One of the major benefits of transitioning at a young age is to not be burdened by decades of "wrong" hormones coursing through one's body.

The trans* population suffers a disproportionately high rate of underemployment, homelessness, harassment, and family rejection.[30] Forty-one percent have had suicidal ideation or have attempted sui- cide.[31] Many do not have legal documents matching the gender in which they present. In some states, even getting documents changed from a person's birth sex to reflect their gender identity is not legally possible.

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[30] Paul Guequirre, "Transgender Workers at Greater Risk for Unemployment and Poverty," Human Rights Campaign, September 6, 2013, http://www.hrc.org/blog/entry/ transgender-workers-at-greater-risk-for-unemployment-and-poverty.

[31] Ann P. Haas and Philip L. Rodgers, "Suicide Attempts among Transgender and Gender Non-Conforming Adults," Williams Institute: American Foundation for Suicide Prevention, January 2014, http://williamsinstitute.law.ucla.edu/wpcontent/uploads/AFSP-WilliamsSuicideReportFinal.pdf.

Transetiquette

Although it is natural to be very curious when meeting a transman or transwoman, it's never polite to ask a transman or transwoman about their genitals. Would you think it acceptable if someone asked you about what is inside your underwear? If you are not a potential sex partner or a medical provider, the genitals of another human being, including someone who is transgender, are none of your business.

"Transgender" is an adjective, so "transgendered" is not the proper word; neither is it correct to call someone "a transgender." Also on the "no" list are several completely inappropriate words: "she-man," "she-male," and "tranny."

If you are unsure of a person's gender, it is polite to ask how he or she (or a variety of pronouns now emerging) would prefer to be addressed. The confusion involving gender identity is typically not on the part of a transgender person; they know how they identify. The only way to clear up your own confusion is to ask. A simple question can usually solve your discomfort; ask the same question you might ask any person: "What is your name?" Most transgender people select gender-specific names aligned to their new identity. Use pronouns associated with a person's gender identity; to do otherwise is highly insensitive and, frankly, mean-spirited.

When a person transitions, they might be attracted to the same sex as they were before their transition, or not. Once sexual-social restric- tions are lifted off people who were previously closeted as trans*, they may feel more free to express who they are and to whom they are at- tracted. Which brings us to sexual orientation.

What is sexual orientation?

All people have a biological sex (male, female, or intersex), a gender (male, female, or along the spectrum from male to female), and a sexual orientation. Sexual orientation indicates the sex to which one is naturally attracted.

Sexual orientation is not a fully accurate term because it implies that orientation is only sexual; however, orientation includes emotional and romantic attractions along with sexual attractions. Sexual orientation has three components: sexual identity, sexual behavior, and sexual attraction. Most often, all three are congruent, but not always.

Sexual identity is a personal label an individual uses to describe his or her own sexual attractions. Sexual behavior is the manner in which people regularly express their sexuality. Sexual attraction defines the sex to whom one is naturally attracted. For the majority, all three are in sync. In Chapters 11 and 12, which focus on reparative therapy and mixed-orientation marriages, we'll read stories about people who label themselves heterosexual and engage in heterosexual behavior, yet have a homosexual orientation.

Professional, social, familial, or religious pressures can influence how a person chooses to identify sexually and express his or her sexuality.

Sexual orientation, and sexual attraction in particular, can be organized into general groups:

- *Heterosexuality* – Attraction to the opposite sex: male attraction to females, or female attraction to males. Heterosexual attraction occurs in about 95% of the population.
- *Homosexuality* – Attraction to the same sex: Male attraction to males, or female attraction to females. Homosexuality occurs in about 3.5% of the population, with 11%[32] of the population acknowledging at least some same-sex attraction and behavior.
- *Bisexuality* – Male attraction to both males and females, or female attraction to both males and females. Bisexuality occurs in about 1.8%[33] of the population.
- *Pansexuality* – Attraction to people of male or female sex, whether gender is male or female. A pansexual's attraction

[32] "How Many People."

[33] Ibid.

is not limited by either the sex or the gender of their partner. Pansexuality occurs in less than 1% of the population.

- *Asexuality* – Lack of sexual attraction to either males or females. Asexuals may experience romantic attractions without interest in sexual activity. Often, they participate in sexual activity to please their partners or to have children. Asexuality occurs in about 1% of population.[34] Asexuals may describe their own romantic attractions as heteroromantic, homoromantic, biromantic, panromantic, or aromantic.

All of these traits exist along a spectrum. All combinations and permutations are natural and to be expected as normal variations of human sexuality.

The science of sexual orientation

A rapidly developing body of knowledge strongly indicates that there is a genetic component to sexual orientation; however, there is more going on than just genetics.

Gendering and sexual orientation may be influenced by epigenes from the parents' chromosomal contributions. Recall from the beginning of this chapter that epigenes influence the quantity and type of hormones released during fetal development. As noted earlier, gender, and possibly sexual orientation, is likely established in the brain circuitry by the end of the fourth month of fetal development.

A 2014 study[35] of the DNA of over four hundred gay and straight men indicates that a section on the X chromosome, inherited from the mother, may influence sexual orientation. Other chromosome sections seem to be involved as well, but, as in the example shared earlier regard- ing tallness, there is likely not just one single "gay gene."

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[34] "Research Relating to Asexuality," AvenWiki. http://www.asexuality.org/wiki/index.php?title=Research_relating_to_asexuality.

[35] Michael Bailey, "The Science of Sex and Attraction," American Association for the Advancement of Science in Chicago, Annual Conference, 2014.

Hormones in the fetal environment impact sexual orientation as well. Brain scans that have long indicated observable differences in the brains of heterosexuals and homosexuals have, in recent years, shown such differences *in utero*.[36]

The more times a woman becomes pregnant with a son, each subsequent son's chance of being gay increases by 33%.[37] The strongest theory behind this observation holds that the mother produces testosterone-blocking antibodies in response to carrying a male fetus. These testosterone blockers stay in her body and influence subsequent fetal sons, but not daughters. Hormones don't affect male and female fetuses in the same manner, so there isn't a similar increase in the likelihood of subsequent daughters being lesbians.

Most of the studies involving homosexuality have been conducted on men. Studies on the sexuality of lesbians are more recent. Researchers are discovering that sexuality is more fluid for women than it is for men.[38] Women tend to be more driven by relationships than by the sex of the partner.[39] In studies, even women who identify as strictly hetero- sexual respond to female sexual stimuli when posed in the context of relationship at higher rates than do strictly heterosexual men.[40] What is known about male sexuality cannot be directly transferred to female sexuality, whether heterosexual or homosexual.

One such example is the effects of testosterone on fetuses. Researchers know that a female fetus subjected to an excess release of testosterone in the fourth month of development has a greater chance of being a

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[36] Kim Smythe, "National Geographic Explains the Biology of Homosexuality – Epigenetics" (video originally presented December 2008), posted to YouTube April 3, 2013, https://www.youtube.com/watch?v=H831wTEkSFE.

[37] A. Bogaert and R. Blanchard, "Homosexuality in Men and Number of Older Brothers," *American Journal of Psychiatry* 153 (1996), 27-31.

[38] "Lisa Diamond on Sexual Fluidity of Men and Women" (video), Cornell University, December 6, 2103, https://www.youtube.com/watch?v=m2rTHDOuUBw.

[39] Meredith Chivers, "The Puzzle of Women's Sexual Orientation – Why Straight Sexuality Isn't So Straightforward in Women" (video), WhomYouLove2012, October 17, 2013, https://www.youtube.com/watch?v=nSnywIol20A.

[40] Ibid.

lesbian than being heterosexual. Testosterone is measurable because it lingers in the baby's postnatal body. But testosterone in a female fetus doesn't *always* affect the developing girl, so something else is going on.[41] Likewise, measurable hormone inhibitors which block normal levels of testosterone absorption by a male fetus can create an environment where there is an increased chance that the male will be gay. Prenatal androgens that block testosterone absorption by male fetuses alter both the gait and vocal intonation of the adult male, who will likely identify as gay.[42]

Genes, epigenes, and hormones all influence sexual orientation. We just don't know the precise formula of the interaction and what the exact components are.

> Brain neurology, however, is measurable. There are distinct differences in the brains of homosexual and heterosexual people of the same sex. The hypothalamus of a male homosexual brain has many similarities to a female heterosexual brain. Homosexual men, like heterosexual women, are generally more empathetic than are straight men, as well as being better with verbal fluency, spatial distances, and language skills.[43]

Conversely, lesbians, like heterosexual men, tend to hear lower-pitched sounds and, on average, throw objects (softballs, basketballs, footballs) better than heterosexual women.[44]

Eighty percent of youth who will later identify as gay or lesbian start displaying strong signs of gender-nonconforming behavior as early as age three.[45] Most children who will later identify as gay or lesbian know

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[41] Sabrina Richards, "Can Epigenetics Explain Homosexuality?" *NeuroScientist News*, January 1, 2013, http://www.thescientist.com/?articles.view/articleNo/33773/title/CanEpigeneticsExplainHomosexuality/,

[42] *Sex/Gender Biology.*

[43] James Owens, "Gay Men, Straight Women Have Similar Brains," *National Geographic*, June 16, 2008, http://news.nationalgeographic.com/news/2008/06/080616-gay-brain.html.

[44] Joan C. Chrisler, *Handbook of Gender Research in Psychology* (Springer Science, 2010), 225-227.

[45] Eric Vilain, "Born This Way: Biological Tales of Sexual Orientation" (video), WhomYouLove2012, posted to YouTube October 9, 2013, https://www.youtube.com/watch?v=9MhzXaYOBDk.

between the ages of five and eight that they are different, but they don't yet know how. By puberty, they usually understand that they are at- tracted to the same sex. (We expand upon sexual orientation in gay and lesbian youth in Chapter 14.)

While there is no consensus as to the root cause of sexual orientation, it is agreed by all medical and health care professionals that orientation is not related to a child's postnatal social environment. In other words, there is nothing to indicate that parenting or early-childhood events, such as abuse, affect either gender or sexual orientation.

Feeling like outsiders and sensing that they should not talk about the differences they are experiencing often makes these children more vulnerable to abusers. While there is a higher correlation between homosexual orientation and becoming a victim of sexual abuse, the abuse does not cause homosexual orientation; rather, the orientation makes a child more susceptible to the abuse.[46] This scenario is frequently twisted backwards to say that childhood abuse leads to homosexuali- ty.[47] This is patently false. The fact is that shamed children are easy and vulnerable targets for abusers.

The parts don't fit—or do they?

Throughout the history of human sexuality, "rules" about what people should and shouldn't do sexually with their partners, even their own spouses, were wrapped up in cultural and religious taboos. Many of those old prohibitions carry over to our lives even today, and we're largely unaware of the origin of the beliefs.

An interesting case in point affects every American male to some degree. The percentage of male circumcision in the United States over the last century is directly linked to beliefs and taboos surrounding

[46] "The Problem with the Belief that Child Sexual Abuse Causes Homosexuality, Bisexuality," Pandora's Project, 2009, http://www.pandys.org/articles/abuseandhomosex- uality.html.

[47] "Facts about Homosexuality and Child Molestation," University of California, Davis, Psychology Department, http://psychology.ucdavis.edu/faculty_sites/rainbow/html/facts_molestation.html.

masturbation. In the 1870s, only one percent of American males were circumcised. By 1970, that number had risen to 90%.[48] The increase is totally attributable to taboo and myth. Circumcision was seen as a preventative measure to stop the "self-abuse" of masturbation with its threatened imaginary side effects of mental illness and sterility. Wrote Leslie Weatherhead in 1931:

> In olden days—not so very olden either—this practice was painted as the blackest of all possible sins. Anyone who practiced it was pretty sure of hell. Our grandfathers, including our medical grandfathers, if they did not avoid all reference to it, taught that it was not only a dreadful sin, but that also it had physical and mental consequences which were terrible, these consequences being regarded as the just punishment of God for human wickedness. It was said that the victim of this habit invariably brought disease upon himself and that if he did not speedily check it he would go mad. . . . The only hope of cure held out was said to lie in the exercise of the victim's will assisted by religious exercises of prayer and Bible reading.[49]

Similar prohibitions on sex acts—again, even between husbands and wives—have existed for centuries. For the most part, we remain unaware as to why we perceive some acts as "icky" and unnatural.

In the ancient world, sex was divided along two major axes: purpose (procreative or non-procreative) and role (active or passive). Immorality and "sin" were easily defined within those boundaries. In the 19th century, any sexual behavior not intended to lead to procreation, even

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[48] "A Short History of Male Circumcision," http://www.whale.to/a/circumcision1.html.

[49] Leslie Weatherhead, *The Mastery of Sex through Psychology and Religion*, 1931. Cited in: Ralph Blair, "The Real Changes Taking Place in the Ex-Gay Movement," Evangelicals Concerned Inc., Fall 1986, http://ecinc.org/the-real-changes-taking-place-in-the-ex-gay-movement/.

within marriage, was considered by society to be immoral, and by the religious community to be sinful. Regarding the roles played (as we learned in Chapter 1), simply put, men who took the passive role in sex were disgraced. This concept is intrinsically connected to the low value placed on women. However, we (at least in the United States and many other countries of the world) no longer live in a culture where to be like a woman is contemptible, so the sexual taboos attached to patriarchal cultures have been disintegrating over time for both heterosexual and homosexual behavior.

Some non-procreative sexual acts commonly enjoyed today by heterosexual couples were taboo only sixty years ago. Sexual-social norms in general have changed dramatically in the past century. Today sex is seen as an opportunity to express affection, desire, comfort, bonding, love, and passion for one's partner. Sex isn't just about coitus for the sake of making babies anymore. A 2010 Indiana University study de- fined forty different ways in which people regularly engage in sexual practices.[50] Warning: If you are bothered by imagining or thinking about "gay sex," skip the next few paragraphs. The bottom line of this section is this: Sexual intercourse works just as well for gay people as it does for straight people.

What follows is a primer on human sexuality leading to better understanding of "gay sex," with much of it equally applicable to the "heterosexual lifestyle" for the sake of added heterosexual enjoyment. Let's start with an anatomy lesson.

All men, gay or straight, have a prostate, a walnut-sized gland located between the bladder and the penis and just in front of the rectum, an area of the body with an abundance of nerve endings. Stimulation of the prostate gland with a finger or the penis inserted into the rectum via the anus can be highly pleasurable and can lead to orgasm. It can be

[50] "Sex Practices National Survey of Sexual Health and Behavior," Indiana University, 2010, http://www.nationalsexstudy.indiana.edu/graph.html.

a safe practice between partners in loving sexual exchanges, caring for each other by using lubricants and condoms.

Not all gay couples engage in anal sex, and not all couples who engage in anal sex are gay. One-quarter of all heterosexual women under age forty participate in anal sex; the numbers vary across age demographics and ethnicity.[51] Likewise, many heterosexual men derive great pleasure from their female partners stimulating their prostate glands.

During the Victorian Age, and until the middle of the 19th century, women of social status typically did not participate in sex for pleasure. It was considered "vulgar."[52] Historically, heterosexual acts have been focused on male pleasure; women's sexual enjoyment came more into focus with the availability of birth control options. Whether a woman even had clitoral or vaginal orgasms was debated until Masters and Johnson "proved" in the 1950s that women experienced both.

Most women do not reach orgasm through coitus alone. Only one-third of women climax with coitus, another one-third with coitus plus additional stimulation, and another one-third only with stimulation other than coitus.[53] Two women having sexual contact with each other don't need a penis to reach orgasm. In fact, women have a higher chance of being pleased by other women because they rely on non-penile stimulation by their partners. Putting it plainly, the "natural way" of having male-female sex is typically more satisfying for heterosexual men than for heterosexual women.

How clever of God, the designer of human sexuality, to create the human body in such a way as to allow ample provision for mutually satisfying relationships between loving couples! Though used by many a preacher in the pulpit, the "male plug and female adaptor-cord analogy" is limiting, even for heterosexual couples. It describes one type of sexual interaction. Human sexuality is far more complex and beautiful than electricity.

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[51] Ibid.

[52] *Marriage, a History*, 190.

[53] "Female Orgasm: Myth and Facts," The Society of Obstetricians and Gynaecologists of Canada, http://sogc.org/publications/female-orgasms-myths-and-facts/.

In terms of sex between same-sex partners, the objection that "the parts don't fit" doesn't make sense on even the most logical level. If the parts didn't work together, frankly, people wouldn't be putting them together. Gay sex not only fits—it works.

Human sexuality is far more elaborate than male and female and men with women. It is certainly more complicated than those who penned the words of the Bible or lived before the turn of the 20th century could have imagined.

Finally, we're ready to look at the passages of Scripture often used to create a Christian sexual ethic for lesbian, gay, bisexual, and transgender people, and for believers in general. Armed with some basic understanding about the biology and the science of sex, gender, and sexual orientation, we can allow the knowledge to inform us about the beauty and diversity of God's natural creation as it acts in harmony with the richness of God's spiritual recreation.

Walking the Bridgeless Canyon examines the lenses through which we, in particular Christians, have come to view the LGBT community. One by one, each chapter of the book explores the historical, cultural, psychological, medical, social, and religious views of the LGBT community.

Authorized excerpt from *Walking the Bridgeless Canyon — Repairing the Breach Between the Church and the LGBT Community* by Kathy Baldock, published by Canyonwalker Press, 2014, canyonwalkerconnections.com

Available at CanyonwalkerPress.com and on Amazon, Kindle and Audible.